# North Bristol NHS Trust: CQC Inspection 2014 Action Plan

## Introduction

North Bristol NHS Trust was inspected by the Care Quality Commission (CQC) from the 5th – 7th November 2014, with a subsequent unannounced and out-of-hours visit on 17th November 2014.

A team of 51 CQC inspectors recruited from across the country reviewed numerous aspects of the Trust's clinical and support services, covering the registered locations; Southmead and Cossham Hospitals, HITU at Frenchay, CCHP, Community CAMHS and the Riverside Unit. They additionally visited the off-site outpatients booking team at Trinity House, and SSD facility at the Quadrant.

The inspection was structured around the CQC's 5 key questions for each of the 8 core services that they inspect; "are services safe, effective, caring, responsive, and well-led?"

The Trust has been overall been assessed as 'Requires Improvement' by the CQC and was given 5 'Outstanding' ratings, 36 'Good' ratings, 25 'Requires Improvement' ratings and 2 'Inadequate' ratings.

The Quality Summit was held on 6th February 2015 and the 7 final reports were published on 11th February 2015 and are available from http://www.cqc.org.uk/provider/RVJ.

## Governance Processes

Internal

- Trust Board directly approves CQC Action Plan & receives monthly assurance updates
- Quality Committee directly monitors and provides assurance on delivery of CQC actions
- QRMC provides NED led independent scrutiny

External

- CQC regulates delivery of CQC Action Plan
- System Flow Partnership will oversee Patient Flow related actions to ensure contributions across whole system are in line with plan.
- CCG Quality Sub Group will oversee non Patient Flow related actions.
- Other external stakeholders receive assurance on CQC Action Plan progress (reviewed and signed off by Trust Board)

| Version Control | |
|---|---|
| Version(s) | Approval |
| Drafts v1-11 | Collation and consultative review as part of development process |
| V1 | NBT Trust Board 26/03/15 |
| V2 | Updates in light of feedback from Trust Board. 27/03/15 |
| | |
| | |
| | |
| | |
| Action Plan submitted to CQC | 27 March 2015 |

| Internal Oversight Responsibilities | | |
|---|---|---|
| **Theme** | **Exec lead(s)** | **Corporate lead** |
| Overall Plan | Andrea Young, CEO | Paul Cresswell |
| Patient Flow | Kate Hannam, DO | Rosanna James |
| Patient Safety | Chris Burton, MD | Paul Cresswell |
| Patient Experience | Sue Jones, DN | June Hampton |
| Safe Staffing, Wellbeing & Engagement | Sue Jones, DN<br>Harry Hayer, DPOH | Sarah Dodds<br>Emma Light |
| Training | Harry Hayer, DPOH | Jane Hadfield |

## CQC Enforcement and Compliance Actions Status – Position at 27 March 2015

| Theme | Regulation | Final Action Date | No. of Actions | | Completed | | On track | | Risks overdue | | Overdue / Concern | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Must | Should | Must | Should | Must | Should | Must | Should | Must | Should |
| **Patient Flow** | **Enforcement Action: Warning Notice 16th December 2014.** Care and welfare of people who use services. **Compliance Action 1:** Care and welfare of people who use services. ***(#1A – 6)*** | 31/10/2015 | 9 | 0 | 0 | 0 | 6 | 0 | 3 | 0 | 0 | 0 |
| **Patient Flow** | **Other Actions** ***(#7-11)*** | 31/12/2015 | 2 | 3 | 0 | 1 | 2 | 2 | 0 | 0 | 0 | 0 |
| **Patient Safety** | **Compliance Action 2:** Assessing and monitoring the quality of service providers. ***(#12-16)*** | 31/07/2015 | 3 | 2 | 0 | 0 | 3 | 1 | 0 | 1 | 0 | 0 |
| **Patient Safety** | **Compliance Action 3:** Safeguarding people who use services from abuse. ***(#17-18)*** | 31/07/2015 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| **Patient Safety** | **Compliance Action 4:** Management of medicines. ***(#19-22)*** | 01/07/2015 | 1 | 3 | 0 | 0 | 0 | 3 | 1 | 0 | 0 | 0 |
| **Patient Safety** | **Compliance Action 5:** Care and welfare of people who use services (Records). ***(#23-27)*** | 31/12/2015 | 2 | 3 | 0 | 0 | 1 | 2 | 1 | 1 | 0 | 0 |
| **Patient Safety** | **Compliance Action 6:** Safety, availability and suitability of equipment. ***(#28-32)*** | 30/09/2015 | 4 | 1 | 0 | 1 | 4 | 0 | 0 | 0 | 0 | 0 |
| **Patient Safety** | **Compliance Action 7:** Safety and suitability of premises (HITU specific). ***(#33)*** | Completed | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Patient Safety** | **Other Actions** ***(#34-39)*** | 303/11/2015 | 1 | 5 | 0 | 2 | 1 | 3 | 0 | 0 | 0 | 0 |
| **Patient Experience** | **Other Actions** ***(#40-52)*** | 31/10/2015 | 1 | 12 | 0 | 0 | 1 | 10 | 0 | 2 | 0 | 0 |
| **Staffing Levels, Wellbeing & Engagement** | **Compliance Action 8:** Staffing. ***(# 53-63)*** | 31/12/2015 | 5 | 6 | 0 | 1 | 4 | 4 | 1 | 1 | 0 | 0 |
| **Training** | **Compliance Action 8:** Staffing. **Compliance Action 9:** Supporting staff. ***(#64-72)*** | 30/09/2017 | 4 | 5 | 1 | 0 | 3 | 5 | 0 | 0 | 0 | 0 |
| **TOTAL** | | | **34** | **41** | **2** | **5** | **26** | **31** | **6** | **5** | **0** | **0** |

**KEY – Action Confidence Assessment**

Blue = Completed  Green = On-track  Amber = Risk of non-delivery  Red = Overdue & cause for concern

N.B. Many Actions have a number of components, with different completion dates. The Action Status will reflect all components and will only be marked 'completed' if these have all been delivered.

## GLOSSARY

| | | | |
|---|---|---|---|
| AAU | Acute Assessment Unit | HITU | Head Injury Therapies Unit |
| AD | Associate Director | HoN | Head of Nursing |
| AEC | Ambulatory Emergency Care | HR&D | Human Resources & Development |
| AGM | Assistant General Manager | ISTC | Independent Sector Treatment Centre |
| AWP | Avon and Wiltshire Mental Health Partnership | LHPD | Leaving Hospital Patient Database |
| BCH | Bristol Community Health | LOS | Length of Stay |
| BNSSG | Bristol, North Somerset, South Gloucestershire | MHA | Mental Health Act |
| CCG | Clinical Commissioning Group | MIU | Minor Injuries Unit |
| CCS | Core Clinical Services | MLE | Managed Learning Environment (NBT Training Record) |
| CD | Clinical Director | ORCP | Operational Resilience and Capacity Plan |
| COIC | Control of Infection Committee | QRMC | Quality Risk Management Committee |
| DOLS | Deprivation of Liberty Safeguards | QUESTT | Quality, Effectiveness and Safety Trigger Tool |
| DTA | Decision To Admit | RAG | Red, Amber, Green |
| DTOC | Delayed Transfer of Care | RAT | Rapid Assessment and Treat |
| eAIMS | Electronic Accident & Incident Management System | RTT | Referral To Treatment |
| ECIST | Emergency Care Intensive Support Team | SGCCG | South Gloucestershire Clinical Commissioning Group |
| ED | Emergency Department | SOP | Standard Operating Procedure |
| EDIP | Emergency Department Improvement | SRG | System Review Group |
| EDMT | Emergency Department Management Team | SWS | Supervisory Ward Sisters |
| ENP | Emergency Nurse Practitioner | TDA | Trust Development Authority |
| EOL | End of Life | TTT | Time To Triage |
| F&PC | Finance & Performance Committee | UCRP | Urgent Care Recovery Plan |
| GM | General Manager | W&Cs or WCH | Women & Children's |
| GP | General Practitioner | WLI | Waiting List Initiative |
| HALO | Hospital Ambulance Liaison Officer | WTE | Whole Time Equivalent |

## NBT Improvement Theme 1: Patient Flow

**Enforcement Action: Warning Notice 16th December 2014. Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.** There were restrictions, due to the capacity of the emergency zone, on the ability of the provider to provide prompt assessment of patients, diagnosis, care and treatment. Patients waited too long in the emergency zone and were sometimes accommodated inappropriately in the Seated Assessment Area which was not designed or equipped to accommodate patients for extended and/or overnight stays. This meant the provider had not taken proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment.

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|---|---|---|---|---|---|---|
| **Actions with System Partners** | | | | | | |
| **EA** | **1. Take action, with others as needed, to improve the flow of patients into, through and from the hospital. This includes:**<br><br>a. ensuring that patients are cared for in the most appropriate place and are supported to leave hospital when they are ready to do so.<br><br>b. ensuring there is capacity in the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and wellbeing. This includes a robust hospital-wide system of bed management.<br><br>c. ensuring that patients arriving at the emergency department by ambulance do not have to queue outside the department because there is no capacity to accommodate them in clinical areas of the emergency zone.<br><br>d. ensuring that the discharges of medical and surgical patients are always planned effectively to avoid delaying discharge when medically fit to leave. | Trustwide<br><br>ED | Strengthened collaborative actions to improve System Flow, which impact upon all of these 'must dos' and will drive compliance with the Enforcement Action have been agreed across the health system. They are set out within the **System Flow Partnership Key Priorities Action Plan and covering letter** to the Trust Development Authority and NHS England dated 20/03/2015.<br><br>Four themes have been designated;<br>1. Admission Avoidance:<br>2. Internal Flow:<br>3. Enabling Discharge:<br>4. Frailty Pathway<br><br>Responsibilities, actions, impact measures and milestones are set out in detail within the plan, which is embedded in this document.<br><br>Lead responsibilities are as follows;<br><br>1. <u>Admission Avoidance</u><br>• GP Support Service (GPSS) – SGCCG<br>• Cluster working for admission avoidance – Sirona<br>• REACT at front door – BCH | (Lead agency - named individuals if NBT)<br><br>*SGCCG*<br>*Sirona*<br><br>*BCH* | <u>Latest date in each Plan</u><br><br>14/04/15<br>26/06/15<br><br>08/06/15 | <br><br>Set out in plan<br>Set out in plan<br><br>Set out in plan |

