Oxford University Hospitals NHS
NHS Trust

Trust Board: Wednesday 9 July 2014

TB2014.75

Title	**CQC Inspection Report**

Status	For information
History	Trust Management Executive, Thursday 22 May and Thursday 12 June 2014 Quality Committee, Wednesday 11 June 2014

Board Lead(s)	**Eileen Walsh, Director of Assurance**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This paper presents the Board with information in relation to the last CQC inspection and a link to the final reports published by the CQC on 14th May 2014.
2. The report provides the overall results from the inspection. The Trust was given a `good' rating overall. The CQC assess against five key domains, which are: safe, effective, caring, responsive to people's needs, and well-led. The Trust overall scored 'good' against each of these areas.
3. The Trust received six compliance actions. There were also many areas of good practice and the overview of those provided in the Trust-wide report are included as part of the paper.
4. The action plan for the six compliance actions has been appended to this paper and was approved by the Trust Management Executive and sent to the CQC on 12th June 2014. The action plan covering the remaining actions is due to the CQC by 31st July 2014.

Recommendation

5. The Board is asked to:
   - Note the action plan developed to address the compliance actions.

1. Introduction

1.1. The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 25th and 26th February 2014. A team of 51 inspectors visited the Trust's four hospital sites for two days and conducted further unannounced spot checks on the 2nd and 3rd March.

1.2. Both prior and during the inspection, the Trust provided a large amount of documentation to the CQC. As part of the inspection, the CQC spoke to patients, visitors, carers and staff to gain a view of the eight service areas and to rate each of these in relation to five domains:

- Were services safe?
- Were services effective?
- Were services caring?
- Were services responsive to people's needs?
- Were services well-led?

1.3. The CQC also held two public meetings, one in Oxford and one in Banbury, to hear from local people and to try and get to the heart of patients' experiences.

1.4. The Trust received the final draft in advance of the Quality Summit arranged by the CQC on 12th May 2014. The Quality Summit was attended by invited members of the Trust Board and external stakeholders, including commissioners, NHS England and the Trust Development Authority.

2. Report findings

2.1. The CQC published its inspection reports for the Trust on Wednesday 14th May 2014. There was a report for the Trust overall and four further reports for each of the Trust's hospital sites.

2.2. The Trust as a whole has received a `good' rating overall and a rating of `good' for each of the five domains.

2.3. The CQC inspection was a comprehensive and thorough review of the way services are provided. The clear and overriding message from the report is that the inspectors observed caring and compassionate staff throughout the four hospitals and noted many examples of good team working. The detailed inspection reports offer a clear endorsement of the hard work put in on a daily basis to make sure compassionate and excellent care is provided to patients. The full reports are available through the following link: http://www.cqc.org.uk/directory/rth

2.4. The CQC assessed services on each site and rated them overall against the five domains, across eight core service areas, as defined by the CQC (where they are provided). All were rated 'good' except for A&E and Surgery at the John Radcliffe site, which were rated as 'requires improvement'.

2.5. The Trust-level report also specified the following areas where the Trust **must improve**:

- The Trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.

- The Trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times.
- The Trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.
- The Trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with good practice standards.
- The Trust needs to ensure that staff receive suitable induction to each area that they work within the Trust.
- The Trust needs to ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

2.6. In each of the reports specific to each site, there were areas that the CQC had stated '**should improve'**.

3. Development of the CQC Action Plan

3.1. The Trust submitted the initial action plan in relation to the six areas identified as compliance actions on 12th June 2014. The action plan provided (Appendix 1) was developed through working with divisional colleagues.

3.2. The Trust Management Executive is monitoring the completion of the action plan on a monthly basis and the next progress report is due to be presented to TME at its meeting on 10th July 2014.

3.3. In addition each site has a list of areas that 'should be improved'. A further plan will be developed in relation to these other actions and provided to the CQC by 31st July 2014.

4. Recommendations

4.1. The Trust Board is asked to:

- Note the action plan developed to address the compliance actions.

