Oxford University Hospitals NHS
NHS Trust

Oxfordshire Health Overview and Scrutiny Committee: Thursday 18 September 2014

Title	**CQC Action Plans**

Status	For information

Oxford University Hospitals

Executive Summary

1. This paper presents the final approved action plans developed by Oxford University Hospitals [OUH] NHS Trust in response to the Care Quality Commission Chief Inspector of Hospital's Reports, published by the CQC on 14th May 2014.
2. The action plan to address compliance actions ('Must Do actions') was submitted to the CQC as required on 12 June 2014. A copy is provided at **Appendix 1**.
3. The action plan to address the advisory actions ('should do' actions) was submitted to CQC as required on 31 July 2014. A copy is provided at **Appendix 2**.
4. The Care Quality Commission formally approved both Action Plans on 14 August 2014.
5. The Trust proposes that it should provide the Health Overview & Scrutiny Committee with an update on progress with the implementation of both action plans in December 2014

6. **Recommendation**

HOSC is asked to:

- Note the action plan developed to address the compliance actions ('Must Do actions'); and
- Note the action plan developed to address the advisory actions ('should do' actions) and
- Note that both action plans were formally approved by the CQC on 14 August 2014
- Agree to the submission of an update on implementation of these action plans in December 2014.

1. Introduction

1.1. The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 25 and 26 February 2014.

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

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

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

2. Report findings

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

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

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

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

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

- The Trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.
- The Trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times.
- The Trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.

- The Trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with good practice standards.
- The Trust needs to ensure that staff receive suitable induction to each area that they work within the Trust.
- The Trust needs to ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

2.6. In each of the reports specific to each site, there were areas that the CQC had stated '**should improve'**. These are referred to as advisory actions which the Trust has reviewed in detail.

3. Action Plans

3.1. OUH Trust developed and submitted its action plan in relation to the 'Must Do' Compliance actions raised in the CQC reports on 12 June 2014. A copy of the final approved action plan is provided as Appendix 1.

3.2. The 'Should Do' Advisory Action Plan was submitted to the CQC on 31 July 2014. A copy of the final approved action plan is provided as Appendix 2.

3.3. The CQC formally approved both action plans on 14 August 2014.

3.4. Progress against both action plans is monitored and reported on regularly to the OUH Trust Management Executive Committee.

3.5. The Trust proposes that it should provide HOSC with an update on progress with implementation of these plans in December 2014.

4. Recommendations

HOSC is asked to:

- Note the action plan developed to address the compliance actions; and
- Note the action plan developed to address the 'should do' actions; and
- Note that both action plans were formally approved by the CQC on 14 August 2014.
- Agree to the submission of an update on implementation of these action plans in December 2014.

Eileen Walsh, Director of Assurance
September 2014
Prepared by: Clare Winch Deputy Director of Assurance

'COMPLIANCE ACTIONS' ACTION PLAN

Oxford University Hospitals NHS Trust received five reports setting out the findings from its recent inspection:

- An over-arching trust wide report containing a summary of all compliance actions from the individual hospital reports (the compliance 'must do' action plan attached covers all action included as part of this report)
- Four reports, one for each of the hospital sites; the Churchill Hospital, the Horton General Hospital, the John Radcliffe Hospital and the Nuffield Orthopaedic Centre. In addition to listing the compliance actions these reports included a number of 'should do' recommendations (this action plan is provided as Appendix 2).

Key

The following abbreviation relates to the trust's internal monitoring system:

CA – Compliance Action

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

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

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
CA 1.1	The **accident and emergency** department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively.	The following outlines key actions already in place and additional actions developed as a result of the CQC inspection. These have been developed with involvement of key members of staff. **Actions relating to input from surgical specialties** • Following initial patient assessment in Emergency Department (ED), time critical diagnostics will continue to be ordered by ED. When investigations are assessed by ED to be less time critical, but they require a surgical opinion, patients will be immediately transferred to Surgical Emergency Unit and Specialist Surgery In-Patients ward. • Patients will be managed on an ambulatory basis wherever possible. • Where patients are assessed as not requiring ED medical input, they will be directly referred internally to the relevant specialty. • Patients requiring a surgical opinion in ED will be transferred to the ward for assessment if a request for assessment on ED is not responded to within 30 minutes, prior to a check on the capacity of staff to maintain the required frequency the required frequency of observations. The above actions will be supported by: • Diagnostic availability to SEU will be enhanced to that of ED and Emergency Assessment Unit (EAU)	**Executive Director accountability:** Director of Clinical Services Operational Lead: Divisional General Manager for Medicine Rehabilitation and Cardiac (MRC)	Actions in place by 4 June 2014 Performance improvements to be delivered by 31 August 2014	ED Action Plan (Item 7) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		Improved Use of the Transfer Lounge • Ensure that all specialties actively support the flow of patients by identifying patients to move to the Transfer Lounge before 10.30am. • Matrons to support ward staff to obtain early decisions on discharge from all hospital medical teams. • Operations Team will support ED and EAU Coordinator by working more closely with the wards to ensure beds are made available, when required. • Further support to be provided by the Directorate Operational Service Managers and Matrons with escalation to the Divisional General Managers and Divisional Nurses when constraints are not being actively managed.	Operational Lead: Divisional Nurse MRC Matrons Operations Team ED and EAU Coordinator Directorate Operational Service Managers	Actions in place by 4 June 2014 Performance improvements to be delivered by 31 August 2014 4 June 2014	ED Action Plan (Item 14) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.
		• Discharge by time of day to the Transfer Lounge will be reviewed weekly to monitor performance. • Breach analysis to be undertaken for any patients discharged directly from the ward (rather than via the Transfer lounge) to monitor performance	Operational Lead: Divisional Nurse MRC		Weekly monitoring reports	
		Expected referrals and transfers • From 4 June 2014, patients expected from GPs will be admitted directly to the appropriate ward and not held in ED • Transfers from the Horton ED for specialty opinion to be direct to the appropriate ward and not held in ED	Operational Lead: Divisional General Manager MRC	Actions in place by 4 June 2014 Performance improvements to be delivered by August 2014	ED Action Plan (Item 8) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.
		• Paediatrics • Paediatric Clinical Decision Unit (CDU) to continue to pro-actively 'pull' patients who are ready to be transferred from ED at all times of the day and night. • Requests for Paediatric opinions at the Horton will be consistently responded to within 30 minutes by	Paediatric CDU staff	As above 4 June 2014	ED Action Plan (Item 10) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained as above.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		consultants giving 24/7 resident presence.				
		• Monitor this by escalation to the Children's' & Women's Divisional Nurse and General Manager when this is not met.	Children's' & Women's Divisional Nurse and General Manager	With effect from 4 June 2014		
		Actions Internal to the Emergency Department – (To commence Monday, 2nd June 2014). **Plan at 2 hours for all patients in ED** • All patients to be assessed and have a defined clinical management plan within a maximum of 2 hours. • Internal monitoring to be undertaken in real-time by the Divisional and Directorate Management team accessing FirstNet. (FirstNet is the electronic system detailing the status of all patients in both EDs and is remotely accessible). Out of hours this will be done by the Operations Team with oversight from the Duty Manager. • Poor performance from the expected standard to be escalated to nominated shift floor consultant.	Director of Clinical Services Operational Lead: Divisional General Manager MRC	With effect from 2 June 2014	ED Action Plan (Item 6) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained.
		Changes to Portering Activity • Review options to set up a dedicated portering team for ED and EAU to improve responsiveness. • Costed options to be presented to Director of Clinical Services • Implementation plan to be developed for immediate action. • Conduct an impact assessment of the changes to the service.	Divisional General Manager MRC	9 June 2014 30 June 2014 30 September 2014	ED Action Plan (Item 13) Urgent Care Programme Group monitoring Options Appraisal Implementation Plan Impact Assessment	
		Improving Transportation		For the month of	ED Action Plan	

