Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 10 July 2019

TB2019.74

Title	**Response to recent CQC Inspection Reports**

Status	For discussion
History	This is the first paper on this action plan

Board Lead(s)	Eileen Walsh, Chief Assurance Officer			
Key purpose	Strategy	Assurance	Policy	Performance

Executive Summary

1. On 7th June 2019 the CQC published the inspection outcomes for Oxford University Hospitals NHS Foundation Trust, relating to the following inspection activities:

- 19-21 November 2018 – unannounced inspection of 5 core services
- 13 December 2018 - Use of Resources Inspection (announced).
- 8-10 January 2019 - Well led inspection (announced).

2. The report provides a summary of the inspection outcomes for the Trust:

- The Use of Resources inspection outcome is *'Requires Improvement'*.
- The CQC rated the Trust as '*Good*' for Caring, Responsive and Effective domains.
- The CQC rated the Trust as '*Requires Improvement'* for Well-led and Safe domains.
- The overall rating of *'Requires Improvement'* for the Trust.

3. As part of the inspection process the reports have identified a number of actions for the Trust. These are comprised of 35 'Must do' and 24 'Should do' actions. Some of the 'Must do' and 'Should do' actions are repeated across all four sites and core services.

4. As requested by the CQC the Trust will submit a draft response by 5th July 2019, with their acknowledgement that the Board would formally review, discuss and approve the draft response at the next Board meeting. Dependent upon the outcome of the Board discussions the final approved action plan will be submitted in the required CQC template, following the meeting.

5. The report provides a summary of the monitoring processes put in place.

Recommendation

6. The Board is asked to:

- Review and discuss the proposed action plan;
- To approve the formal submission of the actions to the CQC in the required template following the meeting.

Response to recent CQC Inspection Reports

1. Introduction

1.1. On 7th June 2019 the CQC published the inspection outcomes for Oxford University Hospitals NHS Foundation Trust, relating to the following inspection activities:

- 19-21 November 2018 – unannounced inspection of 5 core services
  - Urgent and Emergency Care
  - Medical Care
  - Surgery
  - Maternity
  - Gynaecology.
- 13 December 2018 - Use of Resources Inspection (announced).
- 8-10 January 2019 - Well led inspection (announced).

1.2. Two inspection reports were published on CQC website and the Trust website the two documents are hyperlinked for information.
https://www.cqc.org.uk/sites/default/files/Oxford_University_Hospitals_NHS_Foundation_Trust_Use_of_Resources_published_07_June_2019.pdf
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ4270.pdf

2. Final Ratings

2.1. The following provides a summary of the inspection outcomes for the Trust:

- The Use of Resources inspection outcome is *'Requires Improvement'*.
- The CQC rated the Trust as '*Good*' for Caring, Responsive and Effective domains.
- The CQC rated the Trust as '*Requires Improvement'* for Well-led and Safe domains.

2.2. The overall rating of *'Requires Improvement'* for the Trust is presented in figure 1.

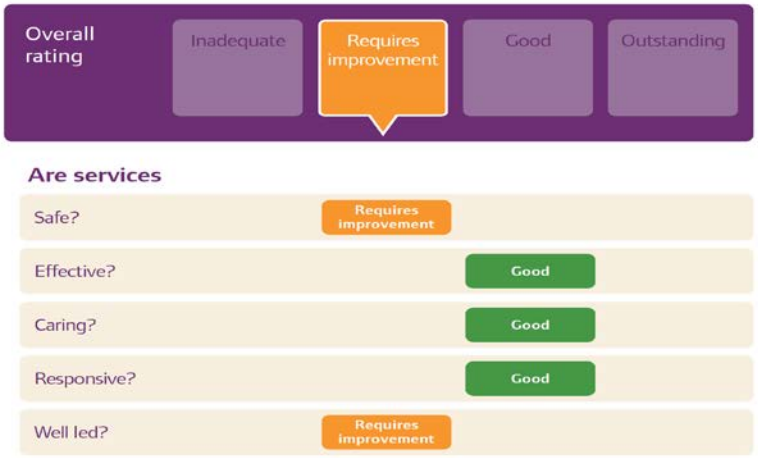

Figure 1

2.3. Whilst reading the detailed findings, it is important to note that the CQC found that:

- *staff care for patients with **compassion and kindness** and they had consistently positive feedback from the patients who they spoke to during their inspections about their treatment.*

- *staff provided **emotional support** to patients to minimise their distress*
- *staff **involved patients** and **those close to them in decisions** about their care and treatment.*

3. Improvement Planning

3.1. As part of the inspection process the reports have identified a number of actions for the Trust. These are comprised of 35 'Must do' and 24 'Should do' actions. Some of the 'Must do' and 'Should do' actions are repeated across all four sites and core services.

