CQC Draft Action Plan

County Durham and Darlington NHS
NHS Foundation Trust

				CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
1	A&E	A&E Quick Wins	Must Do	Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.	UHND now cleaned 24x7 and DMH (currently 12 hours) moving to this shortly. Cleaning audits undertaken weekly by the monitoring officer. Schedules in place for corridors and floors and rooms cleaned as close as possible to schedule given use.	• Implement 24x7 cleaning at DMH	24x7 cleaning to commence at DMH on 1st November 2015. Cleaning audits on going on a weekly basis.	A McCree	31/10/15
2	A&E	A&E Quick Wins	Must Do	Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.	UHND now cleaned 24x7 and DMH (currently 12 hours) moving to this shortly. Cleaning audits undertaken weekly by the monitoring officer. Schedules in place for corridors and floors and rooms cleaned as close as possible to schedule given use.	• Replacement of equipment and chairs that have deteriorated.	Chairs ordered - awaiting delivery. Delivery of x20 second-hand wipe-clean, stacking chairs received by ED, UHND.	Shane Longden	31/10/15
3	A&E	A&E Quick Wins	Must Do	Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.	UHND now cleaned 24x7 and DMH (currently 12 hours) moving to this shortly. Cleaning audits undertaken weekly by the monitoring officer. Schedules in place for corridors and floors and rooms cleaned as close as possible to schedule given use.	• Effectiveness of implementation of cleaning changes and nursing responsibilities (blood spillages for example are the responsibility of nursing staff to clean up) to be checked on Back to Practice Fridays.	Cleanliness of the ED, UHND was assessed as part of 'Back to Practice' session on 17/09/15 and all areas of the department were found to be clean. Cleanliness will be reviewed regularly by matrons and as part of 'Back to Practice' sessions, and is an agenda item on departmental meetings.	Jayne McClelland	Initial action complete - checks ongoing. 30/09/2015
4	A&E	A&E Quick Wins	Must Do	Ensure all toys are cleaned properly to reduce the risk of infection wihtin the A&E department.	Cleaning schedules in place for toys in both A&E's (cleaned daily and cleaning signed off).	• Review the need for toys in A&E against alternatives e.g. pre-packed and disposable colouring books.	Toys removed and disposable packs in place.	Stephen Cronin / Jayne McClelland	31/10/2015 - Complete
5	A&E	A&E Quick Wins	Must Do	Ensure sharp bins are managed appropriately to reduce the risk of needle stick injury within the A&E department.	Weekly audits of sharps bins and communication of issues to nursing staff at the time of the audit.	• The audit and checking process for sharps bins and resuscitation trolleys / airway kit to be checked on Back to Practice Fridays.	Assurance of actions assessed on 'Back to Practice' session 17/08/15 and this will form part of a regular process. Sharps Bin Audit is conducted monthly and results displayed on Staff Notice Board. Agenda item on departmental meetings and Infection Control to be involved. New sharps bins to be ordered at UHND, which offer greater protection to staff against risk of sharps injury. Intention to be used accross both EDs.	Jayne McClelland	Monitoring - complete New bins - 30/11/2015
6	A&E	A&E Quick Wins	Must Do	Ensure that all resuscitation drugs and equipment within the A&E department are regularly checked, cleaned and in date. This should include all grab bags and anaphylaxis kits.	Resus trolley drugs checked twice daily and equipment daily. At UHND drug expiry dates checked weekly. Checklist in place and signed off. Sample audits also undertaken by the CAP Team.		Back to Practice session 17/9/15 revealed all resuscitation drugs were in date in every drawer and the grab bag. All fluids in date. Grab bags were all kitted correctly as was the anaphylaxis kit. Three members of staff could demonstrate where the difficult airway kit was kept.	Jayne McClelland	Initial action complete - checks ongoing
8	A&E	A&E Quick Wins	Must Do	Ensure that all relevant staff know where the difficult airway kit is kept.	All staff have been advised of where the Difficult Airway kit is kept.	• Location of difficult airway kit to be included in induction and induction to be completed.	Back to Practice session 17/9/15 revealed three members of staff spoken to could demonstrate where the difficult airway kit was kept.	Jayne McClelland	Initial action complete - checks ongoing
9	A&E	A&E Quick Wins	Should Do	Encourage all relevant staff to attend violence and aggression training within the A&E department.	Staff booked on to violence and aggression training on available dates.		Now mandatory training in ED.		Complete
10	A&E	A&E Other	Must Do	Ensure that there are robust risk assessments in place for the paediatric environment within the A&E department. These must be readily accessible and available to all staff in the department. Risk mitigation must be outlined and an action plan to improve the area must be written.	Specific risk assessment in place for the paediatric area at UHND supported by an action plan. Specific paediatric waiting room with CCTV in place and safeguarding nurse on each shift at DMH but children may sit elsewhere with parents and we cannot tell them where to sit.	• Sufficiency of risk assessments and action plans at UHND to be checked on Back to Practice Fridays and assured from September 2015.	Back to Practice/Self Inspections	Jayne McClelland	30/09/15