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| | | | • Emergency Zone – NBT | **Sam Patel, CD Medicine, Leilah Dare, ED Speciality Lead** | 29/05/15 | Set out in plan |
| | | | 2. <u>Internal Flow</u><br>• Better Board Round – NBT | **Ops & Directorates** | 31/10/15 (Lorenzo) | Set out in plan |
| | | | • Integrated Discharge Team – Bristol CCG (with support of all partners) | *Bristol CCG* | 01/05/15 | Set out in plan |
| | | | • Elgar's function & partnership working (NBT & Sirona) | *Sirona* & **Rosanna James, Deputy Dir. Ops** | 30/06/15 | Set out in plan |
| | | | 3. <u>Enabling Discharge</u><br>• Demand & Capacity modelling – SGCCG for external partners & internal modelling – NBT | *SGCCG* / **Kate Hannam, Dir. Ops/ Rosanna James, DDOps** | 29/05/15 | Set out in plan |
| | | | • Discharge to Assess (D2A) - SGCCG with support of all partners | *SGCCG*/D**avid Allison, GM, Medicine** | 30/10/15 | Set out in plan |
| | | | • Criteria led Discharges - NBT | **David Allison, GM, Medicine / Rosanna James, DDOps** | 29/05/15 | Set out in plan |

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| | | | 4. <u>Frailty Pathway - Bristol CCG, all partners</u><br><br><u>System Flow Delivery - Governance</u><br>The governance arrangements for the system flow Partnership have been reviewed and clarified. Learning from the Onwards Together week suggests that the representatives from each organisation that formed Silver Command were integral to being able to react quickly to sort out issues that were causing problems with patient flow. It was a very senior team that over the course of the week developed much closer working relationships and increased their knowledge of each organisation's perspectives, constraints and issues.<br><br>The same people make up the Operational and Delivery Group and will oversee the implementation of the plan. This Operational and Delivery Group will meet formally weekly and report as it presently does into System Flow Partnership.<br><br>Escalation of issues will be via System Flow Partnership to the Top Team Leadership meetings. | *Bristol CCG* / **Kate Hannam, Dir. Ops** | 29/05/15 | Set out in plan |

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| **EA** | 2. Improve performance in relation to the time patients wait to be assessed and the time they remain in the emergency department. | ED | (EDIP 4.1) Implement 2nd triage nurse with dedicated room at times of high activity. Ensure prompt and safe triage for all ambulance arrivals prior to immediate signposting and exit from crossroads corridor.<br><br>(EDMT Plan) A 3 option pilot triage process is being evaluated to select the clinically safest one for implementation. The Nurse Co-Ordinator and ENP in charge of Minors to monitor triage times and flex staff to ensure 15 min target is met wherever possible.<br>The selected approach will also include ensuring that the data capture of TTT routinely reflects actual practice – both in short term (manually) and longer term via Cerner & then Lorenzo.<br><br>(EDIP 8.1) Develop triggers internally to commence rapid assessment and treat (RATs). Recruit into ED Consultant posts. Provide consistent RATs 9am-10pm, Monday-Friday. Optimise use of M1/M2 cubicles.<br><br>(EDIP 10.1) Enforce IPS across all Directorates and Specialties. If a clinician cannot attend in 30 minutes, the ED team will arrange transfer to their specialty assessment area where clinically appropriate. Escalate non-compliance to clinical lead/CD/Exec level. | Matt Crabtree, ED Ward Manager<br><br>Leilah Dare, ED Specialty Lead<br><br>Leilah Dare, ED Specialty Lead | 30/04/15<br><br>30/04/15<br><br>30/04/15 | Pilot evaluation & best option enacted. TTT of 15 minutes met for all patients.<br><br>Observational audits. IPS & TTT metrics; acute flow dashboard.<br><br>Ongoing review: ED Management Team (weekly).<br><br>RATs to be implemented consistently to deliver safe care and enable meeting ED IPS.<br><br>95% reviews within 30 minutes of referral. |

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| **CA 1** | 3. Work with healthcare partners to ensure people with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained staff to meet their needs. | ED | (EDIP 9.1) Appointment of psychiatry post at NBT. Explore with AWP option for appointing locum during the recruitment gap. Review and refine SOP with AWP and internal systems to ensure patients are managed in the most appropriate environment.<br><br>(EDIP 9.2) Finalise workforce plan for mental health liaison/psychiatry. | Sam Patel, CD, Medicine.<br>Adam Brown, Mental Health Lead, ED<br><br>David Allison, GM, Medicine/ Sam Patel, CD, Medicine | 30/04/15<br><br>Completed | ED MH Plan approved and enacted, inc. SLAs developed with AWP and CAMHS. MHA within 4 hrs<br><br>Medicine Psychiatry speciality team established. |
| **CA 1** | 4. Reduce the number of operations cancelled. | Trustwide | The two primary causes of cancelled operations have been;<br>i) Difficulties ensuring the right kit was available to undertake the procedure.<br>ii) Lack of available beds due to challenges around patient flow.<br><br>Within this Action Plan a detailed responses have been provided (Action Numbers 28 and 29) to address theatre kit availability and cleanliness in response to **Compliance Action 6: Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.**<br><br>**Actions provided in response to Enforcement Action Warning Notice 16th December 2014. Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and** | See Actions 28 & 29<br><br>See Actions 1A & 1D | | Reductions in Cancellation Operations (same day, non-clinical reasons)<br><br>Improvement towards zero breach of 28 day re-booking for cancelled operations. |

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| | | | **welfare of people who use services.** AND **Compliance Action 1: Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services & Compliance Action 1 address bed availability.**<br><br>**Specifically Action numbers 1A & 1D.**<br><br>Additional actions to utilise external capacity;<br>• Increased day case use,<br>• increased use of Cotswold,<br>• increased use of ISTCs,<br>• Waiting List Initiatives | | | |
| **NBT Internal Actions** | | | | | | |
| **EA** | 5. Ensure that the Seated Assessment Area is used appropriately for the short-term assessment, diagnosis and treatment of patients who are not expected to be admitted. If patients require a lengthy or overnight stay, they must be accommodated in an appropriately equipped ward that provides same-sex accommodation to ensure their dignity is protected. | ED | (EDIP 1.1) Determine other safer areas in emergency zone to review, observe and care for ED patients safely until bed capacity becomes available for patients with decisions to admit. Locations affording 'better place of safety' might include Majors; MIU; AEC; AAU GP assessment area. Once available capacity in each area agreed and confirmed, rewrite and deploy ED surge SOP.<br><br>(EDIP 5.1) Task and finish group to define and agree function of AEC (Ambulatory Emergency Care) area, LOS and patient appropriate categories. Utilise ECIST and AEC network to | ED Matron / CD Medicine<br><br>Rosanna James, deputy Dir. Of Operations<br>ED Matron / | Complete<br><br>31/05/15 | Daily internal audit - daily escalation sheets.<br><br>eAIMS submitted if >10 in corridor and escalated at Safety Briefings<br><br>AEC Network attendance 24/3/15. |

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| | | | support development focus and direction. | CD Medicine | | EDMT to monitor compliance of use of AEC via AEC dashboard. |
| **CA 1** | 6. Ensure medical and surgical patients are cared for in the most appropriate wards for their needs, and that reviews are always undertaken in a timely manner. | Medicine<br><br>Surgery | (EDIP 10.1) Enforce IPS across all Directorates and Specialties. If a clinician cannot attend in 30 minutes, the ED team will arrange transfer to their specialty assessment area where clinically appropriate. Escalate noncompliance to clinical lead/CD/Exec level.<br><br>Immediate action was taken during the original inspection to strengthen the management of outlying patients from Medicine Directorate.<br><br>Placement within the right area for each patient's needs is a function of effective operational bed management within the context of the demands of managing overall patient flow. | ED Matron / CD Medicine<br><br>Rosanna James, deputy Dir. Of Operations/ Operations Team | 30/04/15<br><br>30/06/15 | 95% reviews within 30 minutes of referral.<br><br>Minimal outliers tracked through daily Sitrep |
| **N/a** | 7. Take action to address the problem of the backlog of unreported images and ensure that systems are in place to prevent such a backlog occurring in the future. | Core Clinical Services | There has been an improvement in the position of unreported images. At the time of the Inspection the reported position for the 12 month prior period was 4,642 unreported events, this had reduced for the period 01.01.2014 – 31.12.2014 to 1,300.<br><br>1. A revised process for allocating outpatient | Dr Mark | 1. 16/03/15 | |

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| | | | reporting on a daily basis to individual or group folders has been agreed with the Radiologists in the department to ensure reporting demands are met within an acceptable time frame ( with a standard of a maximum of 2 weeks from the event)<br>2. The remaining backlog continues to be addressed by Radiologists and a reporting radiographer performing reporting sessions in their own time. It is expected that there will be no outstanding reports related to 2014 attendances by the end of April 2015<br><br>3. Regular monitoring of the unreported workload to highlight any areas where backlogs may occur | Thornton Specialty lead<br><br>Sean Fry AGM & Dr Mark Thornton Specialty lead<br><br>Sean Fry AGM | 2. 30/04/15<br><br>3. 30/6/15 On-going | Routine monitoring by the clerical team with responsibility for allocating the work<br><br>No outstanding reports from 2014 imaging events<br><br>Described within the SoP for the allocation process<br><br>Regular review of the outstanding reporting position at the imaging management team |
| **N/a** | 8. Continue to take action on, and monitor the patient appointment request backlog and ensure that systems are in place to prevent such a backlog occurring in the future. | Outpatients | Significant improvements have been made since Inspection in November, when there were approx. 40,000 patients on the request list. This has now reduced to 17,000 patients, for which the majority of cases are being booked into appointments from July to Sept 2015. These bookings will be made by the end | Claire Weatherall, GM, R&O | | |