3.2. The 'Must do' actions have been cohorted, by the CQC, against five specific regulations within the Health and Social Care Act 2008:

- Regulation 10 - Dignity and respect;
- Regulation 12 - Safe care and treatment;
- Regulation 15 - Premises and equipment
- Regulation 17 - Good governance
- Regulation 18 - Staffing.

3.3. The report findings and response was discussed at Council of Governors seminar in June and at the Trust's Clinical Governance Committee in June. The formal written response was circulated to the Board on 2nd July for final consideration and comment.

3.4. As requested by CQC the Trust will submit a draft response by 5th July 2019, with their acknowledgement that the Board would formally review, discuss and approve the draft response at the next Board meeting. Dependent upon the outcome of the Board discussions the final approved action plan will be submitted in the required CQC template, following the meeting.

3.5. This report focuses on the response in relation to the 'Must do' actions. There is a separate process in place to develop a similar plan for the 'Should do' actions that is currently under development.

4. Monitoring

4.1. The actions to address the CQC concerns have been mapped to the existing NHSI enforcement undertakings (which have been incorporated into the Integrated Improvement Plan (IIP))

4.2. Progress with CQC actions will be monitored by the Trust Management Executive on a monthly basis (in conjunction with the IIP monitoring process).

4.3. Updates on progress with the actions will be provided to the Board and its sub-committees for discussion on a regular basis, linked to progress updates on the IIP.

5. Recommendation

5.1. The Board is asked to:

- Review and discuss the proposed action plan
- To approve the formal submission of the actions to the CQC in the required template following the meeting.

Eileen Walsh
Chief Assurance Officer

Paper prepared by: Clare Winch, Director of Regulatory Compliance and Assurance
July 2019