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11	A&E	A&E Other	Must Do	Review paediatric nurse cover in the A&E department at Durham to ensure all shifts are covered with a paediatric nurse either through service level agreement with the paediatric department or through the appoinment of paediatric nurses to the department, to ensure a consistent approach across the organisation.	• Paediatric nursing in ED being reviewed as part of clinical strategy work.	• Document current paediatric nursing cover in ED and risk assess remaining gaps, both 'as is' and as intended following implementation of the clinical strategy. Propose interim actions to ECL to address any gaps		Stephen Cronin	15/11/15
12	A&E	A&E Other	Must Do	Review consultant levels against CEM guidance.	• Consultant levels being reviewed as part of clinical strategy work.	• Document current consultant staffing against CEM standards and risk assess remaining gaps, both 'as is' and as intended following implementation of the clinical strategy. Propose interim actions to ECL to address any gaps.	Back to Practice session 17/9/15 revealed consultant staffing levels still below CEM guidelines however two further consultants have been appointed.	Shane Longden	15/11/15
13	A&E	A&E Other	Must Do	Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in the urgent care centres	• UCC recruitment on-going and vacant posts being appointed to. Most now in post, all others have start dates or advertised. Training needs being addressed on appointment. Mentorship programme in place for new starters and competency document used across all centres. • Transforming Unscheduled Care programme in place with ECIST support and including actions from Monitor review, with commissioner support. Significant improvements in performance in Quarter 2 (EL – need to include some specifics). "Perfect week" exercises to be completed by December 2015.		Recruitment on-going all remaining vacant posts being appointed to.	Shane Longdon	31/12/15
14	A&E	A&E Other	Must Do	Review the achievements and actions taken to address national targets within the accident and emergency departments (A&E).	Transforming Unscheduled Care Task Group in place. ECIST actions and actions from Monitor visits incorporated in a single action plan managed by this Group - significant improvements in waiting times and ambulance handover times in Q2. Winter resilience actions being coordinated by Medical Director.		• Follow through of actions monitored by the TUC Task Group • Perfect Week exercises taking place at UHND (Nov 15) and DMH (Dec 15)	Carole Langrick Chris Gray	• TUC action plan. Ongoing, benefits expected 31/12/15 • Perfect week 13/12/15
15	A&E	A&E Other	Should Do	Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.	Audit leads review outcomes of CEM audits and present at clinical governance meetings	• Care Group to ensure that CEM audits are on forthcoming clinical governance meeting agendas. These meetings to ensure robust action plans are in place or there is escalation where they cannot be put in place.	An ED consultant carries out regularly and are fedback at DMH ED Governance Meeting. ED Consultants discuss outcomes/progress at ED Governance Meeting at UHND, and currently no outstanding actions.	Jayne McClelland	31/10/15
16	A&E	A&E Other	Should Do	Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.	Audit leads review outcomes of CEM audits and present at clinical governance meetings	• Operational Governance Committee to provide challenge to any action plans which do not address key audit findings.		Warren Edge	31/10/15
17	A&E	A&E Other	Should Do	Implement assessment tools and improve audit activity to monitor quality and patient outcomes within the urgent care centres.	• Audits in UCCs undertaken by Team Leaders and GP Governance Leads.	Programme of pathway audits to be be developed and ensure outcomes shared across urgent care centres		Jayne McClelland Denise Kirkup	15/11/15
18	A&E	A&E Other	Should Do	Review the need for paediatric trained nurses in Urgent Care Centres.		• Review of the need for Paediatric Nurses in Urgent Care Centres, including current arrangements to access cover and support and taking account of national standards. Outcome to be shared with ECL and, potentially, commissioners (depending on outcome).		Stephen Cronin	31/10/15
19	A&E	A&E Other	Should Do	Review staffing at night in Urgent Care Centres	• UCC recruitment on-going and vacant posts being appointed to. Most now in post, all others have start dates or advertised. Training needs being addressed on appointment. Mentorship programme in place for new starters and competency document used across all centres. • Transforming Unscheduled Care programme in place with ECIST support and including actions from Monitor review, with commissioner support. Significant improvements in performance in Quarter 2 (EL – need to include some specifics). "Perfect week" exercises to be completed by December 2015.	• The Urgent Care Service is the subject of a review with commissioners, which includes consideration of revised proposals for overnight service provision, designed to maintain patient access to the service, whilst optimising overnight staffing arrangements. If accepted, these proposals will mitigate the risks associated with lone working overnight. • In the meantime, security risk assessments to be reviewed with Health and Safety colleagues as well as application of the lone worker policy for staff working in urgent care centres at night. Mitigation to be put in place where gaps are identified from risk assessments.	Recruitment on-going all remaining vacant posts being appointed to (consistency issue). Health and Safety risk assessments already reviewed for some Centres.	Shane Longden	31/12/15