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		• Maintain a log of transportation issues particularly regarding access to 2 man/stretcher crews, to use in negotiation with providers. (defined timeframe) • Regularly review the log and relevant issues to be raised at Urgent Care Programme Group meetings.	All ED staff Director of Clinical Services	June 2014	(Item 15) Urgent Care Programme Group monitoring Transportation issues log	
		Areas for collaborative action with partners • Improved integration of care pathways across hospital, community, primary care and social care services to improve the ability to manage patients in the clinically appropriate setting. Build on current proposals being developed by the Trust and Oxford Health. The support of Oxford Clinical Commissioning Group (CCG) and Oxford City Council will be critical. • Managing demand across emergency care pathways to ensure that patients requiring emergency assessment and care are seen in clinical settings appropriate to their needs. • Collaborative approach to re-development of hospital sites and estate to address unsatisfactory accommodation. • Potential for developments such as patient hotels and family accommodation. • Improved access to hospital sites, additional parking facilities to meet the needs of increasing clinical activity and increased complexity and frailty of patients reflecting the change in clinical services.	**Executive Director accountability**: Director of Clinical Services Director of Planning and Information Director of Development and Estate	Timeframes linked to the Trust Business Plan.	Minutes of meetings between partners. Pathway documentation	Successful collaboration projects developed and delivered
CA 1.2	The **outpatient** department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide	Continue to implement the Outpatient re-profiling project: **Phase 1:** • To review all clinic templates to match demand and capacity run rate (detailed project plan monitored by monthly Outpatient Project Board (DCS Chair)	**Executive Director accountability:** Director of Clinical Services Operational Lead: Deputy Director of	Phase 1 to be completed by 30 June 2014	Project Plan Minutes of Outpatient Project Board – reported to (TME) Draft clinic	Outpatient re-profiling outcome: to provide net extra new outpatient capacity of 34500 slots and reduce follow up ratio from 1:1.88 to 1: 1.32 by

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
	suitable information.		Clinical Services		templates Follow up ratio monitoring	31 October 2014.
		Phase 2: To translate the new clinic templates into operational processes across all specialties	Director of Clinical Services Operational Lead: Deputy Director of Clinical Service	31 October 2014	Outcome of pilot reviewed and reported to TME Roll-out plan Progress report on plan reported to TME	As above: reduce follow up ratio from 1:1.88 to 1: 1.32 by 31 October 2014.
		Change outpatient's system from choose & book to directly bookable system (DBS). • DBS pilot in neurology and gynaecology to run from June - Aug 2014 • To agree an all speciality directly booking roll out plan with the CCG by 31 Aug 2014 • Commence implementation of the roll out plan beginning in Quarter 3.	Director of Clinical Services Operational Lead: Deputy Director of Clinical Service	31 Sept 2014 31 July 2015	Results of pilot roll out Implementation plan Reports on success rates to TME.	DBS outcome: GPs able to book new outpatient appointments in surgery with the aim of reducing failure rate to 10% by July 2015.
CA 1.3	In some **surgical specialties** waiting times for surgery were too long and operations were cancelled too often.	Implement existing plan. This includes utilising private sector providers to clear the high number of patients waiting over 18 weeks in these specialties. This has been initially rolled out in four specialties and will be extended across individual specialities in July. • Performance will continue to be monitored on a weekly basis via joint Trust and CCG 18 week meeting. • Outcomes will continue to be reported on a monthly basis via Integrated Performance Report to Trust Management Executive (TME), Finance and Performance Committee (FPC) and Trust Board.	**Executive Director accountability:** Director of Clinical Services Operational Lead: General Managers	30 June 2014 31 July 2014	Profile report produced for weekly meeting Detailed action plan for each of specialities performing below 90% IPR reports to TME, FPC and Trust Board	Trust level RTT 90% standard achieved Individual specialty RTT 90% standard achieved by 31 August 2014.
CA 1.4	There was not suitable attention paid to the identification, assessment and planning of care needs	**SURGERY** Cross reference to CA 4.1				
		EMERGENCY DEPARTMENT • Develop a Dementia pathway through the work of the	**Executive Director accountability:**	Pathway to be completed and	Reviews of Dementia	Vulnerable patients will be treated in

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	for vulnerable people, particularly those with dementia in **surgery** and **A&E.**	Trust Dementia Steering Group • The pathway will identify those patients that need to be assessed and clinically managed in the Emergency Department (ED), and who require specialist input with guidance on their management with respect to their dementia and cognitive dysfunctional needs. • Continue to provide on-going specialist input and advice from existing staff including gerontologists who work in ED and the Trust psychiatric team, the Trust's dementia clinical lead and the Adult Safeguarding Lead. • Provide multidisciplinary teams with training to further develop knowledge and awareness of the dementia pathway and care of vulnerable patients and optimal communication with relatives. • Continue to implement training on care of patients with dementia to Clinical Support Workers through the CSW Academy at induction and for existing staff within local clinical areas. • Monitor the introduction of the new pathway and implement ongoing monitoring as part of assurance visits to ensure that it is followed appropriately.	Director of Clinical Services Operational Lead Divisional General Manager MRC Clinical Lead for Dementia Acting Chief Nurse (as Dementia Lead Nurse)	in progressive implementation by 31 October 2014 Initial training to be provided by 30 September 2014	Pathway documentation and care and treatment plans making reference to their specific cognitive needs. Records of attendance at training by MDT	the most appropriate setting to meet their needs. Monitoring of complaints shows less incidents relating to vulnerable patients. Initial pathway in place by 31st October 2014.