	Concern (from CQC report)	theme	Reg	Core Service	Overarching action (s)	Executive Lead	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	What resources (if any) are needed to implement the change(s) and are these resources available?	How will people who use the service(s) be affected by you not meeting this regulation until this date?	End date	Status
1	The trust must ensure patients privacy and dignity is maintained when they are asleep, unconscious or lack capacity (surgery core service only). * please note these actions had already commenced in response to the Section 31 notice received from the CQC in December 2018.	privacy	10	Surgery	a) Temporary solution (Dec 2018) : In the interim apply temporary laminated cover to the windows in theatres	COO	These actions form part of the Section 31 action plan put in place with effect from 20 December 2018. Immediate remedial action was taken from 20 December to ensure issues with environment were addressed. The longer term solution was incorporated into the JR 2 Theatre Refresh Project. Delivery of this project plan is reviewed internally on a weekly basis by the Theatre Improvement Group, and is also reported to the CQC enforcement team on a weekly basis. Overall progress with the project plan is monitored by the Trust Management Executive, the Quality Committee and the Trust Board, as appropriate.	The resources have already been allocated and the project is in progress. The project costs of £1,000,000 have been allocated from the Trust Capital Programe, and the additional revenue costs/implications are currently being reviewed.	Immediate actions have been put in place to maintain the monitoring of any potential safety aspects of the risks highlighted within JR2 Theatres until the project is completed.	21/12/18	Completed
		privacy	10	Surgery	b) Permanent solution: Obscured window film to be applied to all doors/windows from the theatre corridor into theatre.	COO				29/01/19	Completed
		privacy	10	Surgery	c) Further consideration will be given to what additional actions may be required to maintain privacy and dignity within theatres	COO				19/12/18	Completed
		privacy	10	Surgery	d) Develop and implement the JR2 Refresh Project to address known risks to the environment in a more sustainable manner.	COO				19/08/19	on track
2	The trust must ensure privacy and dignity of patients is maintained in the Emergency Department (ED and EAU) *please note a number of these actions had already commenced in response to the letter of intent from the CQC received in December 2018.	privacy	10	Urgent and Emergency	Immediate actions taken in December 2018 were to: Develop a communication plan, remove the chair from outside the cubicle, undertake a 15 steps audit with results fed back to all staff in ED and the introduction of a bespoke patient safety checklist on the electronic patient records system entitled HUMFS, incorporating	CNO / COO	Monthly audits continue with 90-100% compliance being recorded and reported locally.	Local actions are being taken and no additional resources are required.	Immediate actions were put in place since December 2018 and the regular monitoring demonstrates continued compliance within ED until the completion of the ED expansion project.	01/02/19	Completed
		privacy	10	Urgent and Emergency	Undertake a review of privacy screens and work with South Central Ambulance Services (SCAS) to enforce practice between workforces	CNO / COO	This is monitored through local walk round processes and it has been noted that the usage of screens for transfer of patients on arrival is standard practice and has been well supported by SCAS.			01/02/19	Completed
		privacy	10	Urgent and Emergency	Develop an alternative assessment for surges in activity, in collaboration with AMR Directorate and NOTSSCaN Division, and ensure this is included in a revised 'Surge Plan'	CNO / COO	The surge plan has been included as part of the Operational Pressure Escalation Level (OPEL) assessment and escalation plan. Monitoring is conducted by the operational team and included in daily reports.			01/02/19	Completed
		privacy	10	Urgent and Emergency	Draw up and deliver plans to increase the size and improve the facilities of the ED at the JR. The expansion will create an extra 9 bays for the immediate care of seriously ill patients, a paediatric resuscitation room and an isolation room with an adjacent CT scanner and control room, as well as improved bereavement and relatives' rooms	CNO / CFO	This project is part of the Urgent Care Improvement Plan developed as part of the NHSI undertakings (work stream 6: Physical Space aimed to increase the assessment space, resus capacity and implement and ambulatory area of emergency surgery), delivery is being monitored via the Trust Management Executive and the Finance & Performance Committee	The resources have already been allocated and the build is in progress. The project costs of £13,800,000 have been allocated from the Trust Capital Programme		31/03/20	In progress
3	The trust must ensure all staff complete their mandatory training and the required level of safeguarding training for their role. (for emergency department only)	training	12	Urgent and Emergency	a) Implement a training plan for all staff groups, b) The Directorate to use the individual alert system to follow-up when training has expired c) Ensure there is monthly monitoring across all staff groups by the clinical directorate team d) Monitoring of progress to be incorporated into the monthly divisional performance reviews and the quarterly performance review by the Executive team.	CPO / COO	Monthly reviews of all staff groups is undertekan by the clinical directorate team. The monitoring of progress will be conducted as part of the monthly divisional perfomance reviews and the quarterly performance reviews by the Executive team.	Additional resources to provide increased training availability of core courses are being addressed locally.	Local monitoring and mitigations ensure that ther is no impect on patients.	31/03/20	In progress
	The trust must ensure patient health records are stored securely in all areas of the ED and EAU.	patient records	12 & 17	Urgent and Emergency	Purchase lockable units for the Emergency Department to secure 'buff notes' prior to the implementation of the 'paper lite' solution.	COO	Lockable units have been purchased. Matron walk arounds are conducted on a regular basis to assess the effectiveness of the actions to manage the transition period to the 'paper lite' solution.	Resources were allocated from the local budget to enable new units to be purchased to house buff notes, these have been obtained and are now in use.	Short term solution should maintain confidentiality until the 'paper lite' solution is delivered.	30/06/19	completed
4		patient records	12 & 17	Urgent and Emergency	A local action plan is in place to deliver a 'paper lite' with no 'buff notes' by 1 November 2019	COO	A local action plan is in place to deliver the 'paper lite' process this is monitored as part of the digital programme.	Resources have been factored into the Trust's digital programme.		01/11/19	in progress