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| | | | of March.<br><br>That will leave approx. 5,000 patients pending at the start of 2015/16.<br><br>Ongoing actions to manage and prevent future backlog;<br>• Restructure of the management team to provide consistent senior support to the centralised booking team.<br>• 5 WTE staff recruited to the centralised outpatients team to validate and reduce the outpatients request queues.<br>• Standard operating procedure is in place for monitoring reduced request queues, with routinely reviewed request queue monitoring report.<br>• Capacity and demand planning in all specialties and directorate to reduce the requirement for follow up request queues. | | 31/03/15<br><br>30/11/15<br><br>30/11/15 | Reduced request queues are monitored at weekly performance meetings and Outpatients Board.<br><br>Outpatients action plan reviewed at Outpatients Board.<br><br>Reductions in pending appointment volumes. |
| N/a | 9. (Should Do) Review and amend the standing operating procedure for the emergency zone and the standing operating procedure for triage in the emergency zone to accurately reflect current practice. | ED | Formalise process with laminated RAG triage task list produced and disseminated to all nursing staff. | Juliette Hughes, Matron, ED / Matt Crabtree, ED Ward Manager | Completed | SOPs in place. |
| N/a | 10. (Should Do) Continue to develop and improve the centralised booking system with increased staffing and training. This should | Outpatients | • 5 WTE staff recruited to the centralised outpatients team to validate and reduce the outpatients request queues. | Claire Weatherall, GM, R&O | 01/04/15 and ongoing | Request queue monitoring report taken to outpatients |

## NBT Improvement Theme 1: Patient Flow

**Enforcement Action: Warning Notice 16th December 2014. Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.** There were restrictions, due to the capacity of the emergency zone, on the ability of the provider to provide prompt assessment of patients, diagnosis, care and treatment. Patients waited too long in the emergency zone and were sometimes accommodated inappropriately in the Seated Assessment Area which was not designed or equipped to accommodate patients for extended and/or overnight stays. This meant the provider had not taken proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment.

**Compliance Action 1: Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.** There were insufficient beds to move patients from critical care when they no longer required that intensity of care. Patients in the emergency department waited too long for a mental health assessment. The discharge of medical and surgical patients was not always planned effectively, delaying their discharge when they were fit to be discharged. Medical and surgical patients were not always cared for in the most appropriate wards for their needs. Reviews were not always undertaken in a timely manner.

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| | include reducing the backlog of appointment requests referrals. | | • Training is being delivered for all centralised outpatients staff in RTT requirements.<br>• Capacity and demand planning in all specialities and directorates to meet demand forecasts for 15/16.<br>• RTT training plan for all North Bristol NHS Trust staff. | Alison Moroz and Rosanna James | Ongoing | board. - Reduced request queue volumes.<br><br>Capacity and demand monitoring at weekly performance meetings. |
| **N/a** | 11. (Should Do) Improve access and flow through the maternity service to ensure capacity meets demand. | Maternity | Capacity actions are focused on smoothing flow across existing services, bolstering staffing and revisiting workforce strategy;<br>1. Encouraging all healthy well women to give birth in birth centres, thus preserving as much acute capacity at Southmead as feasible.<br>2. New staffing models and improved staffing recruitment programme - commenced rolling program to recruit staff to 124%.<br>3. A program is being rolled out to obtain staff input, regarding W&CS Directorate strategy, the new 5 year forward plan and CQC results shape the future workforce by ensuring that we have' the right staff in the right place at the right time'. | Julia James, GM, WCH<br>Lisa Marshall, HoN, Maternity Matrons | 1. 31/12/15<br>2. 31/12/15<br>3. 31/12/15 | Reduction in Maternity closures<br><br>**Monitored via:**<br>1. Maternity Dashboard/ outcomes.<br>2. Friends and family test. |

| NBT Improvement Theme 2: Patient Safety | | | | | | |
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| **Incident Reporting**<br>**Compliance Action 2: Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers.** We saw inconsistent evidence of incident reporting and feedback to staff. We saw no evidence of incident reporting taking place at the Head Injury Therapy Unit and that staff had little understanding of the policy. | | | | | | |
| **CA 2** | 12. Ensure that all incidents are reported and investigated, and that feedback is provided to staff about incidents they have reported. | Trustwide | This requires a combination of using the existing system effectively and supporting this through the central clinical risk management team and committee.<br>1. The eAIMs system provides all reporters with mandatory feedback on individual reports automatically. This will be re-emphasised to all staff.<br>2. A review and closure of historic incidents reported prior to the move to the new Hospital will be tackled via an incident amnesty to reduce excess reminder emails that cloud the focus on current incidents.<br>3. CRC will receive monthly updates on the current status of incidents that have not been managed in a timely way. This information will also be fed back for actions to be implemented at Directorate level.<br>4. Since the CQC Inspection, training has been delivered to senior staff regarding incident reporting triggers with the aim for information dissemination. This has included midwives on site and in the community, school nurses, Core clinical Services Sisters / matrons meetings, ITU sisters meetings. Surgical sisters meetings, Pharmacy, Ulysses user group. RCA training sessions.<br>5. An E Learning module for incident reporting is in development for all staff to complete. A Test version is being drafted, for pilot testing by | Fiona Barnard, Patient Safety Lead<br><br>Ann Remmers, Chair Clinical Risk Committee | 1.Completed<br><br>2. 01/04/15<br><br>3. 30/04/15<br><br>4. Ongoing<br><br>5. Pilot 30/04/15<br><br>Rollout 31/07/15 | Ongoing - decreasing trend in unmanaged reports.<br><br>Agreed at CRC 6/3/15 as future standing item.<br><br>Training records & improved incident reporting and closure of reports.<br><br>Finalised MLE package<br><br>Training records to track completion across Trust. |

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| | | | 30/04/2015. This will subsequently be reviewed at the Trust induction / mandatory training steering group prior to roll out. | | | |
| **CA 2** | 13. Ensure the specialist palliative care team consistently report medication errors. | Palliative Care | A review will be undertaken collaboratively between Pharmacy and the Palliative Care Team to review the NHS England Alert: PSA/D/2014/005: "Improving medication error incident reporting and learning" linked with role of NBT Medication Safety Officer ;<br>1. In line with existing practice, the team will complete an eAIMS at any time an error is identified where there is potential for patient harm.<br>2. A consistent reporting basis for lower risk medication errors will be established by conducting a 2 week baseline audit of medication errors in the patients seen by the SPCT in early April. This will be reviewed via the Patient Safety Group and a threshold agreed for escalation with eAIMS. | Clare Kendall, Palliative Care Lead<br><br>Clare Kendall & Jane Smith, Medication Safety Lead | 1. In place<br><br>2.15/05/15<br><br>30/06/15 | eAIMs reported, actioned and closed.<br>Baseline audit<br><br>Agreed threshold implemented |
| **CA 2** | 14. Ensure that all staff at the Head Injury Therapy Unit understand the incident reporting policy and report all incidents. | HITU | Clinical Risk team will deliver incident report training for HITU staff and submission of incidents will be tracked subsequently to provide evidence of effective use of system in practice. | Fiona Barnard, Patient Safety Lead Emma Hale, Clinical Lead, HITU | 30/04/15<br><br>31/07/15 | Training delivered.<br><br>Incidents submitted and acted upon. |
| **N/a** | 15. (Should Do) Review reported incidents to ensure they represent a full and accurate reflection of the events within the service. | Trustwide | 1. The Trust's incident reporting system was reviewed just prior to the CQC Inspection in October 2014. The review included a comprehensive list of triggers for incident reporting to provide a better focus for those raising them within the system. This has now embedded more consistently.<br>2. The Clinical Risk Team is developing a report of incident reporting trends to present to CRC on 10th | Fiona Barnard, Patient Safety Lead | 1. In place<br><br>2.CRC 30/04/15 | Fewer enquiries received by the Clinical Risk team as staff gain familiarity with the new set up.<br>Report production<br><br>Directorates |

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| | | | April 2015 and will develop this further for directorate level roll out. | | Directorate reports 31/05/15 | reviewing coverage and content of incidents raised. |
| N/a | 16. (Should Do) Demonstrate learning and improvements from remedial actions. | Trustwide | A range of actions are being developed to shift to a proactive approach to the incidents and actions reported.<br>1. A regular patient safety newsletter will be introduced for all Trust staff to include learning from incidents and provide feedback on actions regarding incident trends.<br>2. The Clinical Risk Web Site is being reviewed, linked to the redevelopment of the Clinical Governance site to include RCA synopses that will regularly be highlighted to staff to highlight improvements required and actions underway.<br>3. Baseline audit to be conducted by Clinical Risk Team to track evidence of learning and improvement from incidents reported, including range of Never Events, Serious Incidents and lower level incidents. This will be run centrally and reviewed at CRC with a view of subsequently devolving this to clinical directorates for ongoing assurance. | Fiona Barnard, Patient Safety Lead | 1.31/05/15<br>2. 31/05/15<br>3. 30/06/15 | Reviewed at CRC.<br>Reviewed at CRC.<br>Periodic audits to review action taken for sample of closed incidents/ action plans. Reported to CRC. |
| **Safeguarding & Mental Capacity**<br>**Compliance Action 3: Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse.** Deprivation of Liberty Safeguards in critical care in were not in accordance with the provisions of the Mental Capacity Act 2005. In medicine not all staff were area of which patients had a Deprivation of Liberty Safeguard in place. | | | | | | |
| **CA 3** | 17. Ensure it acts in full accordance with the law as it relates to the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005. | Trustwide | The Trust has taken further legal advice and also feedback from other NHS trusts in their interpretation of the Cheshire West ruling and its practical application within an Intensive Care environment.<br>1. Firstly a test of change for the new process has been agreed, a revised Flowchart describing the | Gareth Wrathall, Lead Consultant | 1. 20/04/15 (test of change | Outcome from Test of change and new |