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

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

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA2.1	There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the **maternity** department and on **surgical wards** and in **operating theatres.**	**<u>MATERNITY</u>** Recruit 14 WTE Band 5/6 midwives to fill remaining vacant posts (14 recruited to date). Those recruited will take up post between June and September 2014.	**Executive Director accountability:** Chief Nurse Operational Lead: Head of Midwifery	30 September 2014	Vacancy Control Form TRAC recruitment system	14 Band 5/6 in post by September 2014
		Recruit to the Delivery Suite Manager post	Head of Midwifery	Complete	Individual in post	Delivery Suite Manager in post
		Recruit to existing Band 7 in Maternity Assessment Unit.	Head of Midwifery	30 September 2014	Individual in post	Band 7 in post
		Review vacant Band 7 post within the community and recruit within 6 months.	Head of Midwifery	31 December 2014	Individual in post	Band 7 in post
		Utilise the reserve list of junior midwives if any vacancies arise, as required.	Head of Midwifery	31 October 2014	Database	Reserve list database in place and will be utilised where required
		Recruit 6.31 WTE Band 2 maternity support workers.	Head of Midwifery	31 October 2014	Vacancy Control Forms TRAC recruitment system	6.31 WTE Band 2 in post
		Implement the remaining aspects of the Maternity Staffing Business Plan agreed by TME in 2013. This includes recruitment of four WTE ward receptionist posts.	Head of Midwifery	31 July 2014	Business case Paper for Divisional Executive	4 WTE receptionists in post
		Continue to use Birth rate + on a 4 hourly basis to monitor activity and acuity to ensure staffing is sufficient to meet the needs of	Head of Midwifery / Clinical Midwifery Manager	Annual review	Annual review of staffing. Birth Rate	Sufficient midwives are in place to meet established staffing

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		women.			acuity tool	levels.
		Continue to support the fluctuating activity in maternity by using staff within the Hospital and community services.	Head of Midwifery	Ongoing	Review of staffing, Daily activity sheets	Sufficient midwives are in place to meet established staffing levels.
		SURGICAL WARDS • Continue to review staffing levels at least twice daily through a RAG (Red/Amber/ Green) rated pre-determined staffing levels tool. • Professional judgement to be utilised to determine if mitigating actions are required, to ensure adequate staff are in place to meet the needs of patients.	**Executive Director accountability:** Chief Nurse Operational Lead: Divisional Nurse Neurosciences, Trauma, Orthopaedics and Specialist Surgery (NOTSS)	Ongoing	Monthly reports on safe staffing levels	Safe staffing levels maintained
		Reduce nurse vacancy band 2-6 to 12% by September 2014 through the following actions:	Matrons for Trauma; Orthopaedics and Theatres; Specialist Surgery; and Neurosciences	30 September 2014	Division's performance reports which include staffing figures against establishment Vacancy Control Forms	Reduce nurse vacancy band 2-6 to 12% by September 2014
		• Continue rolling recruitment adverts for all nursing posts		Monthly review from June 2014		
		• Continue to engage with the Trust-wide overseas recruitment programme		Ongoing	Overseas recruitment programme	Effective use of the overseas recruitment programme, recruiting at least 10 WTE in the Division per year.
		• Weekly review meetings between Divisional Nurse, HR consultant and recruitment team to monitor effectiveness across the Division.	Divisional Nurse NOTSS	30 September 2014	Notes from weekly review meetings	Reduce nurse vacancy band 2-6 to 12% by September 2014
		• Recruit from foundation rotational programme for new graduates from	Divisional Nurse NOTSS	30 September	Staff recruited from graduate	

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		Oxford Brookes University.		2014	programme	
		• Develop quarterly briefing papers to be presented to the Division by each Directorate, providing an update on local recruitment strategies and trajectory for reducing vacancies.	Divisional Nurse	Complete	Quarterly briefing papers	

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

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

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		Ensure that staffing levels within theatres for scrub and anaesthetic and recovery nurses meet the Association of Perioperative Practitioners (AfPP) guidance	CCTA Manager / Theatre Manager	Ongoing	Divisional Performance reports	Relevant staffing levels as outlined by the AfPP are met.
		Use specialist journals in the recruitment of specialist theatre nurse / operating theatre practitioner. (Closing date of 2nd AfPP recruitment advertisement is 28 June 2014).	CCTA Manager / Theatre Manager	28 June 2014	Divisional Performance reports	Recruitment of experience scrub and anaesthetic practitioner to band 5 and band 6 roles to maintain levels of competent skill mix. Evidenced in divisional performance reports
		Continue to work closely with Human Resources towards a goal to optimise recruitment lead times to employment.	Recruitment Manager	28 August 2014	Reports on lead times	Improved advert to appointment time to an average of 8 weeks. Reported to Workforce Committee bimonthly and in the quarterly Organisational Development and Workforce Performance report.
		Attendance at a number of theatre, anaesthetic and recovery speciality specific national conferences as a spot interview opportunity to further optimise interested candidates at those venues	CCTA Theatre Manager	17 August 2014	Successful recruitment Divisional performance report.	Recruitment of experienced scrub and anaesthetic practitioners to balance skill mix and competence.
		Recruitment campaign at the British Anaesthetic and Recovery Nurse Association Conference –-6th June 2014 Greenwich, London	Theatres Band 7 charge nurses	Complete	Attendance record	Booking made and invoiced and staff identified to undertake interviewing on the day.
		Recruitment campaign will be carried out at the Association of Perioperative Practitioners	HR Recruitment lead CCTA Theatre	17 August 2014	Attendance record	Ongoing recruitment evidenced through the

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		Conference –-20th – 22nd June 2014, Brighton and 15th – 17th August 2014, York	Manager		Divisional Performance report	divisional performance report.
		Continue to implement a staged recruitment campaign targeting band 5 recruitment (followed by band 6's) using a co-ordinated approach with the other theatre suites across the Trust.	HR Recruitment lead Theatre Manager Charge Nurses	Ongoing		
		Reduce the use of agency staff through the work of the Agency Task and Finish Group.	Theatre Manager Charge Nurses	31 December 2014	Reduction in the use of agency staff. Task and Finish Group minutes	Ongoing reduction of agency staff (with a view to reducing to 0% within the next 12 months)