	Concern (from CQC report)	theme	Reg	Core Service	Overarching action (s)	Executive Lead	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	What resources (if any) are needed to implement the change(s) and are these resources available?	How will people who use the service(s) be affected by you not meeting this regulation until this date?	End date	Status
5	The trust must ensure medicines are safely and securely managed and stored at all times. (for emergency department only)	medicines	12	Urgent and Emergency	Local actions to address medicines storage in ED are incorporated into the Trust wide implementation of the safe storage of medication plan. This plan includes the need to a) address the access to store rooms and/or drug cupboards b) address any short falls in compliance in practice.	CMO / COO / CNO	Actions taken in ED will be monitored via the trust wide safe storage audit. Additional monitoring is undertaken through the review of storage of medication incidents recorded on datix. Daily monitoring and regular spot checks occur by senior staff In ED. The Trust Internal Audit Program includes medicine storage, the results are reported to the Audit Committee. In addition all internal audit recommendations are monitored to completion as part of the Trust Management Executive. Medicine Management is subject to regular monthly audits that are reported as part of the Trust's Clinical Governance processes. Medicines safety will be part of monthly and quarterly performance management reviews and reported to the Board.	Local actions are being taken and are being addressed by use of local resources. Any additional resources that might be required will be incorporated into the Trust wide response.	The daily monitoring and spot checks will ensure that patients are not affected by any storage of medicine issues.	31/07/19	In progress
6	The trust must ensure that all relevant staff sign Patient group directions documentation to indicate they understand them and will work with the framework as described. (emergency department only)	competency	12	Urgent and Emergency	An nurse manager will be assigned to specifically control and monitor the PDG documentation and to ensure all relevant staff permitted to use the PDGs are recorded as competent.	COO	This is part of a designated role of the Lead Practitioner and will be continually monitored as part of a routine quarterly review process. In order to ensure this is sustainable the Emergency Department team has undertaken a clarification of role and set out bespoke dates for review. In addition there has been clear communication to key staff of their responsibilities.	These responsibilities have been incorporated into an existing role no additional resources have been required.	The programme of dates will ensure that all PDG documentation is kept under consistent review.	31/07/19	In progress
7	The trust must ensure all staff adhere to trust policy regarding infection prevention and control. (emergency department only)	IPC	12	Urgent and Emergency	Local actions are being taken to address the issues identified in the John Radcliffe ED these included: a) Develop a quality improvement approach to addressing infection control issues within ED b) Ensuring the safety checklist used at clinical handover includes a focus on infection control issues c) The implementation of checks to infection Prevention and Control (IPC) practices including the use of sharps bins and hand hygiene practice. Infection Control is part of all staff induction.	CMO / CNO	The team have started auditing with the 'Speedy Audit App' they are currently undertaking a phase 1 audit run from 19th – 30th June 2019. A weekly safety walk around is in place checking all areas in ED and identifying if sharps bins are not being emptied appropriately. These actions will form part of the local CQC action plans that will be in place. This will be monitored monthly as part of the routine governance process. In addition the Infection Prevention and Control team are undertaking regular Hand Hygiene audits and compliance checks.	The local ED team are being supported by the Trust quality improvement hub, this resource is already established and available.	The routine checks will ensure that patients are not affected by any infection control issues.	01/09/19	In progress
8	The trust must review the safe storage of all items stored on trolleys in the children's ED.	premises & equip	15	Urgent and Emergency	Purchase 'closed units' to replace the current trolleys in children's ED in the John Radcliffe Hospital, by 1 September 2019. Implement daily monitoring of children's ED trolleys to maintain safe storage until equipment is delivered.	COO	This action will form part of the local CQC action plan that will be in place and monitored monthly as part of the routine governance process, within the MRC Division.	The department had resource to purchase 'closed units' and they have been ordered.	The routine monitoring will ensure that patients are not affected by storage issues.	01/09/19	In progress