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| | Ensure suitable arrangements in place within Critical Care<br><br>Ensure all staff in medicine are aware of which patients have a DOLs in place. | | planned approach drafted. This will commence within ICU from 8th April 2015.<br><br>2. Following review and agreement of the outcome, the Consent and DoLS Policies will be rewritten so that they cross refer. Draft Restraint Policy to be written and cross referred to Consent and DoLS Policy.<br><br>3. The accompanying flow chart Flow chart is being redesigned by Adult Safeguarding Lead to be complete by 13/05/2015.<br><br><u>Medicine</u><br>4. The review of any DOLs within the ward environment will be added to the Matrons Walkround checks already undertaken.<br><br>5. Compliance with this requirement will be reviewed through the above mechanism on an ongoing basis. | Intensivist<br><br>Sean Collins, Adult Safeguarding Lead<br><br>Sean Collins, Adult Safeguarding Lead<br><br>Andrea Scott, Clinical Matron for Practice Development<br><br>Sam Patel, Clinical Director and Christine Morgan, Medicine, Head of Nursing, Medicine | in ICU concluded)<br><br>2. 31/05/15 (new policies re-drafted)<br><br>3. 13/05/15 (Flow Chart completed / issued)<br><br>4. 31/03/15<br><br>5. 30/04/15 | process approved.<br><br>Revised DOLs documentation to guide and demonstrate clinical application in practice. |
| **N/a** | 18. (Should Do) Make sure that all wards have the correct consent form in place for staff to use when caring for patients who lack capacity to consent to treatment and surgery. | Trustwide | 1. Consent forms are only used for surgery. Clinical Staff to be aware when patients lack mental capacity and to record significant intervention either in the medical record or using the Trust Mental Capacity Recording form. Compliance to be assured by Head of Nursing and Clinical Directors.<br>2. Consent Compliance will be reviewed within the context of current and future Clinical Audit plans. | Clinical Directors and Heads of Nursing<br><br>Paul Cresswell/Frank Hamill | 1. 31/07/15<br><br>2. 31/07/15 | Clinical Audit - Consent compliance & actions to address gaps. |

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| **Medicines**<br>**Compliance Action 4: Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.** Medicines were not always stored securely in the medirooms and surgical wards. Medication was found in some areas to be out of date. Administration of medication was not consistently recorded accurately. The oxygen cylinder in the Head Injury Therapy Unit was out of date. | | | | | | |
| **CA 4** | 19. Ensure that all medicines are stored safely and appropriately and records relating to administration are accurate. | Trustwide | 1. Review of medicines storage capacity which includes:<br>• A Pharmacy review of the space needed for Pharmacy medicines<br>• Elgar House refurbishment to comply with NHS design principles for medicines storage<br>• If any shortfall in storage is identified risk register entries need to be made for that area<br>• Consumables and non-medicines must be relocated from any lockable medicines cupboards<br><br>2. Explore use of ward "drop-boxes" and agree implementation if agreed.<br><br>3. In line with CQC safe & secure handling requirements, formal audits must be completed for all areas every 18 months (includes storage conditions and security)<br><br>4. All medicines stored on wards have their date of expiry checked as part of the weekly stock supply process by pharmacy staff.<br><br>5. Review of MED / 012 – "Prescribing, preparing and administering injectable medicines in clinical areas"<br>6. In- Patient Prescription chart review<br>7. Missed Doses" Patient Safety MM workstream. | Short life working group (led by Sarah Dodds/ Andrea Scott)<br><br>Sarah Dodds/ Jane Smith<br><br>Jill Bate –safe & secure handling audits<br><br>Ward managers – for non top-up wards<br>Jill Bate – for top-up wards | 1. 30/04/15<br><br>2. 31/05/15<br><br>3. 30/06/15<br><br>4.In Place & ongoing<br><br>5. 30/04/15<br><br>6. 30/04/15<br>7. 31/05/15 | Report to Medicines Governance Group – (MGG) with oversight from Drugs & Therapeutics Committee (D&T).<br><br>Decision & action to implement.<br><br>Monthly audit activity report for ASD and MGG<br>Actions identified & closed<br>Pharmacy staff report on eAIMS (ongoing).<br>Top up records<br>Ward staff reports<br><br>Snapshot audit of unattended syringes – report to MGG |

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| N/a | 20. (Should Do) Ensure that refrigerators used to store medicines at controlled low temperatures in the emergency department are regularly checked in accordance with the trust's medicines policy. This is to ensure that medicines are fit for use. | ED | Current policy and procedure review to ensure fit for purpose;<br>1. MED / 007 SOP review<br>2. CP5i policy review – amendments to daily temperature recording where Intellicold system installed<br><br>This will be ensured through;<br>3. Regular temperature checks<br>a. Intellicold - SD card records automatically<br><br>b. Non Intellicold – ward staff record on a daily basis<br><br>4. Audit processes including Safe & secure handling audits (every 18 months for each ward) | Janice Thompson Andrew Davies/Jane Smith<br><br>Ward Staff (review/escalate) Pharmacy Staff (eAIMs reporting/action)<br><br>Ward Staff (record/manage) Pharmacy Staff (eAIMs reporting/action)<br><br>Jill Bate –safe & secure handling audits | 1. 18/05/15<br>2. 30/06/15<br><br>3. Ongoing<br><br>4. 30/06/15 | MGG approval<br><br>MGG Approval<br><br>QA response to issues escalated from wards.<br>Bi monthly eAIMS reporting to MGG |
| | 21. (Should Do) Ensure that appropriate records are maintained for the disposal of controlled drugs in the emergency department, in accordance with the trust's medicines policy. This will reduce the risk of misuse of these medicines. | ED | Improvements in disposal of controlled drugs and their recording to be made by;<br>1. Explore Introduction of pre-filled morphine syringes – i.e. alternatives to working practice of multiple uses of aliquots of syringe for same patient.<br><br>2. Use of log book to confirm sign out of codeine based TTAs & stock checking & stock checking. | ED Matron Admissions Pharmacist<br><br>ED Matron | 1. 01/07/15<br><br>2. Complete & ongoing | Report back to MGG & 6 monthly review of eAIMS trends<br><br>Monthly Pharmacist audits report to ED |

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| | | | 3. Monthly Pharmacist audits reported to ED matron and MGG. | Hazel Arnold / Jill Grinsted: starting April 2015 | 3. 30/04/15 | Matron and MGG |
| N/a | 22. (Should Do) Ensure that appropriate records are maintained in the emergency department in respect of emergency medicines and that the medicines trolley is sealed to show that it has not been used. This will ensure that appropriate emergency medicines are always available when needed. | ED | Improvements in emergency medicines record keeping will be made by;<br>1. Ensure drugs used from Majors or Resus areas and are not stored in the Corridor areas.<br>2. See and treat area: new TTA pack record book to record issue of all medications<br><br>Improvements in the monitoring of ED Resus trollies will be made by;<br>3. Standardised contents list agreed between ED and pharmacy.<br>4. Daily trolley checks and routine auditing of their completion.<br><br>5. Develop/implement tamper evident systems & then include in audit. | Juliette Hughes, Matron, ED<br><br>Jill Bate<br><br>Juliette Hughes, Matron, ED & Pharmacy | 1. Complete<br><br>2. Complete<br><br>3. Complete<br><br>4. Complete & Ongoing<br><br>5. 31/03/15 | Report to MGG 6 monthly eAIMS review – Pharmacy/MGG<br><br>Pharmacist staff top up correct quantities/report discrepancies to ED matron<br><br>Agreed list in place<br><br>Daily checks & Monthly audit to reconcile<br><br>Monthly audit to see if sealed |
| **Records**<br>**Compliance Action 5: Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.** The registered provider did not have appropriate arrangements in place to protect children and young people from the risk of inappropriate care and treatment due to a lack of robust, documented, accurate, individual risk assessments. | | | | | | |
| **CA 5** | 23. Ensure all children and young people in community CAMHS have appropriate risk assessments and clearly documented care plans. | CAMHS | This will be reviewed and improved through consultative process with young people as with any changes made within the service. The steps will be taken as follows;<br>1. Review existing risk assessments and | Maria Hennessy, Head of Nursing & | 1&2. Ongoing | Revised risk assessments and care plans in place.<br><br>Records audit. |

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| | | | standardise.<br>2. Barnardo's young people's group consulted with about the young people friendly nature of careplans and how best to engage young people in their care plans.<br>3. Get framework for careplans and associated guidance agreed and implement across the service.<br>4. Implementation of revised risk assessments and care plans.<br>5. Consult with CAMHS young people about their experience of being involved in their careplan. | Clinical Governance (CCHP) Integrated Lead CAMHS | involvement starting in April<br>3. 30/04/15<br>4. 31/07/15<br>5. 31/12/15 | Caseload supervision / peer review.<br>Improved evidence of planning, clinical intervention and decision making that reflects the contribution and views of children, young people and their family. |
| **N/a** | 24. Ensure that all patients' medical records are available when the patient is being seen and that the reliance on temporary records is reduced to a minimum.<br><br>25. (Should Do) Ensure that medical records are available for patient appointments, mortality and morbidity reviews and data recording, and that they are stored securely so that patient confidentially is maintained. | Trustwide | Existing governance and control measures are;<br>• Patient Records Committee monitors the Trust's risks for medical records and associated controls / mitigation.<br>• Monthly availability and statistics on temporary folders reviewed at the Patient Records Committee and Outpatient Boards.<br>• Daily, weekly and monthly reporting of notes availability monitors performance by speciality / clinic<br><br>New Actions to improve performance to minimum of 95% availability;<br>1. Review of medical records resources to recruit additional staffing resource needed is in place to locate any missing / incomplete records<br>2. Performance manage directorate typing turnaround times within a target of 5 working days, to ensure notes are returned to main libraries and available for future care. | Nathan Vaughan, Patient Records Manager<br><br>As above<br><br>General Managers | Ongoing<br><br>Ongoing<br><br>1&2. 31/03/15 (review)<br>31/05/15 (in post)<br>2. 31/05/15 | Reporting arrangements are in place to monitor and manage performance.<br>Risks closely monitored and suitable controls are in place to mitigate.<br><br>Additional staff to locate records within department areas, not held by medical records<br><br>Increase notes availability to a minimum of 95% |