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

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

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

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

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

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

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		<u>Ward E, NOC</u> Review of current documentation in use across the directorate for identification and on-going management of patients.	Matron NOC NOTSS	31 July 2014	Meeting minutes Assurance audits	Risk assessments and care plans are reviewed and improved
		Establish a working group within orthopaedics facilitated by dementia lead nurse, with multi professional input. • Objectives and terms of reference to be determined at the first meeting. • Key objective to launch a training programme on dementia care that meets the needs of this patient group within an orthopaedic environment	Matron NOC Ward Sisters NOTSS Dementia Leader NOTSS Division	1 September 2014	Minutes of working group Training programme and records	Implementation of the dementia training and ongoing review every 6 months which demonstrates leadership within each ward in the provision of care plans that incorporate dementia patients.
		Divisional Dementia Leaders and Consultant Nurse, Tissues Viability to train and support staff in these areas, including effective record keeping.	Matron NOC with input from Divisional Dementia Leader and Consultant Nurse, Tissue Viability	31 July 2014	Training records	Ward sisters and senior ward staff have knowledge of the care of dementia patients and wound management
		Review ward sisters audit tool to ensure that it takes into account individual patient wound management needs.	Ward Sisters NOC NOTSS	30 June 2014	Snap shot audits by Ward Sisters and Matron	Effective wound management care is in place, (using the safety thermometer to monitor this).
		Review risk assessments and completion of patient records and care plans on a weekly basis.	Matron NOC and Consultant Nurse, Tissue Viability	From July 2014	Record of Weekly reviews	Risk assessments and care plans we well completed for the needs of the individual patient.
		Develop a cross divisional care plan that highlights the requirements for the use and management of VAC therapy for complex wound management.	Matron NOC NOTSS and Consultant Nurse, Tissue Viability	30 September 2014	Care Plan Divisional quality report	
CA 4.2	Records did not contain all the required information to ensure care was delivered safely to meet	**<u>John Warin and Geoffrey Harris Wards</u>** CQC findings to be discussed with all staff working on both wards	Divisional Nurse MRC	Complete	Meeting notes	Staff can demonstrate knowledge of relevant findings and plans

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
	the patient's needs. Risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed.	Review and standardise all assessment forms and handover sheets on both wards to ensure consistency.	Matron for Ambulatory Medicine MRC	30 June 2014	Risk assessment forms and handover sheets	Standardised documents in place that is completed and used to handover
		Matron to train and support staff in these areas, regarding effective record keeping.	Matron for Ambulatory Medicine MRC and Consultant Nurse, Tissue Viability	31 July and ongoing	Training records	Staff have comprehensive knowledge of these areas and plans are well developed
		Audit ten sets of notes every week (five sets of notes on John Warin Ward and five sets of notes on Geoffrey Harris ward) to assess the following; • Risk assessments are completed. • Completed care plans that relate appropriately to the risk assessments • The standard of information documented reflects all the information required to deliver care based on the patients' needs.	Matron for Ambulatory Medicine MRC	31 July 2014	Audit results	As above
		Monitor compliance at directorate level during Directorate assurance visits.	Matron for Ambulatory Medicine MRC Directorate team	30 June 2014 and ongoing	Records of Assurance visit	As above.

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

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

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

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

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		• written plan • copy of the preceptorship package • nominated preceptor.				
		Newly qualified midwives to follow the established process of preceptorship for up to 12 months in order to achieve their competences. (There is a sign off process to ensure this is completed and before a Band 5 can move to a Band 6).	Practice Development Midwives	Complete	Preceptor package, competencies Individuals employed as Band 6's.	
		Continue to ensure that newly qualified midwives are aware of the support group for new graduates. This is currently well attended.	Supervisors of Midwives	Complete	Attendance records and evidence that staff are supported to attend	
CA5.3	Not all nurses qualified overseas working in **A&E** and newly qualified **midwives** were appropriately supervised to ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.	For actions relating to supervision and support in A&E see CA5.1				
		Continue to support the four student Supervisor of Midwives (SOM's) to complete the programme, thereby ensuring from September the caseload ratio will be 1:18.	Local supervising midwifery officer (LSAMO)/Head of Midwifery (HOM)	30 September 2014	Successful completion of programme and demonstrate supervisory activity.	Supervisory caseload ratio 1:18
		To further address this, support will be given to six OUH midwives to attend the programme in 2014/15 to improve the ratio to 1:16 (dependent on leave / turnover).	LSAMO/HOM	30 September 2015	6 midwives supported to attend the programme.	Supervisory caseload ratio 1:16

'SHOULD DO' ACTION PLAN

Oxford University Hospitals NHS Trust received five reports setting out the findings from its recent inspection:

- An over-arching trust wide report containing a summary of all compliance actions from the individual hospital reports (a separate compliance 'must do' action plan has been developed and already submitted to the CQC)
- Four reports, one for each of the hospital sites; the Churchill Hospital, the Horton General Hospital, the John Radcliffe Hospital and the Nuffield Orthopaedic Centre. In addition to listing the compliance actions these reports included a number of 'should do' recommendations.

Of note, where a 'should do' recommendation has been reflected in the Trust compliance 'must do' action plan, the compliance action has been cross-referenced represented in a shaded box.

Key

The following abbreviations relate to the trust's internal monitoring system:

SD – Should Do Action

CA – Compliance Action

JR, NOC, HGH, CH – indicates specific hospital report the should do action was recorded in.

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
ENVIRONMENT AND FACILITIES						
SD1	**Outpatient clinics – Health and Safety/Patient Welfare (CH)** Consideration should be given to the management of the outpatient clinics in the older parts of the hospital. Particular consideration should be given to the patient's welfare and their health and safety. This is because of the limited space in some areas and the general condition of some of the facilities.	Progress the business case initiation proposal for the relocation of Respiratory Services, including outpatients, to the John Radcliffe. (£100k allocated in 2014/15 Capital Programme)	**Executive Director Lead**: Director of Clinical Services <u>Operational Lead:</u> MRC Divisional Director	31 March 2015	Business Case Monitoring of capital programme via Business Planning Group and reporting to Finance and Performance Committee (FPC)	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
		Progress the business case initiation proposal for the relocation of the Clinical Genetics Department, comprising outpatient and office accommodation (£500k allocated in 2014/15 Capital Programme)		31 March 2015	Business Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
SD5	**Premises and facilities (CH)** Identified concerns relating to the facilities in the older part of the hospital were being addressed but the trust needs to ensure that suitable well maintained premises are available to patients and staff.	Progress the business case initiation proposal for the Churchill Day Surgery Unit (DSU) Redevelopment (£900k allocated in 2014/15 Capital Programme)	**Executive Director Lead**: Director of Clinical Services <u>Operational Lead:</u> S&O Divisional Director	31 January 2015	Business Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
		Progress Renal Development project for the Renal Ward (£3m allocation in 2016/17 Trust's Capital Programme)		31 March 2015	Business Case Monitoring of capital programme via Business Planning Group	Capital works completed. Positive feedback from patients, staff and