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9	The trust must ensure risks relating to the fabric of the environment is assessed and take action to ensure it is safe and fit for purpose. (surgery core service only). * please note these actions had already commenced in response to the Section 31 notice received from the CQC in December 2018.	premises & equip	15	Surgery	Conduct an initial walk round assessment of all areas of the main operating theatre (JR2) to identify immediate remedial work to be conducted.	COO	These actions form part of the Section 31 action plan put in place with effect from 20 December 2018, immediate remedial action was taken to ensure issues with environment were addressed, longer term solution incorporated into JR 2 Theatre Refresh Project, this action plan is reviewed internally weekly by the Theatre Improvement Group, reported to CQC enforcement team on a weekly basis and also reported to the Trust Management Executive, the Quality Committee and the Trust Board, wherever necessary.	The resources have already been allocated and the project is in progress, the project costs of £1,000,000 have been allocated from Trust Capital, there are additional revenue costs/implications that are currently being reviewed.	Immediate actions have been put in place to maintain the monitoring of any potential safety aspects of the risks highlighted within JR2 Theatres until the project is completed.	19/12/18	Completed
		premises & equip	15	Surgery	Implement actions to repair damage to floors, doors, walls and work surfaces.	COO				28/12/18	Completed
		premises & equip	15	Surgery	Establish a rapid response team from estates to take risk assessed response to JR2 theatres estates incidents and where possible ensure that issues are remedied within 48 hours of an issue being raised or that appropriate controls are put in place to mitigate the risk where this is not possible.	COO				21/01/19	Completed
		premises & equip	15	Surgery	Establish a group to oversee maintenance of main operating theatres and the work of the rapid response team.	COO				21/01/19	Completed
		premises & equip	15	Surgery	Develop and implement the JR2 Refresh Project to address known risks to the environment in a more sustainable manner.	COO				19/08/19	on track
		premises & equip	15	Surgery	These actions form part of Infection Prevention and Control (IPC) annual plan and include: a) The IPC team to develop an Environmental Audit tool to enable the audit of all clinical areas annually with the local ward leader. b) Clinical area walk-rounds to be undertaken by IPC/Director of Estates to review areas and prioritise any remedial work. c) IPC and Estates to develop a process to provide areas with a clear understanding of how to report environmental issues.	COO	Monitoring of the IPC annual plan is undertaken as part of routine reporting to the Clinical Governance Committee and to Trust Management Executive.	Resources these have been incorporated into the IPC annual plan . Any additional actions identified for remedial action will be included in any relevant business cases, as required.	The monitoring of environmental reporting will identify any areas requiring remedial action. The Audit tool has already been completed and is ready for use and will provide some mitigations until actions are completed.	31/03/20	In progress
10	The trust must ensure operating rooms are suitable for the purpose they are used for, for example have ultra clean ventilation. The theatre departments are clear and maintained properly to ensure adequate cleaning can be carried out. (surgery core service only) * please note these actions had already commenced in response to the Section 31 notice received from the CQC in December 2018.	premises & equip	15	Surgery	a) From December 2018 onwards implement an immediate clean of all equipment held in theatres to be cleaned before and after use.	COO	These actions form part of the Section 31 action plan put in place with effect from 20 December 2018. Immediate remedial action was taken from 20 December to ensure issues with environment were addressed. The longer term solution was incorporated into the JR 2 Theatre Refresh Project. Delivery of this project plan is reviewed internally on a weekly basis by the Theatre Improvement Group, and is also reported to the CQC enforcement team on a weekly basis. Overall progress with the project plan is monitored by the Trust Management Executive, the Quality Committee and the Trust Board, as appropriate.	The resources have already been allocated and the project is in progress. The project costs of £1,000,000 have been allocated from the Trust Capital Programe, and the additional revenue costs/implications are currently being reviewed.	Immediate actions have been put in place to maintain the monitoring of any potential safety aspects of the risks highlighted within JR2 Theatres until the project is completed. Weekly cleaning audits have been in place from 22 January 2019 and demonstrate compliance.	22/01/19	Completed
		premises & equip	15	Surgery	b) Review and update existing SOP for cleaning in theatres, which will include: cleaning before and after use and weekly checking process	COO				22/01/19	Completed
		premises & equip	15	Surgery	c) Develop and implement the JR2 Refresh Project to address known risks to the cleaning of the environment in a more sustainable manner.	COO				19/08/19	on track
11	The trust must ensure information is collected, analysed, managed, and used in such a way to ensure information is presented in clearly easily understood way, which can be used to provide assurance.	governance	17	Trust Level	Review and develop the Trust Board level Integrated Performance report.	CAO / COO	The revised reporting system will be incorporated into the revised performance and accountability framework. Progress will be monitored by the Trust Management Executive and the Trust Board via the Integrated Improvement Plan. Progress against this plan is also reported to NHSI as part of the enforcement undertakings.	The Trust Board has approved resources to support the recruitment of the new Director of Performance and Accountability, which is in progress. Any additional resources to implement the remaining actions are being planned into normal programmes of work with any additional costs being included in relevant business cases, as required.	The availability of good quality performance information covering, all aspects of performance; operations, quality, finance, and workforce performance data enables the senior leaders in the Trust to make more effective decisions about the issues in a more planned and strategic manner, it provides a greater degree of understanding about that level of risk the issues may pose and the potential quality impact of mitigating actions.	30/09/19	In progress
		governance	17	Trust Level	There are a range of actions that have been developed in relation to the development and implementation of the Trust's performance and accountability frameworks. These focus on the following: a) To review, redesign and develop the performance Trust's management & accountability framework. b) Develop and implement the revised reporting of performance information from clinical directorate level to Board level c) Appoint a new Director of Performance and Accountability to lead and support the new performance management function.	CAO	These actions have been incorporated into the Integrated Improvement Plan, linked to the Deloitte Review of leadership and governance (Governance Section). Delivery is being monitored via the Trust Management Executive and the Board and its sub Committees. Progress against this plan is also reported to NHSI as part of the enforcement undertakings.			range of dates up to 31/12/19	in progress
		governance	17	Trust Level	Develop the workforce data and planning tools to enable the monthly reporting of workforce information and workforce dashboards at a clinical divisional level	CPO				30/09/19	in progress