Eileen Walsh
Director of Assurance
July 2014

Report prepared by:

Clare Winch
Deputy Director of Assurance

<u>Compliance Action 1:</u> The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and outpatient care to meet their needs and ensure their welfare and safety.
John Radcliffe and Trust Wide. Treatment of disease, disorder or injury Surgical procedures. Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
CA 1.1	The **accident and emergency** department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively.	The following outlines key actions already in place and additional actions developed as a result of the CQC inspection. These have been developed with involvement of key members of staff. **Actions relating to input from surgical specialties** • Following initial patient assessment in Emergency Department (ED), time critical diagnostics will continue to be ordered by ED. When investigations are assessed by ED to be less time critical, but they require a surgical opinion, patients will be immediately transferred to Surgical Emergency Unit and Specialist Surgery In-Patients ward. • Patients will be managed on an ambulatory basis wherever possible. • Where patients are assessed as not requiring ED medical input, they will be directly referred internally to the relevant	**Executive Director accountability:** Director of Clinical Services Operational Lead: Divisional General Manager for Medicine Rehabilitation and Cardiac (MRC)	Actions in place by 4 June 2014 Performance improvements to be delivered by 31 August 2014	ED Action Plan (Item 7) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		specialty. • Patients requiring a surgical opinion in ED will be transferred to the ward for assessment if a request for assessment on ED is not responded to within 30 minutes, prior to a check on the capacity of staff to maintain the required frequency the required frequency of observations. The above actions will be supported by: • Diagnostic availability to SEU will be enhanced to that of ED and Emergency Assessment Unit (EAU)				
		Improved Use of the Transfer Lounge • Ensure that all specialties actively support the flow of patients by identifying patients to move to the Transfer Lounge before 10.30am. • Matrons to support ward staff to obtain early decisions on discharge from all hospital medical teams. • Operations Team will support ED and EAU Coordinator by working more closely with the wards to ensure beds are made available, when required. • Further support to be provided by the Directorate Operational Service Managers	Operational Lead: Divisional Nurse MRC Matrons Operations Team ED and EAU Coordinator	Actions in place by 4 June 2014 Performance improvements to be delivered by 31 August 2014 4 June 2014	ED Action Plan (Item 14) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		and Matrons with escalation to the Divisional General Managers and Divisional Nurses when constraints are not being actively managed.	Directorate Operational Service Managers			
		• Discharge by time of day to the Transfer Lounge will be reviewed weekly to monitor performance. • Breach analysis to be undertaken for any patients discharged directly from the ward (rather than via the Transfer lounge) to monitor performance	Operational Lead: Divisional Nurse MRC		Weekly monitoring reports	
		Expected referrals and transfers • From 4 June 2014, patients expected from GPs will be admitted directly to the appropriate ward and not held in ED • Transfers from the Horton ED for specialty opinion to be direct to the appropriate ward and not held in ED	Operational Lead: Divisional General Manager MRC	Actions in place by 4 June 2014 Performance improvements to be delivered by August 2014	ED Action Plan (Item 8) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.
		• Paediatrics • Paediatric Clinical Decision Unit (CDU) to continue to pro-actively 'pull' patients who are ready to be transferred from ED at all times of the day and night. • Requests for Paediatric opinions at the Horton will be consistently responded to	Paediatric CDU staff	As above 4 June 2014	ED Action Plan (Item 10) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained as above.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		within 30 minutes by consultants giving 24/7 resident presence.				
		• Monitor this by escalation to the Children's' & Women's Divisional Nurse and General Manager when this is not met.	Children's' & Women's Divisional Nurse and General Manager	With effect from 4 June 2014		
		Actions Internal to the Emergency Department – (To commence Monday, 2nd June 2014). **Plan at 2 hours for all patients in ED** • All patients to be assessed and have a defined clinical management plan within a maximum of 2 hours. • Internal monitoring to be undertaken in real-time by the Divisional and Directorate Management team accessing FirstNet. (FirstNet is the electronic system detailing the status of all patients in both EDs and is remotely accessible). Out of hours this will be done by the Operations Team with oversight from the Duty Manager. • Poor performance from the expected standard to be escalated to nominated shift floor consultant.	Director of Clinical Services Operational Lead: Divisional General Manager MRC	With effect from 2 June 2014	ED Action Plan (Item 6) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained.
		Changes to Portering Activity	Divisional General		ED Action	