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20	Medicine/NIV/ Critical Care		Must Do	Ensure that all resuscitation is checked daily and stored securely, and introduce a monitoring system to ensure that checks take place within the outpatient department	• Tool for daily checking of resuscitation equipment in place within Outpatients Department.	• Quality Metrics audit tool for Outpatients Department is in development to ensure compliance.		Susan Hoare	30/11/15
21	Medicine/NIV/ Critical Care		Must Do	Establish a consistent approach to critical care outreach services across the organisation	• Plans in place to introduce a 24x7 outreach team appropriate to the needs of both acute sites. Plans reviewed by ECL and QHGC in August 2015. Resuscitation and Deteriorating Patient Committee co-ordinating work on business case to be presented to OPG in October 2015.	• Business cases for outreach and pharmacy support to be fast-tracked. ECL to review to expedite through Operational Planning Group.	As per WE comment	R Hixson , P Thurland, J Cram	15/10/15
22	Medicine/NIV/ Critical Care		Must Do	Ensure that there are sufficient numbers of suitable skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require level 2 intervention.	• Patients on NIV being nursed in cohorts on each ward (1 male 4-bedded bay and 1 female 4-bedded bay on each ward). Eight beds closed on Ward 1 to support staffing arrangements and escalation beds on Ward 44 have been ring-fenced. • Competency framework for NIV initiation and administration revised in line with BTS guidelines.	• Respiratory Intermediate Care plan – complete actions following ED review and bring to ECL.	• NIV patients cohorted on both ward 1 and ward 44 at a ratio 1:4 pending Respiratory HDU and staffing adjusted to suit patient ratios. • Outline Respiratory HDU plan reviewed by ECL. Due back November.	Jayne McClelland	31/10/15
23	Medicine/NIV/ Critical Care		Must Do	Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both UHND and DMH	• Procedure and pathway documentation reviewed and updated in line with BTS Guidelines and approved by Clinical Standards and Therapeutics Committee in August 2015. In use on both wards.	• Further NIV outcomes audit to complete	Audit scheduled. In planning stage.	Neil Munro Denise Kirkup	30/11/15
24	Medicine/NIV/ Critical Care		Must Do	Have arrangements in place for patients receiving NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.	• Competency framework for NIV initiation and administration revised in line with BTS guidelines.	• Further NIV outcomes audit to complete	Audit scheduled. In planning stage.	Neil Munro Denise Kirkup	30/11/15
25	Medicine/NIV/ Critical Care		Must Do	Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.	• Patients on NIV being nursed in cohorts on each ward (1 male 4-bedded bay and 1 female 4-bedded bay on each ward). Eight beds closed on Ward 1 to support staffing arrangements and escalation beds on Ward 44 have been ring-fenced.	• Respiratory Intermediate Care plan – complete actions following ED review and bring to ECL.	• NIV patients cohorted on both ward 1 and ward 44 at a ratio 1:4 pending Respiratory HDU and staffing adjusted to suit patient ratios. • Outline Respiratory HDU plan reviewed by ECL. Due back November.	Jayne McClelland	31/10/15
26	Medicine/NIV/ Critical Care		Must Do	Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.	• NIV audit completed for all patients initiated onto NIV in January 2015, to be repeated later in year (provisional date w/c 2nd November 2015).	• Further NIV outcomes audit to complete	Audit scheduled. In planning stage.	Neil Munro Denise Kirkup	30/11/15

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27	Medicine/NIV/ Critical Care	Must Do	Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.	• Clinical Audit team review of compliance on Ward 1 and Ward 44 completed September 2015.	• Feedback of compliance audit results	Clinical Audit Team reveiwed compliance (Ward 1 and 44) on 9/10 September 2015. Procedure and pathway document in place. Staff were completing the documentation in line with the procedure. Patient cohorting was appropriate, nursing staff on the day had their competency assessments completed. NIV training programme has been developed for 2015/16 for clinical staff.	Warren Edge	linital check completed - 30/09/2015. Further audit planned w/c 2/11/2015
28	Medicine/NIV/ Critical Care	Should Do	Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.	• Plans in place to introduce a 24x7 outreach team appropriate to the needs of both acute sites. Plans reviewed by ECL and QHGC in August 2015. Resuscitation and Deteriorating Patient Committee co-ordinating work on business case to be presented to OPG in October 2015.	• Business cases for outreach and pharmacy support to be fast-tracked. ECL to review to expedite through Operational Planning Group.	Approval of funding of 2 WTE Pharmacists for ITUs. Business case for 24x7 outreach progressing. Expected with ECL in November 2015.	R Hixson , P Thurland, J Cram	30/11/15