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
					and reporting to FPC	stakeholders via formal surveys.
SD 14	**Critical Care Security - HGH** The kitchen in the critical care unit should be better secured from the clinical area.	Obtain quotes and schedule for minor works to be completed	**Executive Director Lead**: Director of the Development and the Estate Operational Lead: Matron Adult Intensive Care & Critical Care Follow Up	31 October 2014	Quotes for work Physical check of works completed	Minor works completed.
SD 38	**Improved environment - Critical Care (JR)** The hospital should ensure a better environment within critical care.	Development of affordable Strategic Outline Case for investment (Adult Critical Care JR £9m allocated in 2016/17 Capital Programme).	**Executive Director Lead:** Director of Clinical Services Operational Lead: CSS Divisional Director	31 January 2015	Strategic Outline Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
SD 36	**Premises and equipment – Main JR theatres** The trust should ensure that issues relating to the safety and suitability of premises and equipment in the main theatres are promptly resolved.	Development of affordable Strategic Outline Case for investment (JR 2 Theatres £350k allocated in 2014/15 Capital Programme and further £24.5m in 2015/16 Capital Programme)		31 January 2015	Strategic Outline Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
CARE OF FRAIL, ELDERLY PATIENTS (INCLUDING THOSE WITH DEMENTIA)						
SD 32	**Care of frail elderly (JR)** The trust should continue to ensure that positive	The OUH Dementia Strategy is to be developed via the Dementia Steering Group in alignment with the Oxfordshire	**Executive Director Lead:**	30 November 2014	Minutes and feedback from Dementia Steering	Positive outcomes delivered to frail,

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	outcomes are delivered for frail, elderly patients and those with dementia, especially when working with relatives/carers.	Dementia Development and Implementation Board (DDI) which oversees the regional implementation of the national strategy This includes: • A range of shared learning initiatives across the Trust as part of a cohesive approach to developing frail older person care including • Training programmes that address tiers 1, 2 and 3 training across the Trust • Further training of Dementia Leaders through the Worcester University 8 day programme to cover gaps across the Trust in combination with Oxford Health NHS FT • Wider implementation of the tier 1 training of staff via Dementia Leaders • The development of dementia friendly environments in Trauma, Emergency Departments and EAU as well as the Acute General Medical in patient areas • Reminiscence resources in Post-Acute Unit • Development of an approach to nutritional care included within the Dementia Strategy • Compassionate Care programme	Chief Nurse <u>Operational Lead:</u> Deputy Chief Nurse	31 December 2014	Group. Draft Dementia Strategy for wide consultation Physical inspection of Trauma Ward Reminiscence resources Compassionate Care Programme Attendance records and reporting quarterly to the Dementia Steering Group and nationally Positive feedback from staff, patients and carers Positive benchmarking with other acute Trusts	elderly patients Patient and relatives/carers feedback

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		Trust wide to enable a sensitive approach to communication. • Implementation of the 'Knowing Me' booklet to improve continuity of personalised care				
		Development of a Trust Pressure Ulcer Prevention Clinical Improvement Group (PUPCIG)	**Executive Director Lead:** Chief Nurse <u>Operational Lead:</u> Deputy Chief Nurse	31 July 2014	Implementation of PUPCIG group Terms of reference, agenda and minutes	Progression of the Trust PUP Action Plan
		Development of a Trust Pressure Ulcer (PUP) Action Plan (Valid from July 2014 to April 2016)	**Executive Director Lead:** Chief Nurse <u>Operational Lead:</u> Consultant Nurse, Tissue Viability	Action Plan to be ratified at Patient Safety and Clinical Risk Committee 31 July 2014	Bi monthly monitoring of progress at PUPCIG Quarterly action plan updates at Patient safety and Clinical risk Committee	Progression of action plan to agreed timescale or with agreed extension. Reduction in hospital acquired Pressure Ulcers
		Introduce and implement Fall safe care bundle across MRC Division	**Executive Director Lead:** Chief Nurse <u>Operational Lead:</u> Divisional Nurses	31 March 2015 (decision on implementation plan) with roll out to commence April 2014	Completion of Fall Safe Audits on all wards	Falls Safe Audits undertaken demonstrating 90% compliance with Fall Safe and a reduction in avoidable falls with harm
		Roll out Falls Safe across the NOTSS division in the following order 1 – Neuro, 2- Spec Surg, 3- Trauma, 4 – Orthopaedics	<u>Operational lead:</u> Divisional Falls Prevention Practitioner	On-going		
		Orthogeriatric team to continue to review	**Executive Director**	On-going	Monthly % on pre	Pre and post-op