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		• Review options to set up a dedicated portering team for ED and EAU to improve responsiveness. • Costed options to be presented to Director of Clinical Services • Implementation plan to be developed for immediate action. • Conduct an impact assessment of the changes to the service.	Manager MRC	9 June 2014 30 June 2014 30 September 2014	Plan (Item 13) Urgent Care Programme Group monitoring Options Appraisal Implementation Plan Impact Assessment	
		Improving Transportation • Maintain a log of transportation issues particularly regarding access to 2 man/stretcher crews, to use in negotiation with providers. (defined timeframe) • Regularly review the log and relevant issues to be raised at Urgent Care Programme Group meetings.	All ED staff Director of Clinical Services	For the month of June 2014	ED Action Plan (Item 15) Urgent Care Programme Group monitoring Transportation issues log	
		Areas for collaborative action with partners • Improved integration of care pathways across hospital, community, primary care and social care services to improve the ability to manage patients in the clinically appropriate setting. Build on current proposals being developed by the Trust and	**Executive Director accountability**: Director of Clinical Services Director of	Timeframes linked to the Trust Business Plan.	Minutes of meetings between partners. Pathway documentation	Successful collaboration projects developed and delivered

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		Oxford Health. The support of Oxford Clinical Commissioning Group (CCG) and Oxford City Council will be critical. • Managing demand across emergency care pathways to ensure that patients requiring emergency assessment and care are seen in clinical settings appropriate to their needs. • Collaborative approach to re-development of hospital sites and estate to address unsatisfactory accommodation. • Potential for developments such as patient hotels and family accommodation. • Improved access to hospital sites, additional parking facilities to meet the needs of increasing clinical activity and increased complexity and frailty of patients reflecting the change in clinical services.	Planning and Information Director of Development and Estate			
CA 1.2	The **outpatient** department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide suitable information.	Continue to implement the Outpatient re-profiling project: **Phase 1:** • To review all clinic templates to match demand and capacity run rate (detailed project plan monitored by monthly Outpatient Project Board (DCS Chair)	**Executive Director accountability:** Director of Clinical Services Operational Lead: Deputy Director of Clinical Services	Phase 1 to be completed by 30 June 2014	Project Plan Minutes of Outpatient Project Board – reported to (TME) Draft clinic templates Follow up ratio monitoring	Outpatient re-profiling outcome: to provide net extra new outpatient capacity of 34500 slots and reduce follow up ratio from 1:1.88 to 1: 1.32 by 31 October 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		Phase 2: To translate the new clinic templates into operational processes across all specialties	Director of Clinical Services Operational Lead: Deputy Director of Clinical Service	31 October 2014	Outcome of pilot reviewed and reported to TME Roll-out plan Progress report on plan reported to TME	As above: reduce follow up ratio from 1:1.88 to 1: 1.32 by 31 October 2014.
		Change outpatient's system from choose & book to directly bookable system (DBS). • DBS pilot in neurology and gynaecology to run from June - Aug 2014 • To agree an all speciality directly booking roll out plan with the CCG by 31 Aug 2014 • Commence implementation of the roll out plan beginning in Quarter 3.	Director of Clinical Services Operational Lead: Deputy Director of Clinical Service	31 Sept 2014 31 July 2015	Results of pilot roll out Implementation plan Reports on success rates to TME.	DBS outcome: GPs able to book new outpatient appointments in surgery with the aim of reducing failure rate to 10% by July 2015.