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| | | | 3. Provide additional admin support in OP areas, to organise / prepare notes for clinics<br><br>4. Improve appointment slot utilisation / planning to minimise avoidable short notice bookings.<br><br>5. Digitise referral letter triage process and make referrals available electronically to ensure they are available for all OP appointments.<br><br>6. Implement clinic typing without notes, to reduce office storage needs, and improve notes availability / reduce temporary folder use.<br><br>7. Digitise current paper records, through electronic document management as the medium -long term solution. Seeking contract award in May, with scanning progressing mid to late Summer 2015. | Claire Weatherall OP General Manager<br><br>Sandra Marsh, OP service manager<br><br>Marie White – Admin IT lead<br><br>General Managers<br><br>Nathan Vaughan, Patient Records Manager | 3. 30/04/15<br><br>4. 30/06/15<br><br>5. 31/07/15<br><br>6. 30/09/15<br><br>7. 31/12/15 | availability.<br>Improved organisation of notes in OP areas.<br><br>100% medical records available electronically when required. |
| **N/a** | 26. (Should Do) Take action to improve the standard of record keeping in the Riverside Unit to ensure information held within records is more consistent and accessible. | Riverside Unit | • As below (27) with CAMHS record.<br>• Have young person's involvement/decision making/views clearly evident within record keeping.<br>• Implement records filing standing operating procedure. | Maria Hennessy Head of Nursing & Clinical Governance CCHP<br><br>David Abott, Matron, Riverside<br><br>Joanna Smith Partnership Manager CCHP | 01/09/15 | Revised record keeping.<br>Records audit results demonstrate improved standards of record keeping. |

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| N/a | 27. (Should Do) Improve individual patient record keeping to ensure a consistent approach to records across CAMHS. | CAMHS | • Review record keeping as part of implementing careplan framework.<br>• Establish clear guidelines about patient records – for this to also reflect feedback including CORC and IAPT outcome measures and evidence of shared decision-making.<br>• Implement across the service.<br>• Review information to families on access to their records.<br>• Audit records against guidance after a period of implementation. | Maria Hennessy, Head of Nursing & Clinical Governance (CCHP)<br><br>Integrated Lead for CAMHS (CCHP) | 01/09/15 | Revised record keeping standards.<br><br>Records audit results demonstrate improved standards of record keeping.<br><br>Improved transparency and consistency of record keeping. |
| **Equipment**<br>**Compliance Action 6: Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.** The provider had failed to ensure that equipment was available in sufficient quantities to ensure the safety of service users and meet their assessed needs. The trust had not ensured that all equipment required for surgical operations was available and ready for use. At the Head Injury Therapy Unit equipment was not serviced appropriately, taps were not flushed effectively and consumable items were out of date. | | | | | | |
| CA 6 | 28. Ensure that equipment required for surgical procedures is available in sufficient quantities so all patients operations can go ahead as planned. | Core Clinical Services | Actions Taken since Inspection:<br>1. £2.5m investment in new and replacement surgical instrumentation across all specialities, including standardisation of several instrument sets (ongoing).<br>2. Reminder to AGMs on SOP compliance re closure of theatres lists to maximise equipment gathering preoperatively to ensure available on the day.<br>3. Improved collaborative working between theatres and SSD – monthly quality meeting to review non-conformance, themes and actions.<br>4. Implementation of exchange programme for theatre and SSD staff to understand challenges | Sharon Nicholson, GM, CCS<br><br>Paul Jenkins, Operational Manager, SSD | 1. 15/06/15<br>2. Completed and ongoing (monthly)<br>3. Commenced & ongoing<br>4. Completed and ratified | All new surgical instruments from £2.5m investment within circulation.<br><br>SOP recirculated<br><br>100% of all Band 6&7 Theatre staff visit SSD & 100% of the SSD ATO staff. |

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| | | | faced and their interdependencies.<br>5. Independent Review of SSD undertaken by AGM for CCS.<br><br>6. Transparent use of existing replacement instrument budgets between SSD and Theatres.<br>7. Collaborative working between Theatres and Carillion to resolve issues around electricity failures in theatres.<br><u>Actions Pending:</u><br>8. 'Parachuting in' of SSD management to theatres to provide immediate response to non-conformance.<br><br>9. Addition of SSD KPIs/non-conformance to be added to Theatre Dashboard, for reporting at Theatres Board.<br><br>10. Commencement of weekly scheduling meetings with all specialities to identify instrumentation and equipment requirement for following week.<br><br>11. Potential centralisation of loan equipment processes/personnel.<br><br>12. Sterile services will draft and agree a 'Service Level Agreement' with Theatres stipulating a timeframe in which the department can | | 5. Ongoing<br><br>6. 30/04/15<br><br>7. 30/04/15<br><br>8. 30/04/15<br><br>9. 30/04/15<br><br>10. Completed (commenced)<br><br>11. 30/09/15<br><br>12. 30/04/15 | Recommendations implemented – Theatre Programme Board<br>Regular TPB reporting<br><br>Theatres task & finish group<br><br>SSD Quality Manager within theatre complex for 2 weeks.<br><br>Review at Theatres Programme Board & Directorate DPM<br><br>Aim of 85% in session utilisation<br><br>March 15 expansion of MSK service to cover other specialities<br><br>Sign off expected at Theatres SSD Quality Meeting |

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| **Compliance Actions:** Six compliance actions listed below | | | | | | |
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| | | | 'decontaminate' a surgical set once used within the theatre complex. This will allow scheduling according to 'turnaround times'. SSD will also supply theatres with a complete list of all surgical sets that are detailed on the instrument tracking system and advise of their usage profile.<br>13. SSD and Theatres are to consider the possible appointment of a 'Surgical Instrument Curator' to manager 'instrumentation inventory'. | | 13. 30/06/15 | Further discussions required re-funding and scope for this prospective post |
| **CA 6** | 29. Ensure all surgical equipment and materials are cleaned and sterile and ready for use. | Core Clinical Services | 1. Conduct a skill mix review for SSD, and washer review post containerisation.<br>2. Repatriation of all surgical instrumentation from off-site facility to Brunel Building adjacent to theatres.<br>3. Formation of dedicated team to manage the distribution and collection of instrumentation within the Theatres; use of electronic tracing system to identify location of instrumentation.<br>4. Non-conformance forms submitted with any returned kit to provide rationale for learning/improvement. This process will be converted into an electronic format using the FINGERPRINT system. | Paul Jenkins, Operational Manager, SSD | 1. 30/04/15<br>2. Completed<br>3. 31/10/15<br>4. 30/06/15 | Review subject to business case. Aspirational non-conformance of 0.5% of all instrument trays processed<br>Team in situ now. Implementation plans drafted for system roll out across both theatres and SSD during Q2 of 15/16<br>Evidence of learning & reduced non-conformances. |

| NBT Improvement Theme 2: Patient Safety | | | | | | |
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| **Compliance Actions:** Six compliance actions listed below | | | | | | |
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| | | | | | | |
| **CA 6**<br>**CA 4** | 30. Ensure that equipment and supplies at the Head Injury Therapy Unit are monitored and serviced appropriately to ensure that patients are not at risk of receiving treatment and care using defective or out-of-date equipment. | HITU | HITU has an audit file of all equipment that needs to be monitored with expiry dates, expiry date reminders are also on the outlook calendars of the clinical lead and the admin coordinator. | David Lee, CES Manager<br><br>Emma Hale, Clinical Lead, HITU | Completed & ongoing compliance. | All equipment in date and system in place for Trust to continue to service equipment post move. |
| **CA 6** | 31. Ensure that infection control procedures are followed and monitored in the Head Injury Therapy Unit so that patients are not put at risk. | HITU | Legionella tap flushing log sheet now being completed. All staff have read relevant policies and all staff are up to date with mandatory training. | Emma Hale, Clinical Lead, HITU | 01/04/15 | Checks of flushing log.<br>Staff up-to-date with infection control training. |
| **N/a** | 32. (Should Do) Ensure that resuscitation equipment in the emergency department is appropriately sited and regularly checked. | ED | For Resus trolleys **(also see Action No. 22)**<br>• Devise procedure to explore sealed boxes/tags.<br>• Additional trolley now stocked and ready for use to support Minor Injuries.<br>• Develop and implementation of tamper evident systems – once in place audit compliance. | Matt Crabtree, ED Ward Manager | 15/04/15 | Agree new procedure.<br><br>Pharmacy to carry out monthly audits of tamper evident seals, of Resus trolley contents and contents list. |
| **Facilities**<br>**Compliance Action 7: Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises.** The use of rooms in the Head Injury Therapy Unit is no longer fit for purpose, being cluttered with filing cabinets and equipment and in need of renovation. | | | | | | |
| **CA 7** | 33. Ensure the rooms in the Head Injury Therapy Unit are uncluttered and fit for purpose. | HITU | HITU have moved into newly refurbished fit-for-purpose facility in early March 2015, which has resolved the cluttered state of previous premises. | Emma Hale, Clinical Lead, HITU | Completed | HITU move to appropriate accommodation. |

| NBT Improvement Theme 2: Patient Safety | | | | | | |
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| **Compliance Actions:** Six compliance actions listed below | | | | | | |
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| **Other** | | | | | | |
| **N/a** | 34. Improve compliance with hand washing and ensure that all staff are bare below the elbows in clinical areas. | Trustwide | Since the Inspection Hand Hygiene compliance levels have improved significantly. A sustainability driver diagram has been agreed through COIC, which defines the sub-processes and actions that will enable ongoing achievement of the 95% target. The key components are;<br>• Senior Leadership<br>• Education/Comms – service users and visitors<br>• Identification of exceptions and action<br>• Audit & measurement systems<br>• Staff engagement and competence | Sam Matthews, Nurse Consultant-Infection Prevention Control<br><br>SWS / Matrons | 30/06/15 | Delivery of sub-processes outlined in Driver Diagram (oversight via COIC and Quality Committee).<br>Sustain achievement of 95% Outcome Goal (oversight via COIC and reported in Board IPR). |
| **N/a** | 35. (Should Do) Improve access to cleaning materials on Percy Phillips ward for the cleaning of patient baths. | Maternity | A keypad digit lock is now in place – to enable access for all staff. | Ward Managers Liz Jones & Nicky Chinnock | Completed | Baths are cleaned regularly and this has been added to the Matron's Walkround. |
| **N/a** | 36. (Should Do) Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly. | ED | • (EDIP 7.1) Reception area to be manned at all times and arrangements for clinical escalation to be implemented in the event of patient concerns.<br>• 2 WTE receptionists being recruited (bank staff being used in meantime) to ensure cover during breaks.<br>• Expectations clarified, customer service training provided incorporating Trust Values and performance management implemented. Short-term management presence in the area at all times to enforce and monitor compliance.<br>• Documented 'red flag' symptoms and process created and agreed by ED Management Team, circulated to receptionists with paper copies held | Denver McCrum, AGM, Medicine<br><br>Catherine Bryne, ED Support Manager<br><br>Juliette Hughes, Matron, ED | Completed & Ongoing | Reception to be manned at all times.<br>Observational audit; Patient feedback. |