29	Medicine/NIV/ Critical Care	Should Do	Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.	• Plans in place to introduce a 24x7 outreach team appropriate to the needs of both acute sites. Plans reviewed by ECL and QHGC in August 2015. Resuscitation and Deteriorating Patient Committee co-ordinating work on business case to be presented to OPG in October 2015.		Approval of funding of 2 WTE Pharmacists for ITUs. Business case for 24x7 outreach progressing. Expected with ECL in November 2015.	R Hixson , P Thurland, J Cram	30/11/15
30	Medicine/NIV/ Critical Care	Should Do	Ensure that there is clinical pharmacist input in the intensive care unit in line with 'Core standards for intensive care' guidelines.	Critical Care Delivery Group and Pharmacy Leads developing a business case to appoint clinical pharmacist support to ITU	• Business cases for outreach and pharmacy support to be fast-tracked. ECL to review to expedite through Operational Planning Group.	Executive Directors have approved funding for two clinical pharmacists (WTE) to cover the Trust's intensive care units. The posts are to be filled / allocated.	G Kirkpatrick	31/12/15
31	Medicine/NIV/ Critical Care	Should Do	Review the patient flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.	Patient flow will be formailised through adherance to the critical care admission/discharge policy (complete), discharge escalation policy supported by the development of Outreach. • Critical care admission and discharge policy has been approved. • Patient flow team has been invited to discuss the policy at the Critical Care Delivery Group. • The topic of enforcement of the admission and discharge policy is to be discussed at the November 2015 CCDG meeting with a view to writing a letter to all CDDFT Consultants reinforcing the important points.	• To formalise patient flow through adherance to the critical care admission/discharge policy, discharge escalation policy supported by the development of Outreach.	Critical Care Admission & Discharge Policy now approved	Policies - Matt Wayman / CCDG, Outreach - Richard Hixson / Resus Committee	- Discharge policy 30/9/15 - Outreach development 31/10/15
32	Medicine/NIV/ Critical Care	Should Do	Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks.	Resus trolley drugs checked twice daily and equipment daily. At UHND drug expiry dates checked weekly. Checklist in place and signed off. Sample audits also undertaken by the CAP Team.	Require all start of shift safety huddle to confirm that the resuscitation trolley and drugs have been checked and confirmation to be recorded on the board. Familiarity of all staff on shift with the location of the trolley and the equipment to be confirmed as part of the huddle.		Professor Chris Gray	31/10/15

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33	Medicine/NIV/ Critical Care	Should Do	The trust should ensure that any out of date medication is removed from stock cupboards once it has expired, in line with the trust medication management policy, and have a process for monitoring this within the outpatient departments.	• Pharmacy policy and checklist implemented in each Outpatients Departments to ensure any out of date stock is removed. • AMU UHND has a medicines management assistant in place who is responsible for checking that medication in cupboards is in date and checking fridge temperatures. AMU at DMH have processes for both medication cupboards and fridges overseen by the Ward Manager.	• Back to Practice Fridays to check medication stocks in cupboards and improve and assure processes for doing so.	Back to Practice checks on compliance carried out on 17th September and further regular sessions being held to continually monitor and reinforce compliance with procedures to ensure medication stocks are in date.	Care Group Lead Nurses	Initial action completed - checks ongoing.
34	Medicine/NIV/ Critical Care	Should Do	The trust should ensure that all fridge temperatures are checked daily and that there is a system in place to monitor that checks are taking place within the outpatient departments. The trust should ensure that the cold chain is robust.	• Checklists in place to ensure all fridge temperatures are checked daily in Outpatients Department. • AMU UHND has a medicines management assistant in place who is responsible for checking that medication in cupboards is in date and checking fridge temperatures. AMU at DMH have processes for both medication cupboards and fridges overseen by the Ward Manager.		Back to Practice checks on compliance carried out on 17th September and further regular sessions being held to continually monitor and reinforce compliance with fridge temporature checks.	Care Group Lead Nurses	Initial action completed - checks ongoing.
35	Medicine/NIV/ Critical Care	Should Do	Ensure that there is a training plan in place, which is delivered to all staff involved in the care of patients receiving NIV, and that it is competency based and in sufficient detail to demonstrate competence in all aspects of NIV.	• Staff on Wards 1 and 44 and staff in ED trained and have documented sign off against the framework. The training package was delivered by the Respiratory Nurses. SOP developed and in place.		Complete. Verified on ward visits. Ward 1, UHND to retain competency assessments in a folder on the ward. Training plan in place with dates available in 2015/2016.	Jayne McClelland	Complete
36	Medicine/NIV/ Critical Care	Should Do	Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients admitted to both acute hospitals who require NIV.	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.