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12	The trust must review the effectiveness of their process for ensuring risks are recognised and actions taken to manage the impact of such risks.	governance	17	Trust Level	There are a range of actions that have been developed in relation to improvements in risk management practice these focus on the following: a) The implementation of a strengthened risk escalation process and increased effective utilisation of risk registers across the Trust. b) The re-education of key Divisional staff regarding risk registers, by providing staff with a greater understanding and knowledge on how to identify, escalate and manage risks more effectively at local level. c) The review and update of the Risk Management Policy to act as enabler to	CAO	These actions have been incorporated into the Integrated Improvement Plan, linked to the Deloitte Review of leadership and governance (Governance Section). Delivery is being monitored via the Trust Management Executive and the Board and its sub Committees. Progress against this plan is also reported to NHSI as part of the enforcement undertakings.	Actions undertaken are being planned into normal programmes of work any additional costs are being included in relevant business cases, as required.	Monthly and quarterly performance management review meetings have incorporated a review of risk registers into the process. This will ensure the regular monitoring of risks and enable a focus on the completion of actions.	30/09/19	in progress
13	The trust must ensure the effectiveness of the board is monitored in a formal way.	governance	17	Trust Level	Board will implement an externally recognised tool to assess the effectiveness of the Board. The Board will record and report the results, take any actions as identified and repeat this exercise annually.	CAO	These actions have been incorporated into the Integrated Improvement Plan, linked to the Deloitte Review of leadership and governance (Governance Section). Delivery is being monitored via the Trust Management Executive and the Board and its sub Committees. Progress against this plan is also reported to NHSI as part of the enforcement undertakings.	Actions identified will be planned into normal programmes of for board development.	People using the services will be minimally impacted as the measure of effectiveness will be introduced within a short time frame.	31/09/2019	
14	The trust must ensure patient health records are stored securely in all areas of the ED and EAU. * this is a repeat of the earlier concern number 4	patient records	12 & 17	Urgent and Emergency	See Comments included in relation to Response form number 4	COO	See Comments included in relation to Response form number 4	See Comments included in relation to Response form number 4	See Comments included in relation to Response form number 4	n/a	n/a
15	The trust must ensure patient records are fully completed. (medicine core service)	patient records	17	Medical care	a) Review and update the Trust wide Health Records Policy b) Implement the 'paper lite' project in all inpatient areas across the Trust c) Implement the inpatient digital pathway across the Trust.	COO / CMO / CNO	There is a trust wide audit of health records condicted annually. The Trust Data Quality Group conducts audits of health records across the Trust. The Trust Internal Auditors have a rolling programme of data quality reviews covering the key national performance standards andthis includes information governance checks. Regular review of medical record related incident as recorded on Datix.	Resources have been factored into the Trust's digital programme.	The monitoring of actions will ensure that this does not have an impact on patients.	31/03/20	In progress
16	The trust must ensure risk registers reflect the current risks to their departments, the level of escalation of those risks and their mitigation. These must be reviewed on a regular basis. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.	governance	17	Surgery	See Comments included in relation to Response form number 12	CAO	See Comments included in relation to Response form number 12	See Comments included in relation to Response form number 12	See Comments included in relation to Response form number 12	n/a	n/a
17	The trust must work to improve and meet the national target for patients from referral to appointment of 52 weeks. (Gynaecology core service) * please note this action was part of the Elective Care Improvement Plan as part of NHSI undertakings already in place prior to the receipt of the CQC report and the action was formally closed with effect from 31 March 2019	waiting time	17	Gynaecology	As part of the NHSI undertakings and national targets the Trust was required to take all reasonable steps to 'as a minimum halve the number of patients waiting more than 52 weeks for an elective procedure, and to maintain or reduce the current backlog, within the constraints of system affordability.'	COO	This action was part of the Elective Care Improvement Plan as part of NHSI undertakings (work stream 3: Pathway Management aimed to deliver a reduction in the number of 52 week waits to zero by 31 March 2019) progress was monitored by regular performance reports to Trust Management Executive, Finance & Performance Committee and to NHSI.	Actions undertaken were included in normal programmes of work.	The action has already been completed as a result there is no further affect to patients.	31/03/19	Completed