| NBT Improvement Theme 2: Patient Safety | | | | | | |
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| **Compliance Actions:** Six compliance actions listed below | | | | | | |
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| | | | at reception.<br>• Door release button installed on front desk.<br>• Red flag process of phoning red base rather than walking to triage/NIC.<br>• Request sent to Capital Planning to change security camera screen at front desk to view Crossroads, aiding signposting without leaving desk.<br>• Improve visibility of patients in waiting room from triage door by assessing alternative chair layout. | | | |
| **N/a** | 37. (Should Do) Improve the quality of safety thermometer and patient outcome data and how it collects this data in the critical care unit to ensure the service is able to innovate and improve. | Critical Care | Nurse led audits now fed back through nurse MDT meetings with identified outcomes and reviews. This is in put onto the safety thermometer. The process for capturing the data on forms has been strengthened to ensure full and timely submission. | Gareth Wrathall, Lead Consultant Intensivist | Already actioned & ongoing. | Safety Thermometer information recorded and reviewed monthly. |
| **N/a** | 38. (Should Do) Ensure that monitor alarms in the critical care unit can be heard or seen at all times. | Critical Care | 1. Ventilator Alarms on the new models are now locked so that the volumes cannot be reduced without a password being used.<br>2. Changes to arrest alarms to be audible in all areas by Carillion. | Dominique Duma, Matron, ICU | 1. Completed<br>2. 30/04/15 | Staff observation and testing of alarms. |
| **N/a** | 39. (Should Do) Ensure that the critical care service develops a set of standard operating procedures to ensure consistency of clinical approach to patients. | Critical Care | • Funding has been secured for a health and safety post in ICU to develop ongoing SOPs.<br>• A Bereavement and single room SOP is being developed. In the meantime a priority order of SOPs will be established. | Gareth Wrathall, Lead Consultant Intensivist | 30/11/15 | Critical Care SOPs in place for staff which are easily accessible and routinely reviewed. |

| NBT Improvement Theme 3: Patient Experience | | | | | | |
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| **Compliance Action: - N/A** | | | | | | |
| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| **N/a** | 40. Ensure that the privacy and dignity of patients in the Brunel building is maintained. | Trustwide | Emergency Department;<br>(EDIP 2.1) ED staff will ensure adequate arrangements are implemented in Majors, MIU and AEC to afford privacy and dignity for patients. Practical steps include taller privacy screens and curtains, plus ensuring clinicians only hold appropriate conversations within those areas.<br>Brunel Building (outside of ED);<br>1. Patient choice to be facilitated by providing information in each room encouraging the patient to ask for the window curtain to be drawn if they wish.<br>2. Staff to be reminded of the need to be aware and to protect patient's privacy and dignity via internal Trust communications bulletins / notices.<br>3. Planned monitoring sessions to identify any disregard of patient privacy and dignity by staff.<br>4. Specific action plans to be created in high risk areas (such as ground floor / atrium facing rooms) to protect patient privacy and dignity whilst maintaining patient choice.<br>5. Include in the programme of ongoing monitoring through Matron's Walkrounds. | ED Nurse Manager<br><br>June Hampton, Head of Patient Experience | Completed & Ongoing<br><br>1. 30/04/15<br>2. 30/04/15<br>3. 15/05/15<br>4. 31/05/15<br>5. 30/06/15 | Patient Survey results.<br><br>Lack of patient complaints.<br><br>Outcomes of observational audits & actions.<br><br>Matron's walkround completion & feedback. |
| **N/a** | 41. (Should Do) Continue to participate in local and national audits to benchmark practice and ensure continuous improvement in patient experience and outcomes in the emergency department. In particular, staff should take steps to improve pain management. | ED | (EDIP 6.1);<br>1. To continue to undertake CEM audits to monitor compliance.<br>2. To ensure pain management measures including pre-hospital analgesia are recorded (as current data is skewed due to this not happening consistently).<br>3. To implement RATT to assess and prescribe analgesia promptly. | Leilah Dare, ED Specialty Lead | 30/04/15 | Pain assessment and management standards 100% met – one day per month point prevalence audits. |
| **N/a** | 42. (Should Do) Take steps to improve the experience for patients | ED | A programme of improvement activities will be undertaken; | June Hampton, | | Monitoring of FFT, compliments and |

| NBT Improvement Theme 3: Patient Experience | | | | | | |
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| **Compliance Action: - N/A** | | | | | | |
| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| | and visitors in the emergency department waiting room. This should include customer service training for receptionists, the provision of TVs, appropriate reading material and information about waiting times. | | 1. Customer Service training sessions are being delivered with mandatory attendance (26.02.15, 18.03.15 and 30.03.15 - 2 hour targeted learning).<br>2. Three existing TV screens within the ED area will be activated to enable FreeView.<br>3. Examples of positive and negative comments (FFT and complaints) will be collated for review and learning by reception team.<br>4. Advertise Wi-Fi service, ensuring that in meantime the problems with network connectivity are resolved (IT/Provision).<br>5. Ensure good supply of 'Your Hospital' magazine, other magazines and free newspapers.<br>6. New wall art in waiting areas.<br>7. Implement Crossroads document explaining function of the area. | Head of Patient Experience<br><br>Jane Hill, ED Specialty Manager | 1. 31/03/15<br><br>2. 30/04/15<br><br>3. 31/05/15<br><br>4. 31/05/15<br><br>5. 31/05/15<br><br>6. 31/05/15<br><br>7. 31/05/15 | complaints – more compliments, and reduced complaints. Reading materials, WiFi and TVs are available, accessible and working within the ED waiting room. Wall art is present.<br><br>'Crossroads' Document is available. |
| **N/a** | 43. (Should Do) Ensure that patients are kept informed of the waiting times in clinics. | Trustwide | The Trust will explore various methods of displaying waiting times in clinics and then determine the appropriate method for use in the Trust. Implementation of the selected option will then follow. | June Hampton, Head of Patient Experience | 31/05/15 (options)<br><br>31/07/15 (implement) | A method of displaying waiting times is present in every clinic area. |
| **N/a** | 44. (Should Do) Display safety metrics and quality performance information in the clinic waiting areas. | Trustwide | Quality and Safety metrics boards for clinic waiting areas are being developed for display, and will then be updated on a monthly basis. | June Hampton, Head of Patient Experience | 30/06/15 | Quality and Safety metrics boards are displayed in every clinic. |
| **N/a** | 45. (Should Do) Ensure that chaperoning is available and that patients are aware of this service. | Trustwide | 1. Establish staffing levels required to consistently have chaperones available, identify any shortfalls, and recruit / skill mix review to address this.<br>2. Devise patient information about chaperone availability and how to ask for a chaperone. Inform staff of the availability of chaperones. | June Hampton, Head of Patient Experience | 1. 30/04/15<br><br>2. 31/05/15 | Monitor the use of chaperones. Information about chaperones is available for patients. |

| NBT Improvement Theme 3: Patient Experience | | | | | | |
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| **Compliance Action: - N/A** | | | | | | |
| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| **N/a** | 46. (Should Do) Ensure that information for the benefit of patients, such as translator and interpreter services and chaperoning, is available and visible. | Trustwide | 1. A review will be conducted of the current information about services such as translators, interpreters and chaperones and how this is made available to patients.<br>2. An evaluation of any information shortfalls will be undertaken and improvements made to fully inform patients of these services and how to access them.<br>3. Patient room guides for inpatients will be developed and introduced, which will include the information about translator, interpreter and chaperone services along with other information to inform and enhance their stay. | June Hampton, Head of Patient Experience | 1. 30/04/15<br>2. 31/07/15<br>3. 31/10/15 | Review outcome report. Information is readily available and accessible. Patient guides made available in each room for inpatients. |
| **N/a** | 47. (Should Do) Ensure that information about reporting complaints is clearly displayed and available to patients and visitors to the hospital. | Trustwide | The Trust's Complaint's Improvement Plan will include assessing the best way of visually highlighting the way complaints should be reported, taking account of good practice form other acute hospitals. The selected option will be implemented alongside other improvements as part of the new patient experience strategy. | Paul Cresswell, AD of Quality Governance | 30/06/15 | Visual 'signposts' to complaint process available in each ward and outpatients area. |
| **N/a** | 48. (Should Do) Ensure that the critical care service investigates ways to develop the emotional support offered to patients, their relatives and friends. | Critical Care | 1. The Critical Care service has initiated multi faith services for bereaved relatives. The first one was held Dec 2014, attended by 50 relatives.<br>2. Planned phone contacts in first week after death to offer support. Project to implement patient diaries to be filled in by staff and relatives. | Dominique Duma, Matron, ICU | 1. Complete & Ongoing<br>2. 01/05/15 | Captured through relative feedback forms. |
| **N/a** | 49. (Should Do) Ensure that the critical care service produces a booklet for patients, their relatives and friends about staying on and visiting the unit. | Critical Care | • ICU relative information booklet is currently being written.<br>• In the interim, a short leaflet on ICU is being provided to relatives. | Dominique Duma, Matron, ICU | 30/06/15 | Captured through relative feedback forms. |
| **N/a** | 50. (Should Do) Consider improving early identification of patients who could be in the last year or months of | Trustwide | As part of the 2015-16 CQUIN for end of life care, the early identification of patients as stated is currently being addressed via: | Martin Plummeridge, Clare Kendall, | | |