37	Medicine/NIV/ Critical Care	Should Do	Ensure that this guidance/SOP includes clarity on the setting/ specific ward in which patients can be managed	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.
38	Medicine/NIV/ Critical Care	Should Do	Ensure that this guidance/SOP includes staffing to patient ratios that are in line with current guidance.	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.
39	Medicine/NIV/ Critical Care	Should Do	Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when a bed is unavailable in an appropriate setting and when patient numbers do not match agreed staffing ratios	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.

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41	Record Keeping, Care Planning & Ward Management	Must Do	Ensure that patient records are kept up to date, are patient-centred and contain relevant information about their treatment and care, including awaiting discharge, to eliminate unnecessary delays.	• E-Obs rolled out to all adult IP areas at DMH, UHND and BAH (except Ward 18). Staff responsible for delivering care and recording of observations, including the nurse in charge of the ward area, are sent an alert if a patients are due or overdue. The frequency of observations is dependent upon the patients Early Warning Score in line with patient need. When an observation set is recorded it is date and time stamped and an electronic signature of the recorder stored against the patient record instantly. • Admission and care planning documentation has been reviewed and revised, piloted on both sites and implemented from 3rd August 2015. • Record-keeping included within Quality Matters audit tool.	- Self Inspection to be carried out to ascertain position. - Back to practice Fridays process to review and spot check. - Clinical Audit monthly independent checks to be scheduled. - Monitoring through Senior Nurses Forum and ECL to be established. - Quality Matters ward audits to monitor formally on an ongoing basis.	Self Inspection Peer Reviews completed on 23 and 29 September 2015. Results being analysed. Back to practice Fridays are being undertaken. Feedback provided to staff in real-time. Quality Matters ward audits continue. Clinical Audit independent checks scheduled from November 2015 (in light of recent Self Inspection Peer Reviews) Monitoring through Senior Nurses Forum and ECL established. Quality Matter ward audits to monitor formally on an ongoing basis. Completed and in place as part of the ward audit process. Nursing documentation reviewed and staff received training on completing the document.	Denise Kirkup Noel Scanlon Denise Kirkup Noel Scanlon Julie Race	30/11/15 Ongoing From 1/11/15 Ongoing Ongoing
43	Record Keeping, Care Planning & Ward Management	Must Do	Ensure that the trust undertakes a review of the skills, knowledge and capabilities of nurses to complete accurate and timely care plans that meet the needs of the patients.	• Staff were trained by Matrons prior to the roll out of the new documentation. • Care Planning now included in the nursing preceptorship.	- Self Inspection to be carried out to ascertain position. - Back to practice Fridays process to review and spot check. - Clinical Audit monthly independent checks to be scheduled. - Monitoring through Senior Nurses Forum and ECL to be established. - Quality Matters ward audits to monitor formally on an ongoing basis.	Self Inspection Peer Reviews completed on 23 and 29 September 2015. Results being analysed. Staff training on the new documentation has been undertaken. Record keeping and care planning part of preceptorship. Workshop held on 19 October 2015; scenario based learning on assessment, planning, implementation and evaluating care planning. Further session planned in six months. Workshops will coincide with University newly qualified staff. Clinical Audit independent checks scheduled from November 2015 (in light of recent Self Inspection Peer Reviews) Monitoring through Senior Nurses Forum and ECL established. Quality Matter ward audits to monitor formally on an ongoing basis. Completed and in place as part of the ward audit process.	Denise Kirkup Noel Scanlon Denise Kirkup Noel Scanlon Julie Race	30/11/15 Ongoing From 1/11/15 Ongoing Ongoing
44	Record Keeping, Care Planning & Ward Management	Must Do	Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR).	• The need for MCA has been included in DNACPR audits by the Cardiac Arrest Prevention (CAP) Team. It is only needed where a benefits v burden decision is made (not one re futility).	• CAP team to ensure DNACPR audits consider the MCA within their routine audit programme. • Include consideration of recording of MCA assessments for patients who are unable to participate in decisions about DNACPR in weekly mortality reviews, feeding back any issues to clinicians through the established process.		Lisa Ward Graeme Kirkpatrick	Audits (31/10/15) Mortality process to be adapted (15/11/15)

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45	Record Keeping, Care Planning & Ward Management	Must Do	Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR).		• CAP team to assess whether to include in their routine audit programme.	Completed	Lisa Ward	31/10/15
46	Record Keeping, Care Planning & Ward Management	Must Do	Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.	• The need for MCA has been included in DNACPR audits by the Cardiac Arrest Prevention (CAP) team. It is only needed where a benefits v burden decision is made (not one re futility).	• CAP team to ensure DNACPR audits consider the MCA within their routine programme.		Lisa Ward	31/10/15
47	Record Keeping, Care Planning & Ward Management	Should Do	Review dedicated management time allocated to ward managers.	• Baseline reports created to monitor supervisory time by ward and individual wards reviewing the outputs.	• Embed reporting and review of supervisory time on wards. • Care Groups to routinely review reports and identify and tackle issues. • Senior Nurses forum to monitor.		Julie Clennell, Jason Cram, Jayne McCelland, Noel Scanlon	30/11/15