	Concern (from CQC report)	theme	Reg	Core Service	Overarching action (s)	Executive Lead	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	What resources (if any) are needed to implement the change(s) and are these resources available?	How will people who use the service(s) be affected by you not meeting this regulation until this date?	End date	Status
18	The trust must ensure they have the right people with the right skills at executive level. * please note this action was part of the Deliotte Action Plan already in place prior to the receipt of the CQC report	staffing	18	Trust Level	Undertake a formal consultation with relevant staff on proposals to strengthen and restructure the Executive and Senior Management teams.	CEO	The consultation was managed in accordance with the Trust's Managing Organisational Change Procedure, staff responses were considered by the Trust Board and by the Remuneration & Appointments Committee during March and April 2019.	Actions undertaken were included in normal programmes of work any additional costs are being included in relevant business cases, as required.	The current identified gaps in Board capacity and capability have been recognised and have been re-profiled across the current Executive team until the full implementation of the revised structure has been completed	31/03/19	Completed
		staffing	18	Trust Level	Ensure the implementation of the agreed revised structure (new COO, Chief Digital and Partnership Officer, Chief People Officer coupled with the implementation of consistent of job titles across other executive roles)	CPO	These actions have been incorporated into the Integrated Improvement Plan, linked to the Deloitte Review of leadership and governance (Governance Section). Delivery is being monitored via the Trust Management Executive and the Board and its sub Committees. Progress against this plan is also reported to NHSI as part of the enforcement undertakings.			31/01/20	in progress
		staffing	18	Trust Level	Engage the Foundation Trust Governors in the identification of current and future skills gaps in the Non-Executive Directors , with a view to future recruitment of NED roles.	Chair	Discussed at the Council of Governors' Remuneration, Nominations and Appointments Committee Remunerations and at the Council of Governors Seminar in June 2019	This action was included in normal work programmes and did not result in additional costs.	This action has already been completed so there is no further impact in relation to this action.	18/06/19	Completed
19	The trust must ensure there is a board level development plan which reflects the needs of the board and supports them in developing the knowledge required to maintain oversite organisations priorities. * please note this action was part of the Deliotte Action Plan already in place prior to the receipt of the CQC report	staffing	18	Trust Level	Create and implement a Board Development Programme linked to the development of the Trust's strategy. Work is in progress and is also includes the support and induction of new NEDS into the Trust to ensure that they land with confidence.	CAO	These actions have been incorporated into the Integrated Improvement Plan, linked to the Deloitte Review of leadership and governance (Governance Section). Delivery is being monitored via the Trust Management Executive and the Board and its sub Committees. Progress against this plan is also reported to NHSI as part of the enforcement undertakings.	External support has been commissioned from Deloitte to assist with the creation of the Board Development Programme. This was subject to a formal tendering process and resources allocated to undertake this work were agreed.	People using the services will be minimally impacted as the measure of effectiveness will be introduced within a short time frame.	31/08/19	in progress
		staffing	18	Trust Level	Undertake a facilitated Executive development programme (Affina Programme)	CPO	Workforce Improvement Plan as part of NHSI undertakings (work stream 8: leadership, ownership and capability building, included Board and executive leadership development)	Support is being provided by NHSI / HEE as part of the culture and leadership review.	This action has already been completed so there is no further impact in relation to this action.	18/06/19	Completed
20	The trust must ensure managers appraise staff's work performance.	appraisal	18	Trust Level	Ensure that 85% of permanently employed staff, whose contract extends beyond 12 months, have a completed appraisal. This includes: a) The development and implementation of a new approach to appraisal and performance management of individuals b) Holding workshops to launch the new approach.	CPO	There is a system in place to record and monitor compliance rates. This is to be incorporated into the performance monitoring review process.	This action will be included in normal work programmes and will not result in additional costs.	Monthly and quarterly performance management review meetings will incorporated a review of appraisal rates into the process. This will ensure the regular monitoring of actions to improve appraisal rates.	31/03/20	In progress
21	The trust must ensure staff are **competent for their roles** and managers appraise staff's work performance. (emergency department only)	appraisal	18	Urgent and Emergency	Ensure that all staff are competent to perform their role and ensure that staff are up to date with statutory and mandatory training and have regular appraisal, that managers understand how to appraise staff. A local action plan is under development this will include a) Defined roles and specific courses for each grade b) To be monitored as part of the divisional governance meeting on a monthly basis.(in addition see action numbers 3 and 20 in relation to statutory and mandtory training and appraisals)	CPO / COO	A local action plan is under development this will include a) Defined roles and specific courses for each grade b) To be monitored as part of the divisional governance meeting on a monthly basis.	A number of the courses cost more than is in CPD budget to cover the MRC Division, this will need further review.	The routine monitoring of safe staffing level will ensure that patients are not affected by this issue.	30/09/19	In progress
22	The trust must ensure they are sufficient number of staff the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. (surgery core service only)	staffing	18	Surgery	a) Develop and implement a business case to increase consultant capacity with the Surgery and Oncology Division b) Introduce a new code for urgent requests for NHSP staff, that must be authorised by the Divisional Nurse c) Review the use of 'long lines' for certain staff groups d) Recruitment processes to focus on hard to recruit staff groups for example theatre nurses e) Undertake Listening in Action events to disucss the results from the staff survey in relation to staffing issues.	COO	Safe staffing process are in place and regular mitigation actions are taken on a daliy basis. Safe staffing information is reported to the Trust Board on a regular basis. All Divisions monitor performance against safe staffing levels on a monthly basis and this forms part of the routine divisional performance review process	Actions undertaken were included in normal programmes of work any additional costs are being included in relevant business cases, as required.	The routine monitoring of safe staffing level will ensure that patients are not affected by this issue.	30/09/19	in progress