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		all patients with fractured neck of femur (FNOF) with specific interest in cognition and delirium. This includes evidence-based drug chart review, continence management and nutrition.	**Lead** Medical Director Operational Lead: Clinical Lead Geratology & Stroke		and post-op AMTS collected on all FNOF patients in >98% of cases	AMTS collected on all FNOF patients in >98% of cases
		Orthogeriatric team to continue to support the primary named nurse in discharge planning. This includes discussions with families about pre-existing memory problems, behaviours and concerns. On occasion this has led to diagnosis of dementia and/or formal best interests meetings with the rest of the MDT.				
		Continue to provide teaching sessions provided to the MDT on dementia and delirium			Training materials and attendance records	
		Continue to refer cases to the Psychological Medicine Team as required for their expertise and input.			Referral numbers	
SD 9 24, 32	**Staff training in dementia in ED – HGH and JR**	***(Compliance Action response for CA1.4)***				
LEARNING FROM INCIDENTS, COMPLAINTS AND PATIENT FEEDBACK						
SD 18	**Cross hospital and divisional learning from incidents (NOC)** The process for sharing learning following incidents was not effective. Staff were not	The results of the last Annual audit of the Incident Reporting and Investigation Policy to be reviewed to identify potential gaps in the system.	**Executive Director Lead:** Interim Medical Director Operational Lead:	31 October 2014	Audit Results	More staff report via staff survey results that they are aware of actions in relation to incidents.
		Survey staff to identify current approaches to feedback and learning from incidents.		30 September 2014	Survey results and results analysis	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	aware of the learning from incidents in other parts of the hospital or trust.	Undertake a wider review of local processes in relation to sharing learning and actions from incidents.	Head of Clinical Governance	30 September 2014	Staff survey results and action plans	Incident reporting rate grows and Trust benchmark in relation to NRLS reporting data improves from lower quartile upwards. Staff survey show improved results in relation to feedback from incident reporting
		Develop a method of measuring impact of any changes.		30 November 2014	Method of measuring impact of any changes.	
		Identify current trust wide groups (e.g. sub committees of CGC) / formal meetings in place and add a standing agenda item to cover cross divisional learning.		30 September 2014	Map of committees / formal groups in the Trust Agendas for each group	
		Learning from incidents will be disseminated to all sites using the 'At a Glance' process as described in the current Trust Policy.		30 September 2014	'At a Glance' notices issued Local assessment and use of notices	
		TME paper Quality Governance – Optimising the management and escalation of quality related issues will review the internal communication methodology.		30 September 2014	Communication review notes Procedure note on communication flows	
		Staff survey results for current year include aspects of feedback to staff following incidents. Local action plans in place to address issues. Link to • Pressure Ulcer Prevention Plan • Diabetes Business Case -Widening diabetes team		30 September 2014	Divisional staff survey action plans Progress on Pressure Ulcer Plan and Diabetes Business case monitored	
		Set up a working group to review and improve learning from the non-clinical incident reporting process.	**Executive Director Lead:**	30 September 2014	Terms of reference for Working Group	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
			Director of Development and the Estate Operational Lead: Deputy Director of Assurance		Minutes Procedure note.	
SD 25	**Complaints feedback ED (JR)** Staff in the A&E department should be made aware of complaints from patients to enable them to understand the need for changes and improve their practice.	Trust wide Complaints Review presented to TME 12 June 2014 – Action Plan to cover • Investigation Process • Training • Complaints Management System • Quality of complaints service and assurance • Reporting	**Executive Director Lead:** Chief Nurse Operational Lead: • Head of Clinical Governance/ • Safeguarding and Patient Services Manager	Evaluation of the full action plan to be completed by 30 November 2014	Quarterly Complaints Review Quarterly theme based Complaints Reports Quarterly Patient Experience Reports Update on progress reported to TME	Staff are aware of changes in practice that link to complaints. Reduction in number of complaints
		Local action within ED Complaints reviews already form part of regular Governance Meetings. Local complaints champions to be identified covering each staff forum to promote 'complaints conversations'	**Executive Director Lead:** Chief Nurse Operational Lead: • Safeguarding Adults and Patients Services Manager • Divisional Nurse MRC • Matron for ED & MAU	31 August 2014	Governance meetings Named champions in place	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
SD 35	**Learning from serious incidents (JR)** The trust should ensure that lessons learnt from serious incidents are promptly disseminated and embedded in practice.	As per SD 18 above linked to revised Incident and Investigation Policy. A paper on learning from serious incidents is to be presented to Quality Committee In August 2014 to address these issues.	**Executive Director Lead:**Interim Medical Director Operational Lead: Head of Clinical Governance	31 August 2014	Quality Committee paper	SIRI learning is further improved across the Trust and relevant actions are taken to enforce learning.
SD 28	**Improve Friends and Family response rate (JR – ED and Maternity)** The response to the Friends and Family test should be improved in A&E and Maternity.	Patient Experience Strategy Implementation Plan presented to TME 10 April 2014. Action Plan covers the recruitment of key staff, real time patient experience feedback and FFT. • ED – now 20% • Maternity – Head of Midwifery and Clinical Leads promoting FFT and accessing relevant lead.	**Executive Director Leads**: Chief Nurse and Director of Workforce and Organisational Development (OD) Operational Leads: • Safeguarding Adults and Patients Services Manager • Matron for ED & MAU • Head of Midwifery	Impact analysis from the full implementation plan to be reported to Quality Committee February 2015.	Divisional Quality Reports and Quarterly Performance Reports	By Q1 ED response rate to be over 15% By Q4 adult inpatient response rate to be 40%
		Monitoring of FFT response rates at TME and via performance review meetings.	**Executive Director Leads**: Chief Nurse and Director of Workforce and OD Operational Lead: Safeguarding Adults and Patients Services Manager	Completed		

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
STAFFING						
SD4	**Medical beds and staffing levels (CH)** The trust should continue with its recruitment efforts to ensure that sufficient medical beds are available to patients and safe staffing levels are maintained.	Recruit to current vacancy on John Warin Ward of 1.0 wte band 5 role (advert out) Await start dates for 2.0 wte Band 5 newly appointed candidates	**Executive Director Lead:** Chief Nurse Operational Lead: MRC Divisional Nurse	31 October 2014 30 September 2014	Monthly vacancy rates monitored against establishment figures	Maintenance of 33.14 wte establishment on John Warin Ward
SD 10	**Paediatric nurse on duty (HGH)** Although all A&E staff were trained in paediatric life support, guidance said the department should have trained paediatric nurses on duty at all times.	Actively attempt to recruit dual trained nurses (though it is recognised that this is a national shortage). To provide 24/7 cover 5.6wte nurses are required. Continue compliance with paediatric life support training for nurses band 5 and above	**Executive Director Lead:** Chief Nurse Operational Lead: Deputy Matron, Emergency Department	30 September 2014 31 October 2014	Skill mix review documentation Training documentation reports	Dual trained nurse employed 100% compliance within department for paediatric life support
SD 33	**Staffing - therapy staff (JR)** The trust should continue with their plans to ensure sufficient therapeutic staff, like speech and language and physiotherapists are available to meet patients' needs in a timely manner.	The Therapy Business Plan (Page 4 & 5; point 1.10 -1.12) addresses the therapy strategic workforce needs to 2019. Therapies are undertaking a partnership working approach with therapy staff and stakeholders to undertake full evaluation of workforce needs to include benchmarking, appraisal of evidence, data, and therapy team workshops. A gap analysis in the Critical Care Units against the Critical Care Standards and NICE CG83 Rehabilitation Guidelines has been completed. Business cases for	**Executive Director lead:** Director of Clinical Services Operational Lead: Head of Therapies	31 January 2015	Therapy Business Plan 2014-19 submitted to the MRC Division in February 2014. Business cases sent to Directorates for consideration	Evidence to demonstrate staffing levels are adequate to deliver a quality rehabilitation service