48	Record Keeping, Care Planning & Ward Management	Should Do	Ensure patients have their medicines reconciled in accordance with trust targets.	Initial meeting have been held with DMH and UHND Pharmacy site leads to discuss extending the Pharmacy service.	• A review of service provision improvements is being undertaken by the Deputy Chief Pharmacist and site Lead Pharmacists. This will include a review of MR targets.		Jamie Harris	31/10/15

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49	End of Life		Must Do	Ensure that staff know the syringe driver policy and carry out/record syringe driver checks in line with this policy.	• Variation in syringe driver practice was discussed at ECL and key messages issued via a bulletin.	• Additional awareness raising around syringe driver policy and completion of monitoring forms to be raised through Equipment Controller Networks and the Medical Devices Newsletter		Rhona Beecham	31/12/15
50	End of Life		Must Do	Add audits of syringe driver administration safety checks to the annual end of life audit programme.		• Audits of syringe driver compliance to be added to the medical devices annual audit programme and audits to be performed this year. Further audits to be performed, by Matrons, in the current year.		Rhona Beecham Julie Clennell	31/12/15
51	End of Life		Must Do	Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.	• A Band 8 manager has been appointed to support the service and work with the lead MacMillan Nurse and medical consultant clinical lead in providing operational leadership. • The EoL Steering Group has been reviewed and its terms of reference strengthened. A direct reporting line is in place to the QHGC.	• Complete appointment process and finalise EoL Group ToRs	The Band 8a is in post. The Terms of Reference for the End of Life Group have been reviewed and approved by sub-committee of the Board - complete	Julie Clennell	Complete
52	End of Life		Must Do	Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.	• A Band 8 manager has been appointed to support the service and work with the lead MacMillan Nurse and medical consultant clinical lead in providing operational leadership. • The EoL Steering Group has been reviewed and its terms of reference strengthened. A direct reporting line is in place to the QHGC.	• Develop proposals and associated business case to provide a face to face specialist palliative care services from at least 9am to 5pm, 7 days per week		Julie Clennell	31/10/15
53	End of Life		Must Do	Ensure data are available to identify and demonstrate the effectiveness of the end of life service.	• Core data items required to demonstrate effectiveness of the service identified and administrative support approved by Executive Directors. Work on extraction and reporting of data is on-going with Information Services.	• Complete work with Information on metrics, data sources, information gathering and reporting processes		David Oxenham	31/03/16
54	End of Life		Must Do	Address the lack of consultant medical staff cover in end of life community services.	Needs assessment discussed and core reasons for under-provision agreed with commissioners. New funding in place from commissioners for consultant post and middle grade post. • Agreement to develop training fellowship in palliative care. Consultant job descriptions agreed and posts advertised but no applicants	• Revise consultant job descriptions and advertise	First recruitment campaign unsuccessful. Further campaign to be undertaken	David Oxenham	30/09/15
55	End of Life		Must Do	Address the lack of consultant medical staff cover in end of life community services.	• Re consultant cover, needs assessment discussed and core reasons for under-provision agreed with commissioners. New funding in place from commissioners for consultant post and middle grade post. • Agreement to develop training fellowship in palliative care. Consultant job descriptions agreed and posts advertised but no applicants	• Develop proposals and associated business case to provide a face to face specialist palliative care services from at least 9am to 5pm, 7 days per week		Louise Shutt	31/10/15
56	End of Life		Must Do	Develop access to out-of-hours advice for healthcare professionals caring for palliative and end of life patients within the community.	Staff in the community have access to advice out of hours from Speciality Macmillan nurses working in the three hospices in county Durham and Darlington	Seek to enable access for community staff to advice from a specialist consultant. However, it should be noted that those who host the register for the south of the trust locality will not enter into such an agreement with the Trust until the Trust has a minimum of three consultants in post and is able to contribute to the rota. The Trust is, as noted above, actively looking to recruit further consultants.	Action complete (Access to advice from MacMillan Nurses) We will continue to seek recruitment of additional consultants and participate in the out of hours rota as soon as we are able to.	David Oxenham	Complete
58	End of Life		Must Do	Ensure there is effective leadership and management in place to maintain and develop the community end of life service.	• A Band 8 manager has been appointed to support the service and work with the lead MacMillan Nurse and medical consultant clinical lead in providing operational leadership. • The EoL Steering Group has been reviewed and its terms of reference strengthened. A direct reporting line is in place to the QHGC.	• Complete appointment process and finalise EoL Group ToRs	The Band 8a is in post. The Terms of Reference for the End of Life Group have been reviewed and approved by sub-committee of the Board - complete	Julie Clennell	Complete

				CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
59	End of Life		Should Do	Ensure actions in response to the National Care of the Dying Audit (NCDAH) and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.	• Detailed action plan in place for NCDAH audit and implementation being monitored through the End of Life Steering Group.		Process in place through End of Life Steering Group	Julie Clennell	Complete
60	End of Life		Should Do	Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.	• Full thematic review of complaints and incidents reported over the last 12 months with an update to the EoL Steering Group.	• Develop an EoL patient / relative experience programme and PE report		Julie Clennell	31/12/15
61	End of Life		Should Do	Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.	• Full thematic review of complaints and incidents reported over the last 12 months with an update to the EoL Steering Group.	• Develop similar Patient Safety report to Steering Group		Julie Clennell	31/12/15
62	End of Life		Should Do	Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.	• Full thematic review of complaints and incidents reported over the last 12 months with an update to the EoL Steering Group.	• Complete update of Safeguard to include categories for incidents and complaints which can be identified to EoL		Julie Clennell	31/12/15
63	Maternity & O&G		Must Do	Ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced medical staff within maternity and gynaecology services.	• Job Planning review in Maternity and Gynaecology has commenced	• Conclude job planning for Obs and Gynae staff, providing sufficiently for handover and availability of staff within both O&G (including rota adjustments, and adjustments to PAs, as necessary).		John McDonald	01/12/15
64	Maternity & O&G		Must Do	Ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced medical staff within maternity and gynaecology services.	• Job Planning review in Maternity and Gynaecology has commenced	• Review amended O&G staffing arrangements in practice.		John McDonald	31/03/16
65	Maternity & O&G		Must Do	Ensure that there are processes in place by which to identify, acknowledge and address risks through robust management processes within maternity and gynaecology services.	• Patient Safety and Quality Midwives in post in Maternity and Nurses with allocated time in Gynae to implement risk management processes. Risk management triggers reviewed in line with the NRLS and standards and risk notice boards for each site demonstrating learning and actions.	• Complete Risk Management SOP for O&G (outlines responsibilities for risk management, incident reporting, RCA and duty of candour)		Anne Holt	31/10/15
66	Maternity & O&G		Must Do	Ensure that there are processes in place by which to identify, acknowledge and address risks through robust management processes within maternity and gynaecology services.	• Patient Safety and Quality Midwives in post in Maternity and Nurses with allocated time in Gynae to implement risk management. Risk management triggers reviewed in line with the NRLS and standards and risk notice boards for each site demonstrating learning and actions.	• Patient Safety and Quality Midwives to attend recently established regional meetings of maternity risk managers which is linked to the clinical network.		Anne Holt	31/10/15
67	Maternity & O&G		Should Do	Consider ways of improving engagement between staff and managers with the care closer to home directorate with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service-level decisions within this service.	Care Groups are being restructured to align them to Core Pathways and provide smaller **spans** of control. Maternity and Gynaecology will form part of a designated Family Health Care Group from 1st November, facilitating greater responsibilities in decidion making and Care Group governance with respect to this **sense**.	• Complete CG restructuring (top level). • Implement management + governance structures with the Family Health Care Group.		Carole Langrick Maria Willoughby	01/01/2016 31/01/2016
68	Maternity & O&G		Should Do	Consider ways in which it can identify the required standards within the maternity service dashboard.	• Multi-disciplinary team within Maternity, O&G meeting to develop dashboard and time allocated through job planning for labour ward clerks to ensure that dashboards are maintained and risk management processes complied with. • Boards ordered for both Labour Wards to display dashboard statistics which will be updated monthly.	• Finalise the dashboard, identify sources of information and the process for update.	Dashboard has been developed and data sources have been identified. Procedure to be developed	Anne Holt	02/10/15
69	Maternity & O&G		Should Do	Consider within the maternity and gynaecology services clinical and quality strategy for 2014-16 timelines for review and achievement.	• Defined clinical strategy in place for Gynaecology. For Obstetrics, the strategy is being developed in line with Trust priorities alongside the SeQiHS and clinical strategy roadmap work.	• Service strategy to be completed alongside Trust Clinical Services Strategy. Timelines to be determined once the Trust-wide work, and any resulting consultation is complete.		John MacDonald Carole Langrick	1st iterations 31/01/16

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
70	Maternity & O&G	Should Do	The trust should consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.	• Defined clinical strategy in place for Gynaecology. For Obstetrics, the strategy is being developed in line with Trust priorities alongside the SeQiHS and clinical strategy roadmap work.	• Service strategy to be completed alongside Trust Clinical Services Strategy. Timelines to be determined once the Trust-wide work, and any resulting consultation is complete.		John MacDonald Carole Langrick	1st iterations 31/01/16