CA 1.3	In some **surgical specialties** waiting times for surgery were too long and operations were cancelled too often.	Implement existing plan. This includes utilising private sector providers to clear the high number of patients waiting over 18 weeks in these specialties. This has been initially rolled out in four specialties and will be extended across individual specialities in July. • Performance will continue to be monitored on a weekly basis via joint Trust and CCG 18 week meeting.	**Executive Director accountability:** Director of Clinical Services Operational Lead: General Managers	30 June 2014 31 July 2014	Profile report produced for weekly meeting Detailed action plan for each of specialities performing below 90%	Trust level RTT 90% standard achieved Individual specialty RTT 90% standard achieved by 31 August 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		• Outcomes will continue to be reported on a monthly basis via Integrated Performance Report to Trust Management Executive (TME), Finance and Performance Committee (FPC) and Trust Board.			IPR reports to TME, FPC and Trust Board	
CA 1.4	There was not suitable attention paid to the identification, assessment and planning of care needs for vulnerable people, particularly those with dementia in **surgery** and **A&E.**	**SURGERY** Cross reference to 4.1				
		EMERGENCY DEPARTMENT • Develop a Dementia pathway through the work of the Trust Dementia Steering Group • The pathway will identify those patients that need to be assessed and clinically managed in the Emergency Department (ED), and who require specialist input with guidance on their management with respect to their dementia and cognitive dysfunctional needs. • Continue to provide on-going specialist input and advice from existing staff including gerontologists who work in ED and the Trust psychiatric team, the Trust's dementia clinical lead and the Adult Safeguarding Lead. • Provide multidisciplinary teams with training to further develop knowledge and awareness of the dementia pathway and care of vulnerable patients and optimal	**Executive Director accountability:** Director of Clinical Services Operational Lead Divisional General Manager MRC Clinical Lead for Dementia Acting Chief Nurse (as Dementia Lead Nurse)	Pathway to be completed and in progressive implementation by 31 October 2014 Initial training to be provided by 30 September 2014	Reviews of Dementia Pathway documentation and care and treatment plans making reference to their specific cognitive needs. Records of attendance at training by MDT	Vulnerable patients will be treated in the most appropriate setting to meet their needs. Monitoring of complaints shows less incidents relating to vulnerable patients. Initial pathway in place by 31st October 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		communication with relatives. • Continue to implement training on care of patients with dementia to Clinical Support Workers through the CSW Academy at induction and for existing staff within local clinical areas. • Monitor the introduction of the new pathway and implement ongoing monitoring as part of assurance visits to ensure that it is followed appropriately.				

<u>Compliance Action 2:</u> The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed.
John Radcliffe and Trust Wide. Treatment of disease, disorder or injury; Surgical procedures; Family planning; Maternity and midwifery services; Termination of pregnancies. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA2.1	There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the **maternity** department and on **surgical wards** and in **operating theatres.**	**<u>MATERNITY</u>** Recruit 14 WTE Band 5/6 midwives to fill remaining vacant posts (14 recruited to date). Those recruited will take up post between June and September 2014.	**Executive Director accountability:** Chief Nurse Operational Lead: Head of Midwifery	30 September 2014	Vacancy Control Form TRAC recruitment system	14 Band 5/6 in post by September 2014
		Recruit to the Delivery Suite Manager post	Head of Midwifery	Complete	Individual in post	Delivery Suite Manager in post
		Recruit to existing Band 7 in Maternity Assessment Unit.	Head of Midwifery	30 September 2014	Individual in post	Band 7 in post
		Review vacant Band 7 post within the community and recruit within 6 months.	Head of Midwifery	31 December 2014	Individual in post	Band 7 in post
		Utilise the reserve list of junior midwives if any vacancies arise, as required.	Head of Midwifery	31 October 2014	Database	Reserve list database in place and will be utilised where required
		Recruit 6.31 WTE Band 2 maternity support workers.	Head of Midwifery	31 October 2014	Vacancy Control Forms TRAC	6.31 WTE Band 2 in post