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		increased staffing levels against these standards are being presented to the Directorates /Divisions for the CTCCU and the NICU units.				
		Speech and language therapists are employed by Oxford Health. Review existing Service Level Agreement for the services they provide to OUH and as part of this process, review options for service provision.		31 January 2015	Formal review of the SLA. Options appraisal Implementation plan regarding SALT provision	Evidence to demonstrate that adequate SALT provision is in place
SD7	**Critical Care Medical Staffing (HGH)** The hospital should have cover at all times from medical staff trained in critical care.	Conduct a Trust-wide critical care review as a basis for the development of a Trust Strategy.	**Executive Director lead:** Director of Clinical Services Operational Lead: Division Director CSS Division	30 September 2014	Strategy and Implementation Plan.	Agreed Strategy in place with supporting Implementation Plan
		Review and agreement of a Divisional Plan detailing the types of patient acuity cared for on the HGH Critical Care Unit		31 October 2014	As part of the strategic review the specific review of HGH CCU acuity and recommendations	Divisional Plan detailing the types of patient acuity cared for on the HGH CCU in place and implemented.
SD 20	**Staffing levels (OCE at the NOC)** The trust should continue with active recruitment, as despite recent improvements in staffing levels in OCE, staff felt they required more staff to provide the care some patients needed.	To continue with active recruitment - current vacancy is 3.3 WTE for Band 5	**Executive Director Lead:** Chief Nurse Operational Lead: Matron for OCE in MRC	30 November 2014	Report on vacancy rates	All vacancies filled. Sickness rates reduced to Trust accepted rates of 3%
		To use long line agency to support current staff		30 November 2014	Staffing rotas	
		To reduce current high levels of sickness absence.		30 November 2014	Sickness figures	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
RECORD KEEPING						
SD6 SD 17	**Standardised Codes – cardiac arrest (CH, HGH)** Codes used to inform staff of the medical procedures to be followed for specific patients in the event of a patient having a cardiopulmonary arrest should be standardised across the hospital.	Discuss findings and proposed actions at Trust's Resuscitation Committee on 23 June	**Executive Director Lead:** Interim Medical Director Operational Lead: Senior Resuscitation Manager	23 June 2014	Minutes of meeting	Resuscitation Committee is engaged in the CQC action planning process
		Ensure relevant staff are aware of correct documentation in relation to DNACPR decisions and inform them of risks associated with use of codes.	**Executive Director Lead: Interim** Medical Director Operational Lead: Divisional directors via divisional nurses, clinical directors and matrons.	31 October 2014	Email / minutes or other documentation showing information cascaded to staff in divisions DNACPR audit records	Staff will articulate correct use of documentation in relation to DNACPR as demonstrated during periodic DNACPR audit.
		Agree acceptable & standardised terminology to be used when needed in communicating existence of decision between colleagues e.g. in ward handover. This format to be DNACPR	**Executive Director Lead:** Interim Medical Director Operational Lead: Senior Resuscitation Manager	23 June 2014	Minutes of Resuscitation Committee Meeting	No evidence of alternate codes being used communication (eg on post take sheets, whiteboards etc) found during Matron's rounds, Executive walk rounds, spot checks by Resuscitation Department etc. /
		Circulate standardised codes and agreed terminology by email to all Divisional Directors and Divisional Nurses / equivalent for cascade to directorates / CSU's		31 October 2014	Email sent out	
		Modify DNACPR audit template to enable monitoring of awareness and implementation of standardised codes		31 October 2014	Audit templates revised and questions trialled	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		and agreed terminology.				if alternate codes found in use action taken to alert staff to risks, and to modify practice to meet agreed standard.
SD 29	**Record keeping (JR)** The trust should ensure that patient records accurately reflect the care and treatment that had been planned and agreed for each patient in line with clinical guidelines and good practice standards, especially for those patients who cannot direct or inform staff of their needs.	Review current Trust guidance, good practice and existing measures in the Trust, then create an overarching action plan to address issues found. Some aspects to be addressed by EPR NHSLA standards to be used as the basis of good practice, results of documentation reviews to be shared and improved trust wide standard developed.	**Executive Director Leads:** Chief Nurse and Interim Medical Director <u>Operational Leads:</u> Divisional Nurses and Clinical Leads	31 August 2014 for standards to be re-issued	Revised standards	Trust can evidence improvements in documentation standards compliance via robust audit results.
		Provide support / education to all staff in regard to assessments / care planning and documentation standards across the Trust. Develop training programme (non-mandatory) on assessments / care planning and documentation standards across the Trust.		30 September 2014.	Training documentation.	
		Develop a records audit strategy with escalation process for poor performance and maintain rolling audit review to monitor compliance with records standards.		31 July 2014 for strategy and 30 November for rolling monitoring.	Audit documentation Audit Strategy & escalation plan	
SD 11	**Record keeping (HGH)** Clinical notes for patients in the medical wards	CQC findings to be discussed with all staff working on AGM wards. Matron and PDN to provide support /	**Executive Director Lead:** Chief Nurse	Completed	Meeting notes Band 5 foundation	Staff can demonstrate knowledge of

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	should include a records of all agreed care given to patients.	Education to all staff in regard to assessments / care planning and documentation standards. Include as part of Band 5 foundation programme.	Operational Lead: Matron / Ward sisters AGM		programme.	relevant findings and plans. All patients have a relevant, updated care plan that reflects the care they are receiving
		AGM JR / HGH are currently reviewing documentation to support care planning.		31 August 2014	Care plan template AGM documentation group minutes	
		Audit ten sets of notes monthly in AGM wards to ensure that:- • Risk assessments are completed. • Completed care plans that relate appropriately to the risk assessments • The standard of information documented reflects all the information required to deliver care based on the patients' needs.		To fit with timeframes from audit strategy 30 September 2014	Audit results	
		Monitor compliance at directorate level during Directorate assurance visits.		30 September 2014	Assurance visits feedback	
SD 34	**Record keeping – patient observation (JR)** The recording of patients observations could be improved to ensure the plan of care is followed and any changes in patients' conditions are quickly identified and actions taken.	***Observation of care to be included in action SD 29***				
SD	**Agency staff access to**	Longstanding Agency / Bank trained on	**Executive Director**	30 June 2014	Records of	No clinical

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
21	**EPR** The trust should ensure that in line with the electronic patient records policy, all agency staff have appropriate access to the electronic patient record system to avoid any potential risk to delivery of patient care.	EPR & issued with a smartcard Agency with a smartcard have it activated for the period of time they are contracted to work. All agency medical staff issued with time limited smart card Other nursing staff who do not have a smartcard, are buddied with a substantive member of staff in case they need to read EPR. ALL nursing documentation is paper based. Risk assessed that impossible to meet training needs of individual nursing staff doing one off shift and not needed as nursing documentation all paper based	**Lead:** Chief Nurse Operational Lead: • Matron Orthopaedic Directorate – Nursing • Clinical Director – Medical Staff		Smartcards issued and returned to / from Agency Staff	problems through lack documentation or documentation errors through lack of training on EPR
RESUSCITATION						
SD 17	**Review of DNAR decisions (HGH)** Decisions made by patients around resuscitation should be reviewed as required.	Discuss findings and proposed actions at Trust's Resuscitation Committee on 23rd June.	**Executive Director Lead:** Interim Medical Director Operational Lead: Senior Resuscitation Manager	23 June 2014	Minutes of meeting	Resuscitation Committee is engaged in the CQC action planning process
		Via Divisional Directors and Divisional Nurses all clinical staff are made aware and apply the Adult Unified DNACPR policy.		31 October 2014	Email to all Divisional directors and divisional nurses for cascade via directorates to CSUs.	Clinical staff will demonstrate awareness of policy in relation to review in response to modified question set during periodic DNACPR audit.