71	Maternity & O&G	Should Do	The trust should consider ways for improving timely and responsive human resource management processes, including personnel issues that impact on service delivery in maternity and gynaecology services.		• HR Directorate restructuring progress to provide more resource for critical priorities (in consultation).	Consultation on new structure taking place.	Morven Smith	31/12/15
72	Children's and Safeguarding	Must Do	Ensure the paediatric high dependency unit room has specific SOPs or protocols available to guide suitably trained staff.	• Paediatric HDU SOP now in place.		Complete	Stephen Cronin	Complete
73	Children's and Safeguarding	Must Do	Ensure advanced paediatric nurse practitioners have a set of SOPs available to guide their practice and care.	APNPs now working to different model. Paediatric index used by APNPs - this is an MDT document but fully inclusive of the relevant SOPs.		Complete	Stephen Cronin	Complete
74	Children's and Safeguarding	Should Do	Ensure that all clinicians have the appropriate level of children safeguarding training within children's community services.	• Community CYP clinicians – 93% compliant with training requirements now. All staff attendance is monitored through performance management and appraisal and support is provided by cover using bank staff and extra hours.	• Continued monitoring of staff not meeting requirements.	Training rates for Safeguarding of Children monitored through monthly OD & Workforce meetings and reported to a Board Committee every quarter	Morven Smith/Lead Nurses	Ongoing - quarterly review from 30/10/15)
75	Children's and Safeguarding	Should Do	Formally nominate an executive or non-executive director to represent children at board level, separate from the safeguarding children executive lead role.	• Professor Paul Keane, Chairman, appointed as the director to represent children at Board level.		Complete		Complete
76	Governance & Strategy	Must Do	Review current governance processes to ensure they are embedded to ensure consistency across acute and community services	• Care Groups being restructured and leadership arrangements being reviewed to support improved engagement and communication between Care Group and specialty level (smaller groups focused on pathways) and improved decision-making. The clinical governance framework is being reviewed, reiterated and as necessary streamlined as part of this process (CL/ WE, first phase from November 2015).	• Complete the roll out of the Care Group restructuring. • Support implementation of consistent governance processes in Care Groups and audit their implementation.		Carole Langrick Warren Edge	• 1st Phase 30/11/15 • 2nd Phase (31/01/15) • Audit of implementation (31/03/15)
77	Governance & Strategy	Must Do	Review and ensure that all members of the board are fully aware of their lead responsibilities within the Board Assurance Framework	• BAF discussed with all Directors individually once a quarter and with EDs as a whole in the month prior to reporting to the Board including confirmation of responsibilities and actions (ED discussions start Sept 2015).	• All Board Committees to receive the BAF and validate their objectives, risk and actions every quarter, as well as considering BAF updates, from business discussed at each meeting.	BAF discussed at all Board Committees + objectives validated, October 2011	Warren Edge	30/11/15

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
78	Governance & Strategy	Should Do	Review access to patient information in languages other than English.		• Commission and complete review of Patient Information with Healthwatch support		Warren Edge	28/02/16
79	Governance & Strategy	Should Do	Review the complaint process in terms of board oversight, CEO involvement and clinical direction.	• Patient Experience Team (PET) have reviewed the complaints process and CEO will sign off all complaints received through the CEO office going forward and review a monthly summary of complaints. • Board will continue to receive updates on complaints and lessons learned in the Director of Nursing's report. • Peer review process in place in PET to check quality of complaints responses before issue. • Only nominated senior staff in Care Groups can sign off complaints	• Complete review of the complaints process with Healthwatch support.		Noel Scanlon	31/12/15
80	Governance & Strategy	Should Do	Review the complaint process in terms of board oversight, CEO involvement and clinical direction.	• Patient Experience Team (PET) have reviewed the complaints process and CEO will sign off all complaints received through the CEO office going forward and review a monthly summary of complaints. • Board will continue to receive updates on complaints and lessons learned in the Director of Nursing's report. • Peer review process in place in PET to check quality of complaints responses before issue. • Only nominated senior staff in Care Groups can sign off complaints	• Explicitly identify those nominated to sign off complaints in the complaints policy and ensure that they are trained and assessed as competent to do so.		Maureen Grieveson	31/12/15
81	Governance & Strategy	Should Do	Review the complaint process in terms of board oversight, CEO involvement and clinical direction.	• Patient Experience Team (PET) have reviewed the complaints process and CEO will sign off all complaints received through the CEO office going forward and review a monthly summary of complaints. • Board will continue to receive updates on complaints and lessons learned in the Director of Nursing's report. • Peer review process in place in PET to check quality of complaints responses before issue. • Only nominated senior staff in Care Groups can sign off complaints	• Provide samples of complaint responses (post response) to Quality and Healthcare Governance Committee periodically for review.		Noel Scanlon	30/11/15