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
					recruitment system	
		Implement the remaining aspects of the Maternity Staffing Business Plan agreed by TME in 2013. This includes recruitment of four WTE ward receptionist posts.	Head of Midwifery	31 July 2014	Business case Paper for Divisional Executive	4 WTE receptionists in post
		Continue to use Birth rate + on a 4 hourly basis to monitor activity and acuity to ensure staffing is sufficient to meet the needs of women.	Head of Midwifery / Clinical Midwifery Manager	Annual review	Annual review of staffing. Birth Rate acuity tool	Sufficient midwives are in place to meet established staffing levels.
		Continue to support the fluctuating activity in maternity by using staff within the Hospital and community services.	Head of Midwifery	Ongoing	Review of staffing, Daily activity sheets	Sufficient midwives are in place to meet established staffing levels.
		SURGICAL WARDS • Continue to review staffing levels at least twice daily through a RAG (Red/Amber/ Green) rated pre-determined staffing levels tool. • Professional judgement to be utilised to determine if mitigating actions are required, to ensure adequate staff are in place to meet the needs of patients.	**Executive Director accountability:** Chief Nurse Operational Lead: Divisional Nurse Neurosciences, Trauma, Orthopaedics and Specialist Surgery (NOTSS)	Ongoing	Monthly reports on safe staffing levels	Safe staffing levels maintained
		Reduce nurse vacancy band 2-6 to 12% by September 2014 through the	Matrons for Trauma;	30 Septemb	Division's performanc	Reduce nurse vacancy band 2-6

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		following actions:	Orthopaedics and Theatres; Specialist Surgery; and Neurosciences	er 2014	e reports which include staffing figures against establishment	to 12% by September 2014
		• Continue rolling recruitment adverts for all nursing posts		Monthly review from June 2014	Vacancy Control Forms	
		• Continue to engage with the Trust-wide overseas recruitment programme		Ongoing	Overseas recruitment programme	Effective use of the overseas recruitment programme, recruiting at least 10 WTE in the Division per year.
		• Weekly review meetings between Divisional Nurse, HR consultant and recruitment team to monitor effectiveness across the Division.	Divisional Nurse NOTSS	30 September 2014	Notes from weekly review meetings	Reduce nurse vacancy band 2-6 to 12% by September 2014
		• Recruit from foundation rotational programme for new graduates from Oxford Brookes University.	Divisional Nurse NOTSS	30 September 2014	Staff recruited from graduate programme	
		• Develop quarterly briefing papers to be presented to the Division by	Divisional Nurse	Complete	Quarterly briefing	

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		each Directorate, providing an update on local recruitment strategies and trajectory for reducing vacancies.			papers	

		Support existing staff with retention strategies including:
		• Continue roll out of focus groups for nursing across Division, led by HR Consultants. Areas to be covered :
		  • Neurosciences
		  • Specialist Surgery
		  • Trauma
		  • Orthopaedics
		• Formulate and implement action plans as an outcome of focus groups.
			Divisional Nurse NOTSS and Senior Business Partner.	31 March 2015	Focus Group action plans	Nursing vacancy rate of 12% or less across the Division.

		Recruit and appoint two further Professional Development Nurses, to ensure inpatient areas have access to this support.	Divisional Nurse NOTSS	Complete for one post and in progress for the other by 31 July 2014.	Vacancy Control Forms TRAC recruitment system	Staff supported by Professional Development Nurses as evidence by CGC papers and ward feedback/executive walkrounds.
	There were not sufficient numbers of suitably qualified, skilled and experienced staff	**OPERATING THEATRES** Recruitment into substantive theatres and sterile services manager vacancy (Surgery & Oncology Division) and	**Executive Director accountability:** Director of Clinical	30 September 2014	Individuals in post	Appointments made & reduction in vacancies.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
	employed in the **maternity** department and on **surgical wards** and in **operating theatres.**	deputy theatre manager vacancy (Clinical Support Service Division)	Services Operational Lead: CCTA Manager / Theatre Manager			
		Ensure that staffing levels within theatres for scrub and anaesthetic and recovery nurses meet the Association of Perioperative Practitioners (AfPP) guidance	CCTA Manager / Theatre Manager	Ongoing	Divisional Performance reports	Relevant staffing levels as outlined by the AfPP are met.
		Use specialist journals in the recruitment of specialist theatre nurse / operating theatre practitioner. (Closing date of 2nd AfPP recruitment advertisement is 28 June 2014).	CCTA Manager / Theatre Manager	28 June 2014	Divisional Performance reports	Recruitment of experience scrub and anaesthetic practitioner to band 5 and band 6 roles to maintain levels of competent skill mix. Evidenced in divisional performance reports
		Continue to work closely with Human Resources towards a goal to optimise recruitment lead times to employment.	Recruitment Manager	28 August 2014	Reports on lead times	Improved advert to appointment time to an average of 8 weeks. Reported to Workforce Committee bimonthly and in the quarterly Organisational Development and