| NBT Improvement Theme 3: Patient Experience | | | | | | |
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| **Compliance Action: - N/A** | | | | | | |
| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| | their life. | | 1) The ICE discharge summary has been modified to include a mandatory field requiring patients within the last months of life to be identified to primary care on discharge.<br>2) Institution of a detailed treatment escalation plan for all patients admitted via AAU and the stroke unit. This prompts a holistic assessment of the patient's health including an opinion about whether they are in the last months of life. This is then used to inform decisions about appropriate care/intervention and ceiling of therapy together with decisions about DNACPR. | Clinical Leads for Palliative Care | 1. Complete & ongoing<br>2. Trial in MAU – audit data review. 30/04/15 | Outcomes monitored per CQUIN measures for End of Life (EOL) care at EOL Strategy Group |
| **N/a** | 51. (Should Do) Ensure that the availability of a chaperone is displayed for patients in the outpatients and diagnostic and imaging departments at Cossham Hospital. | Cossham | The following actions will be delivered to ensure this is made clear to patients at Cossham;<br>• Posters will be displayed in patient waiting areas.<br>• Recruit to vacant nursing and health care assistant post within the centralised outpatient's team.<br>• Review skill mix to ensure appropriately trained staff in all outpatient locations. | Claire Weatherall, GM, R&O | 31/03/15 | Information regarding chaperoning visible in all patient areas at Cossham.<br>Workforce reviews and sickness absence monitoring. |
| **N/a** | 52. (Should Do) The community CAMHS should ensure children, young people and their families are fully engaged in their care and are provided with a written plan of care that they agree to. | CAMHS | This will be actioned by;<br>1. Consulting with Barnardo's young people's group about the young people friendly nature of careplans and how best to engage young people in their care plans.<br>2. Reviewing care plans used nationally at http://www.camhsnetwork.co.uk/7HelpfulHabits/care-plans.htm.<br>3. Agreeing and ratifying and new care plans, ensuring consultation with CAMHS young people, following scoping work noted above. | Maria Hennessy, Head of Nursing & Clinical Governance (CCHP)<br>Integrated Lead for CAMHS (CCHP) | 1. 01/09/15<br>2&3. 01/09/15 | Improved evidence of planning, clinical intervention and decision making that reflects the contribution and views of children, young people and their family.<br>Revised care plan documentation and engagement |

| NBT Improvement Theme 3: Patient Experience | | | | | | |
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| **Compliance Action: - N/A** | | | | | | |
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| | | | 4. The resulting Framework for careplans and associated guidance will then be implemented across the service. | | 4. 31/12/15 | process in place. Records audit results demonstrating improved standards of record keeping. |

## NBT Improvement Theme 4: Staffing Levels, Wellbeing & Engagement

**Compliance Action 8: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery, maternity services at Southmead Hospital and child and adolescent mental health teams.

| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
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| **CA 8** | 53. Review staffing levels to ensure they reflect current demand. | Trustwide | 1. Develop a workforce plan to reduce reliance on bank and agency staffing.<br>2. Ensure all wards are undertaking SafeCare acuity and dependency recording twice daily and review against staffing levels.<br>3. All wards, Theatres and Intensive Care nurse staffing levels to be reviewed by end of March 2015 with recommendations made of changes required to Trust Board in April 2015.<br>4. Director of Nursing to provide 6 monthly assurance to the Trust Board that staffing is safe through ongoing review using SafeCare and staffing fill rates. | Sarah Dodds, DDoN<br>Heads of Nursing | 1. 30/04/15<br>2. 30/04/15<br>3. 30/04/15<br>4. 30/04/15 (& 6 mthly) | Reduction in bank and agency usage.<br>Performance reviewed weekly.<br>Evidence of all areas reviewed and recommendations approved.<br>Monthly exception reporting via Integrated Performance Report.<br>6 Monthly Board report. |
| **CA 8** | 54. Ensure there are enough staff with the right skills and experience to provide safe and quality care to patients at all times. | Trustwide | 1. Ensure that recruitment strategy is in place, for both short term and long term recruitment to include recruiting staff to turnover in clinical areas.<br>2. Recruit Nurse Recruitment and Retention Manager<br>3. Recruit 40 Registered Nurses from Spain to commence in July and August 2015.<br>4. Undertake training needs analysis every 6 months for all areas and work with Learning and Research department to ensure appropriate training and education in place.<br>5. Review impact of standardised shift pattern and disseminate recommendations on how to manage staff wellbeing and patient care throughout the shift.<br>6. Monitor reporting of staffing shortages | Sarah Dodds, DDoN<br>Heads of Nursing<br>Matrons<br>SWS | 1. 31/03/15<br>2. 30/04/15<br>3. 30/09/15<br>4. Ongoing<br>5. 30/07/15<br>6. Ongoing | Reduction in vacancies.<br>Reduction in turnover of staff. Monitored at monthly Workforce Committee.<br>Improvement in Staff Survey (2015).<br>Working group of standardised shift patterns feedback.<br>Monthly review of staffing related incidents at Directorate Governance groups |

## NBT Improvement Theme 4: Staffing Levels, Wellbeing & Engagement

**Compliance Action 8: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery, maternity services at Southmead Hospital and child and adolescent mental health teams.

| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
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| | | | through the use of incident reporting and QUESTT and take action to manage. | | | and QUESTT. |
| **CA 8** | 55. Ensure that nurse staffing levels in the emergency department are urgently reviewed and aligned to match current patient demand, flow and acuity. | ED | 1. (EDIP 3.1) Secure additional staff to support the department - implementation of SOP which requests additional short term support from wards and corporate roles. This includes recruiting 5.45WTE B5 nurses to undertake additional triage function.<br>2. Ensure ED staffing is within parameters of draft ED NICE staffing guidance (even at times of surge).<br>3. Completion of staffing spreadsheet and monthly monitoring of vacancies. | Juliette Hughes, Matron, ED<br>Christine Morgan, HoN, Medicine<br>Matt Crabtree, ED Ward Manager<br>Jane Hill, ED Specialty Manager | 1. 15/04/15<br>2. Ongoing<br>3. Ongoing | 100% agency fill rate.<br>Daily internal audit.<br>80% reduction in ED related staffing incident reports.<br>Monthly monitoring of vacancies. |
| **N/a** | 56. Take action to support emergency department staff, including senior staff, to ensure their psychological wellbeing. | ED | Support to be provided by co-creating this between HR and the directorate team.<br>1. Develop and roll-out customer care training – which has proved successful with ED receptionists in exploring how staff can support each other, and the ways in which the organisation can better support staff.<br>2. HR meeting with ED managers to discuss and agree action plan.<br>3. Discussions with ED staff and review of key indicators in ED – Staff FFT, sickness, turnover – and possible use of HSE stress audit, to further analyse and understand staff wellbeing and stress in ED | Mondel Mings (AGM, ED)<br>Caroline Hartley (HR Business Partner) / Juliette Hughes (Matron, ED) | 1. 31/03/15<br>2. 30/04/15<br>3. 30/06/15 | Review of hard data;<br>• HR metrics - sickness & turnover<br>• Staff F&FT results<br>• Reasons for sickness & absence<br>• Review of eAims forms, complaints & grievances<br>Qualitative data;<br>• Regular 'temperature' checks with staff |

## NBT Improvement Theme 4: Staffing Levels, Wellbeing & Engagement

**Compliance Action 8: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery, maternity services at Southmead Hospital and child and adolescent mental health teams.

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| | | | 4. Review need for developing staff wellbeing workshops tailored specifically to the needs of the ED staff | | 4. 30/06/15 | • Focus groups at regular intervals<br>• Staff Wellbeing 'champions' feedback |
| **CA 8** | 57. Address workforce issues across community CAMHS to ensure that each of the teams has an appropriate number of staff with the right level of skills and experience to meet the needs of local children and young people. | CAMHS | This is recognised as a critical area to address, particularly in light of national shortages of skilled staff in this area. The actions to deliver sustainable workforce will be to;<br>1. Re-establish CAPA Steering group.<br>2. Undertake team and individual analysis to assess current caseloads and capacity.<br>3. Benchmark CAPA capacity against referral rates for 14-15 and Workforce review and redesign to increase WTE and ensure there is an equitable balance of clinical expertise across CCHP. Undertake a skill mix gap analysis as intrinsic part of this process.<br>4. Use the 2014-15 appraisals identify training needs and source appropriate training programmes. | Jo Smith, Partnership Manager<br><br>Integrated Lead CAMHS<br><br>Integrated Lead CAMHS | 1. 01/09/15<br>2. 01/09/15<br>3. 01/09/15<br>4. 01/09/15 | Equitable caseloads that provide capacity to manage referrals.<br><br>Sufficient WTE to meet demand and equitable provision of skills/experience.<br><br>Robust professional development programme action plan. |
| **CA 8** | 58. (Should Do) Ensure that concerns about nurse staffing levels are appropriately documented on the emergency department risk register and escalated for consideration at the directorate and/or trust level, as appropriate. | ED | Develop an appropriately assessed risk register entry on ED staffing levels which is monitored by the Medicine Directorate, actively mitigated, and escalated to Trust level as needed. | Juliette Hughes, Matron, ED /Matt Crabtree, ED Ward Manager | 31/03/15 | Monitoring at Medicines Directorate Meeting. |
| **CA 8** | 59. (Should Do) Undertake a staffing review and report on staffing at the Cossham Birth Centre separately from the main unit at Southmead to ensure that the midwife-to-births ratio is within the limits set by the Royal | Cossham | Cossham's 1-1 care in labour is 98% - this is demonstrated via Euroking (Maternity IT system) and the team's daily Acuity tool. This will be added into the reporting Dashboard | Gina Augarde, Matron for Normal Birth | 31/12/15 | 100% 1-1 care. Monitored via Maternity Dashboard. |