	Concern (from CQC report)	theme	Reg	Core Service	Overarching action (s)	Executive Lead	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	What resources (if any) are needed to implement the change(s) and are these resources available?	How will people who use the service(s) be affected by you not meeting this regulation until this date?	End date	Status
23	The trust must ensure there are sufficient numbers of suitably qualified, competent skilled and experienced staff to meet the needs of the service, both midwifery and medical. (maternity core service only)	staffing	18	Maternity	Ensure the Trust is compliant with NHS Resolution Maternity Incentive Scheme standards, these cover a) Medical workforce planning b) Midwifery Workforce Planning and c) Key element of training.	CPO / CNO	Compliance is monitored by the Maternity Directorate Governance meetings and reported to the Board on a bi-annual basis.	Actions undertaken were included in normal programmes of work any additional costs are being included in relevant business cases, as required.	The routine monitoring of safe staffing level will ensure that patients are not affected by this issue.	16/08/19	in progress
24	The trust must ensure security to the children's ED entrance is maintained. (emergency department only)	premises & equip	15	Urgent and Emergency	Undertake a risk assessment of the issues identified and review the signage within the ED.	COO	Reviewed signage is in place. All security relation incidents reported via datix are subject to review. Regular monitoring is in place from the security team and there are regular matron walk rounds in the department.	This action will be included in normal work programmes and will not result in additional costs.	The action has already been completed as a result there is no further affect to patients.	21/06/19	Completed
25	The trust must ensure the service meets its major trauma centre requirements for consultant cover.	staffing	18	Urgent and Emergency	Develop a detailed action plan to address the findings from the MTC Peer Review and ensure it is provided to NHSE. Part of the action plan contains the development of further business cases to gain additional funding for a revised staffing structure.	COO / CMO	The MTC Peer Review Action Plan was developed and presented to the Trust Management Executive (TME) and the Trust Board, it was also sent to NHSE. The action plan will be subject to review and reported to TME.	Actions undertaken were included in normal programmes of work any additional costs are being included in relevant business cases, as required.	The routine monitoring will ensure that patients are not affected by staffing issues.	end date TBC	In progress
26	The trust must ensure substances hazardous to health are always stored safely. (medicine core service only)	safety	12	Medical care	Ensure that Control of Substances Hazardous to Health Regulations 2002 (COSHH) are complied with. This is done by: a) Communications sent out to all Departments/Teams via email and staff briefings. b) Those responsible for hazardous substances are reminded of the duty to control them and only use the amount you need. c) Conduct a review to ensure correct safe storage facilities are available and being used if not purchase adequate COSHH Cabinet/Cupboard.	CNO	Regular checks are in place to ensure that hazardous substances are put away after use and not left out and to ensure that correct storage facilities are available and are used. Refresher training (remind & revise) for staff who are responsible for hazardous substances. Regular checks / inspections by management to ensure this is implemented.	Actions undertaken were included in normal programmes of work any additional costs are being included in relevant business cases, as required.	The routine monitoring will ensure that patients are not affected by COSHH issues.	31/03/20	In progress
27	The trust must review auditing processes to ensure they are effective in identifying areas for improvement and driving positive change. (gynaecology core service only)	audit	17	Gynaecology	Undertake a range of actions to improve cors processes within the Gynaecology Direcotrate to include a) Run the Trust IMPACT programme with the Direcotrate Team b) Use the transformation team to provide assistance with key projects	CMO	IMPACT programme provides long term support to embed good practice skills into the leadership team. Transformation processes use the plan, do study act process to review and improve processes and ensure they are embeded and sustainable. Monitoring is undertaken as part of the routine divisional performance review processes.	Actions undertaken are included in normal programmes of work.	The action has already been completed as a result there is no further affect to patients.	30/06/19	Completed