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
						Workforce Performance report.
		Attendance at a number of theatre, anaesthetic and recovery speciality specific national conferences as a spot interview opportunity to further optimise interested candidates at those venues	CCTA Theatre Manager	17 August 2014	Successful recruitment Divisional performance report.	Recruitment of experienced scrub and anaesthetic practitioners to balance skill mix and competence.
		Recruitment campaign at the British Anaesthetic and Recovery Nurse Association Conference –-6th June 2014 Greenwich, London	Theatres Band 7 charge nurses	Complete	Attendance record	Booking made and invoiced and staff identified to undertake interviewing on the day.
		Recruitment campaign will be carried out at the Association of Perioperative Practitioners Conference –-20th – 22nd June 2014, Brighton and 15th – 17th August 2014, York	HR Recruitment lead CCTA Theatre Manager	17 August 2014	Attendance record Divisional Performance report	Ongoing recruitment evidenced through the divisional performance report.
		Continue to implement a staged recruitment campaign targeting band 5 recruitment (followed by band 6's) using a co-ordinated approach with the other theatre suites across the Trust.	HR Recruitment lead Theatre Manager Charge Nurses	Ongoing		
		Reduce the use of agency staff through the work of the Agency Task and Finish Group.	Theatre Manager Charge Nurses	31 December 2014	Reduction in the use of agency	Ongoing reduction of agency staff (with a view to reducing to 0%

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
					staff. Task and Finish Group minutes	within the next 12 months)

<u>Compliance Action 3:</u> The provider had failed at times to deliver care to patients that ensured their privacy, dignity and human rights were respected.
John Radcliffe and Trust Wide. Treatment of disease, disorder or injury. Regulation 17(1)(a) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.

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CA 3.1	The use of the **accident and emergency** triage room, the atrium area, and layout of the reception did not give patients privacy and dignity**.**	These issues were discussed by senior members of the ED Team and the Director of Clinical Services and the following actions were agreed:	**Executive Director accountability:** Director of Clinical Services	Complete	Meeting notes	Patient privacy and dignity maintained as evidenced by patient feedback, and internal assurance visits.
		Frost covering for the Triage Room windows to be ordered and the door lock to be removed.	Operational Lead: Divisional General Manager MRC	Complete	Frosting in place and door lock removed	
		Atrium issues to be addressed through actions taken to address patient flow (as set out in CA1.1).				
		Additional frosting to be ordered for Trust offices that overlook the Atrium to improve privacy issues.	Divisional General Manager MRC	20 June 2014	Visual check of completion	Patient privacy and dignity maintained as evidenced by patient feedback, and internal assurance visits.
		Display notices at the ED reception desks to explain the process for disclosing private information. This will include the opportunity for patients to write information, rather than verbalise it.	Divisional General Manager MRC	Complete	Notices in place	