| NBT Improvement Theme 4: Staffing Levels, Wellbeing & Engagement | | | | | | |
|---|---|---|---|---|---|---|
| **Compliance Action 8: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery, maternity services at Southmead Hospital and child and adolescent mental health teams. | | | | | | |
| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| | College of Obstetricians and Gynaecologists and that one-to-one care in labour is provided 100% of the time. | | separately. | | | |
| **CA 8** | 60. (Should Do) Review the number of supervisors of midwives to ensure a supervisor-to-midwives ratio of 1:15 is met at Cossham Birth Centre. | Cossham | There are 11.2 midwives at Cossham and three Supervisors of midwives, so the Trust's ratio is 1:4. | Gina Augarde, Matron for Normal Birth | Completed | Monitored via:<br>1. Dashboard<br>2. Local Supervising Authority Audit |
| **N/a** | 61. (Should Do) Review the operational management arrangements across the community CAMHS teams to ensure arrangements are put in place to support all staff effectively. | CAMHS | 1. Complete the implementation of the Operational Management workforce redesign.<br>2. Appoint Integrated Therapy Lead for CAMHS to support partnership development.<br>3. Appoint Team leaders for each of the areas to support staff from a clinical perspective. | Jo Smith, Partnership Manager | 1. 31/03/15<br>2. 31/03/15<br>3. 30/04/15 | Revised operational and clinical leadership model in place.<br>Improved staff engagement and positive feedback from staff.<br>Staff satisfaction survey demonstrates improvement. |
| **N/a** | 62. (Should Do) The provider should communicate more effectively and keep staff up to date with arrangements on the retendering for CCHP, including CAMHS. | CCHP & CAMHS | • Agree and share communication strategy.<br>• Reintroduce retendering newsletter for cascade to all staff.<br>• Share retendering briefings with staff.<br>• Discuss at all CCHP locality communication meetings.<br>• Clinical networks led by Lead CCG ongoing with clinical representation informing service specification.<br>• Service managers and line managers to discuss retendering at team meetings.<br>• Ask staff for suggestions for how else they would like to be informed and involved. | Sasha Karakusevic, Director of Strategy<br><br>Jane Schulte Partnership Director (CCHP)<br><br>Jo Smith Partnership Manager | Immediate & Ongoing | Improved staff engagement and knowledge of retendering.<br>Clinical reps at networks feedback at CCHP Clinical Strategy Board confirming high level of clinical engagement. |

## NBT Improvement Theme 4: Staffing Levels, Wellbeing & Engagement

**Compliance Action 8: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery, maternity services at Southmead Hospital and child and adolescent mental health teams.

| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
|---|---|---|---|---|---|---|
| N/a | 63. (Should Do) The provider should seek to actively involve staff much more in the redesign of CAMHS. | CAMHS | 1. Continue work on service re-design involving staff from all localities and professions including joint working with CCG's and Local Authority (started 2014)<br>2. Review terms of reference of clinical development meetings.<br>3. Improve communication updates to all Teams in regard to progress of any development programme. To include increased attendance at area team meetings, regular newsletters, standing agenda item at all business and professional meetings.<br>4. Request staff feedback on any proposed redesign. | Jo Smith, Partnership Manager | 1. Ongoing 2014-15<br>2. 30/04/15<br>3. 30/09/15<br>4. 30/09/15 | Phase 1 service redesign completed.<br>Ongoing evaluation of quality and effectiveness of service.<br>Staff are actively involved: This will be measured by membership at redesign groups.<br>Increase in individual and team feedback. |

## NBT Improvement Theme 5: Training

**Compliance Action 8: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery, maternity services at Southmead Hospital and child and adolescent mental health teams.

**Compliance Action 9: Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff.** Mandatory training was not being consistently undertaken across the trust. Less than 50% of nursing staff in critical care have a post-registration qualification in critical care.

| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
|---|---|---|---|---|---|---|
| **CA 9** | 64. Ensure staff meet the targets for statutory and mandatory training. | Trustwide | 1. Agreed in 2014 that staff annual pay increment to be received on condition that full compliance with mand/stat training can be demonstrated. This principle is applicable to all staff from April 2015 onwards.<br>2. Updated Training Needs Analysis – will publish training requirements and update frequency by staff group in more accessible format.<br>3. Review and launch of updated mand/stat training programme.<br>4. BNSSG/Bath Passport Protocol – staff transferring between regional NHS Trusts will retain and transfer their individual training record – therefore retaining compliance with in-date mand/stat training.<br>5. Improved and strengthened eLearning options and availability to make mand/stat training updates easier and more accessible.<br>6. HR Partners to actively monitor and ensure staff in their Directorates are compliant in mand/stat training. | Susan Nutland, Programme Lead<br><br>Jane Hadfield, AD Learning & Development<br><br>HR Business Partners<br>ALL Appraisers<br>ALL Staff | 1. 31/03/15<br><br>2. 30/04/15<br><br>3. 31/05/15<br><br>4. 31/05/15<br><br>5. 30/06/15<br><br>6. 30/09/15 | Ongoing assurance via Workforce Committee to implement new phase of programme.<br><br>Ongoing evaluation of provision will continue by participants, peer review, and compliance achievements. |
| **CA 9** | 65. Ensure that temporary staff employed in the emergency department receive appropriate induction to ensure their familiarisation with the department and their competence in the role. | ED | • Re-familiarise staff with NBT eXtra processes for the local induction of temporary staff – ensure use of checklist for new temporary staff and return of completed checklist to NBT eXtra. | Juliette Hughes, Matron, ED<br><br>Matt Crabtree, ED Ward Manager | Complete | Improved local induction compliance in ED, monitored monthly by NBT eXtra. |

## NBT Improvement Theme 5: Training

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| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
|---|---|---|---|---|---|---|
| **CA 9** | 66. Enable and facilitate emergency department staff to undertake mandatory and essential clinical training and professional training and development. | ED | • ED Consultant nominated as responsible for compliance with mand/stat training, will monitor MLE for staff list and compliance.<br>• Consultants to be added to rolling training programme for safeguarding training.<br>• Practice development nurse (B7, 1.5WTE) to be employed in order to deliver ED nursing training. | Leilah Dare, ED Specialty Lead<br><br>Juliette Hughes, Matron, ED<br><br>Matt Crabtree, ED Ward Manager | 01/07/15 | ED staff compliant with mand/stat training – monitored via MLE reports. |
| **CA 9** | 67. Ensure that more than 50% of the nursing staff in critical care have attained their post-registration qualification in critical care nursing. | Critical Care | • Practice Development Sister is in post and is using the 'Skills for Health' competency framework built into the staff training and development plan, along with mentorship.<br>• University post graduate course has been commissioned. First course planned for September/October 2015 – this will be a rolling programme and will take less than 2 years to achieve 50% (dependent upon staff turnover). | Lorraine Motuel, HoN, CCS | 30/09/17 | More than 50% of critical care nurses have attained their post-registration qualification. |
| **CA 8** | 68. (Should Do) Keep under review the emergency department staff skill mix and training to ensure staff are competent to care for children. | ED | Detailed Nurse Staffing review undertaken January 2015, which included skills mix and training requirements.<br><br>Additional Practice Development nurse resource has been agreed (B7, 1.5WTE) in order to deliver ED nursing training. | Juliette Hughes, Matron, ED/ Matt Crabtree, ED Ward Manager | 30/06/15 | |
| **CA 8** | 69. (Should Do) Improve the provision and take up of training for emergency department | ED | • Department Champion to be identified.<br>• Champion to identify training needs and | Juliette Hughes, | 01/10/15 | ED staff receiving dementia care |

| NBT Improvement Theme 5: Training | | | | | | |
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| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| | staff in dementia care, supported by departmental champions and the development of a pathway for dementia care. This is so that the needs of patients with dementia are identified and appropriately met. | | develop pathway. | Matron, ED<br><br>Matt Crabtree, ED Ward Manager | | training, based around an approved dementia care pathway, which is supported and monitored by an ED Dementia Care Champion. |
| **N/a** | 70. (Should Do) Ensure that the reception staff in the emergency department are receptive to patients arriving and observe those that are waiting to be seen. | ED | 1. Documented 'red flag' symptoms and process created and agreed by ED Management Team, circulated to receptionists with paper copies held at reception.<br>2. Door release button installed on front desk.<br>3. Red flag process of phoning red base rather than walking to triage/NIC.<br>4. Request sent to Capital Planning to change security camera screen at front desk to view Crossroads, aiding signposting without leaving desk.<br>5. Examples of positive and negative comments (FFT and complaints) collated for review and learning by reception team.<br>6. Customer Service training sessions to be delivered with mandatory attendance. Dates 26.02.15, 18.03.15 and 30.03.15 (2 hour targeted learning). | Mondel Ming, AGM, Medicine<br><br>Jane Hill, ED Specialty Manager | Completed<br><br>Completed<br>Completed<br><br>Completed<br><br>Completed and ongoing<br><br>6. 01/04/15 | Monitoring of FFT and complaints – more positive comments, and no complaints received. |
| **N/a** | 71. (Should Do) Ensure staff meet the targets for annual appraisals and performance reviews. | Trustwide | 1. Agreed in 2015 that staff annual pay increment to be received on condition that annual appraisal has been completed. This | Robert Baker, AD of HR&D<br><br>Jayne Stone, | 1. 30/04/15 | Compliance rates in year will remain in range of 93-100%. |

| NBT Improvement Theme 5: Training | | | | | | |
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| CQC Compliance Action Ref. | Action required by CQC | Service Area | Actions | Lead(s) Responsible | Completion Due Date | Outcome/Success Criteria (including ongoing assurance) |
| | | | principle is applicable to all staff from April 2015 onwards.<br>2. Review of appraisal paperwork and policy. | Assistant HR Director<br>ALL Appraisers<br>ALL Staff | 2. 30/04/15 | |
| **N/a** | 72. (Should Do) Ensure all staff are trained to enable optimal end of life care to be delivered. | Trustwide | • Staff to receive training via EoL eLearning package.<br>• Learning & Development to facilitate communications plan/training needs analysis as required.<br>• All staff to be trained on revised care plan at ward level. | End of Life Working Group<br><br>Penny Close, Palliative Care Specialist Nurse | 31/05/15 | Clinical staff have access to the EoL eLearning package. Availability of the eLearning will be communicated via the passport training programme for clinical staff. |