<u>Compliance Action 4:</u> The provider had failed at times to take proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment arising from a lack of proper information about them, by means of the maintenance of an accurate record in respect of each patient, including appropriate information and documents in relation to that care and treatment.
NOC, Churchill, Trust wide. Treatment of disease, disorder or injury. Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with good practice standards.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA 4.1	There was no suitable information within care records to inform staff about the individual care patients needed. This was particularly in relation to the needs for vulnerable people, particularly those with dementia and patients requiring complex wound management.	**<u>Oxford Centre for Enablement Ward (OCE)</u>** To review and revise the risk assessments for post-acute patients requiring rehabilitation, with the input of relevant specialist advice to meet the needs of these patient groups. Benchmark and utilise existing approaches within the Trust where this is being well implemented.	**Executive Director accountability:** Medical Director Chief Nurse Divisional Director MRC Operational Lead: Divisional Nurse MRC Therapy Lead	31 July 2014	Patients risk assessments care plans	Risk assessment are in place and well completed
		Develop a system for individual patient care plans for in-patients on OCE ward.	Matron for OCE MRC	31 July 2014	Review of patient care plans	Care plans are in place and well completed
		Identify lead people with specialist expertise on dementia and wound management to train and support staff in these areas, including effective record keeping.	Matron for OCE MRC and Consultant Nurse, Tissue Viability	From July 2014 (and ongoing)	Training records	Staff have comprehensive knowledge of these areas and plans are well developed
		Review risk assessments and	Ward sisters with	From	Record of	Risk assessments

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		completion of patient records and care plans on a weekly basis.	oversight from Matron for OCE MRC	July 2014	Weekly reviews	and care plans are well completed for the needs of the individual patient.
		Monitor compliance at directorate level during Directorate assurance visits.	Matron for OCE Directorate Operational Service Managers MRC	31 July 2014 and ongoing	Records of Assurance visit	As above.
		Ward E, NOC Review of current documentation in use across the directorate for identification and on-going management of patients.	Matron NOC NOTSS	31 July 2014	Meeting minutes Assurance audits	Risk assessments and care plans are reviewed and improved
		Establish a working group within orthopaedics facilitated by dementia lead nurse, with multi professional input. • Objectives and terms of reference to be determined at the first meeting. • Key objective to launch a training programme on dementia care that meets the needs of this patient group within an orthopaedic environment	Matron NOC Ward Sisters NOTSS Dementia Leader NOTSS Division	1 September 2014	Minutes of working group Training programme and records	Implementation of the dementia training and ongoing review every 6 months which demonstrates leadership within each ward in the provision of care plans that incorporate dementia patients.
		Divisional Dementia Leaders and Consultant Nurse, Tissues Viability to train and support staff in these areas,	Matron NOC with input from Divisional Dementia	31 July 2014	Training records	Ward sisters and senior ward staff have knowledge of

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		including effective record keeping.	Leader and Consultant Nurse, Tissue Viability			the care of dementia patients and wound management
		Review ward sisters audit tool to ensure that it takes into account individual patient wound management needs.	Ward Sisters NOC NOTSS	30 June 2014	Snap shot audits by Ward Sisters and Matron	Effective wound management care is in place, (using the safety thermometer to monitor this).
		Review risk assessments and completion of patient records and care plans on a weekly basis.	Matron NOC and Consultant Nurse, Tissue Viability	From July 2014	Record of Weekly reviews	Risk assessments and care plans we well completed for the needs of the individual patient.
		Develop a cross divisional care plan that highlights the requirements for the use and management of VAC therapy for complex wound management.	Matron NOC NOTSS and Consultant Nurse, Tissue Viability	30 September 2014	Care Plan Divisional quality report	
CA4.2	Records did not contain all the required information to ensure care was delivered safely to meet the patient's needs.	**John Warin and Geoffrey Harris Wards** CQC findings to be discussed with all staff working on both wards	Divisional Nurse MRC	Complete	Meeting notes	Staff can demonstrate knowledge of relevant findings and plans
	Risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to	Review and standardise all assessment forms and handover sheets on both wards to ensure consistency.	Matron for Ambulatory Medicine MRC	30 June 2014	Risk assessment forms and handover sheets	Standardised documents in place that is completed and used to handover
		Matron to train and support staff in	Matron for	31 July	Training	Staff have

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
	be managed and care was to be provided. This placed patients at risk of not receiving the care they needed.	these areas, regarding effective record keeping.	Ambulatory Medicine MRC and Consultant Nurse, Tissue Viability	and ongoing	records	comprehensive knowledge of these areas and plans are well developed
		Audit ten sets of notes every week (five sets of notes on John Warin Ward and five sets of notes on Geoffrey Harris ward) to assess the following; • Risk assessments are completed. • Completed care plans that relate appropriately to the risk assessments • The standard of information documented reflects all the information required to deliver care based on the patients' needs.	Matron for Ambulatory Medicine MRC	31 July 2014	Audit results	As above
		Monitor compliance at directorate level during Directorate assurance visits.	Matron for Ambulatory Medicine MRC Directorate team	30 June 2014 and ongoing	Records of Assurance visit	As above.

<u>Compliance Action 5:</u> The provider did not have suitable arrangements in place in order to ensure that all staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard through receiving appropriate training, professional development and supervision.
John Radcliffe. Treatment of disease, disorder or injury; Maternity and midwifery services. Regulation 23(1)(a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to ensure that staff receive suitable induction to each area that they work within the trust.

The trust needs to ensure that newly qualified midwives are appropriately supported.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA5.1	Some of the new nursing staff coming to work at the hospital did not have sufficient induction into the **A&E department**.	Review and update local induction pack for new starters with consultant nurse in ED and cohort of new starters.	**Executive Director accountability:** Chief Nurse Operational Lead: Divisional Nurse MRC	31 July 2014	Minutes of meetings	Staff complete their induction and competencies are achieved as evidence by detailed monitoring of process in February 2015.
		Develop a new pack to be published, tested and implemented with overseas staff to ensure assessments and competencies meet their learning needs.	Divisional Nurse MRC	31 July 2014		
		Monthly sessions for the first 6 months from their start date, for new starters to feedback any concerns in the form of action learning sets.	Divisional Nurse MRC	With effect from 1 August 2014	Summary of action learning sets Competencies achieved	
CA5.2	Newly qualified **midwives** did not always receive	Review and update the preceptorship package for all areas	Head of Midwifery	31 July 2014	Completion of preceptorship	Staff are supported

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
	adequate preceptorship.	in the maternity service with liaison with ED (as outlined above) to ensure that shared learning is in place.			package and attendance at the Trust preceptorship programme.	through effective preceptorship as evidence by a staged review of process in February 2015 and July 2015.
		Ensure midwives have the support required to induct them into the clinical areas. Each midwife to have: • written plan • copy of the preceptorship package • nominated preceptor.	Clinical Midwifery Managers	Ongoing	Positive feedback from new graduates.	
		Newly qualified midwives to follow the established process of preceptorship for up to 12 months in order to achieve their competences. (There is a sign off process to ensure this is completed and before a Band 5 can move to a Band 6).	Practice Development Midwives	Complete	Preceptor package, competencies Individuals employed as Band 6's.	
		Continue to ensure that newly qualified midwives are aware of the support group for new graduates. This is currently well attended.	Supervisors of Midwives	Complete	Attendance records and evidence that staff are supported to attend	
CA5.3	Not all nurses qualified overseas working in **A&E** and newly qualified **midwives** were appropriately supervised to	For actions relating to supervision and support in A&E see CA5.1				
		Continue to support the four student Supervisor of Midwives (SOM's) to complete the programme, thereby	Local supervising midwifery	30 September 2014	Successful completion of programme	Supervisory caseload ratio 1:18

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
	ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.	ensuring from September the caseload ratio will be 1:18.	officer (LSAMO)/Head of Midwifery (HOM)		and demonstrate supervisory activity.	
		To further address this, support will be given to six OUH midwives to attend the programme in 2014/15 to improve the ratio to 1:16 (dependent on leave / turnover).	LSAMO/HOM	30 September 2015	6 midwives supported to attend the programme.	Supervisory caseload ratio 1:16