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		Write to all OUH Consultants to advise them of the Adult Unified DNACPR policy and provide clarification in relation to reasons: (Committee to draft letter for approval and sign off by Medical Director)		30 September 2014	Copy of letter	Review section will be completed appropriately as demonstrated during periodic DNACPR audit.
		Modify DNACPR audit template to enable monitoring of awareness and implementation of the Adult Unified DNACPR policy		31 October 2014	Audit templates revised and questions trialled	Data from revised audit tool provides information about practice within organisation in relation to DNACPR review
		Participate in review of Unified DNACPR policy for adults V2 with representatives from regional organisations and review OUH implementation guidance in light of any recommendations or change from Resuscitation Council (UK) following on from recent 'Tracey' case.		To be determined when (expected) national guidance published.	Revision to policy and OUH local implementation guidance	Any revision to policy reflected in local implementation guide, awareness demonstrated during training and audit.
DIABETES CARE PATHWAY						
SD3 SD 19 SD 30	**Diabetes Care Pathway (CH, JR, NOC)** Identified shortcomings in the care and treatment pathway of inpatients with diabetes were being addressed but the trust needs to ensure that outcomes are delivered to	Diabetes Business Case Implementation Plan is in place and subject to active monitoring at the Trust Management Executive. The plan covers the following key developments There are several key areas for development work:	**Executive Director Lead:** Interim Medical Director Operational Lead: Divisional Director MRC	The Implementation Plan is due to complete 30 September 2015	TME monitoring, next scheduled review 10 July 2014. Internal performance reporting via Quality Committee	The Trust can demonstrate evidence based improvements in diabetes care and can show improved results in national clinical

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	these patients in line with good practice and clinical guidelines.	• Nurse recruitment and development • Podiatrist recruitment • Consultant appointment and reconfiguration of consultant support across Diabetes and Acute General Medicine • Establishment of the Diabetes Quality Group • Development of training packages for diabetes management across the organisation • Development of proformas for patients with diabetes admitted to the Trust • Development of automatic warning flags to ensure that all patients with an abnormal blood result are flagged to the diabetes specialist team • Early agreement of a suite of clinical indicators to measure performance and patient outcomes.			and to the Board.	audits.
BED MANAGEMENT						
SD8	**Bed capacity and A&E waiting times (HGH)** The hospital needs to ensure it has sufficient bed capacity for A&E to meet Government target waiting times.	***(Compliance Action response CA1.1)***				
SD 23	**Resuscitation beds ED (JR)**	Develop a specification and floor plan to increase resuscitation bays from 4 to 6/7	**Executive Director lead:**	Completed	Specification document and	Evaluation complete with

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	The trust should evaluate the provision of resuscitation beds in A&E so they are meeting the needs of patients at all times.	spaces.	Director of Clinical Services Operational Lead: ED Consultant		Floor Plan developed ED Action Plan (Item 19)	plan for increased provision
SD 26	**Management of bed meetings (JR)** The bed meetings should conclude with actions for staff and departments to take to proactively manage identified pressures.	Amend bed meeting report to include agreed actions and confirm that Trust system wide escalation policy is re-introduced	**Executive Director lead:** Director of Clinical Services Operational Lead: Deputy Director of Clinical Services	19th June 2014	Sample of revised report	Report includes agreed actions and the Trust can demonstrate
SD 39	**Improve number of high dependency beds (JR)** The trust should reduce the number of delayed transfers from ICU due to the limited high dependency beds within the hospital.	A Trust-wide critical care review has commenced which is leading to the development of a Trust Strategy, which will include examination of high dependency requirements across the whole of the Trust.	**Executive Director lead:** Director of Clinical Services Operational Lead: Divisional Director CSS	31 October 2014	Strategy and Implementation Plan.	Agreed Strategy in place with supporting Implementation Plan
		The matron for adult critical care continues to work with the Lead Nurse of the Patient Pathway Co-ordinator Team to work through issues leading to patients being slow to transfer from critical care.	**Executive Director lead:** Director of Clinical Services Operational Leads: Matron Adult Intensive Care & Critical Care Follow Up	On-going	Updates at Monthly Trust Clinical Governance Committee	Reduction in the number of delayed transfers from Critical Care

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
RESPONSIVENESS – SERVICE PROVISION						
SD 15	**Critical care Outreach Service (HGH)** The provision of an outreach service for critically ill patients should be revisited.	A Trust-wide critical care review has commenced which is leading to the development of a Trust Strategy which will include examination of critical care outreach service requirements across the whole of the Trust.	**Executive Director lead:** Director of Clinical Services Operational Lead: Divisional Director CSS	31 October 2014	Strategy and Implementation Plan.	Agreed Strategy in place with supporting Implementation Plan
SD 12 **SD 33**	**Access to specialist medical services (HGH)** Patients should have access to specialist medical services when they are needed.	Map current provision of specialist medical services including on-call and cover arrangements (includes respiratory, cardiology, diabetes, endocrinology, neurology, oncology, dermatology, rheumatology) Risk assess gaps in access and related mitigating actions Clinical lead to continue to attend Risk Summit 24/7 meetings to ensure issues captured by Associate Director of Clinical Services	**Executive Director lead:** Director of Clinical Services Operational lead: • Clinical Lead Horton Medicine • Clinical Director Acute Medicine & Rehabilitation	31 October 2014 31 October 2014 On-going	Schedule of specialist medical services provided at Horton	No gaps in cover arrangements
DISCHARGE ARRANGEMENTS						
SD2 SD 31	**Discharge Arrangements (CH, JR)** The trust should continue making improvements to the internal and external discharge arrangements so that people who do not require a hospital environment are discharged to community services timely and	**Developing teams and services** • Discharge assurance & oversight group established. • Re-design and develop the Discharge Pathways Team, including the recruitment of more dedicated discharge coordinators. Systems resilience group established as part of the winter	**Executive Director lead:** Director of Clinical Services Operational lead: Deputy Director of Clinical Services	Complete 31 August 2014	Minutes of the Discharge Assurance and Oversight Group Operational plan for the development of the SHDS.	Patients are discharged to appropriate care settings, receive the care they require and are not delayed in this process.

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	effectively.	contingency planning • Further development of the Supported Hospital Discharge Service (SHDS) to include registered nurses and an extension of the time that they can take patients		30 November 2014		
		Policy • Update of the Corporate Bed Management Policy, including review of the repatriation policy. • Develop a non-medical led discharge procedure to cover the activity of nurses and therapists? In discharging patients. • Develop an Oxfordshire-wide Patient Choice Policy	**Executive Director lead:** Director of Clinical Services <u>Operational lead:</u> Deputy Director of Clinical Services	Complete December 2014 Complete	Updated Corporate Bed Management policy Non-medical led discharge procedure Patient Choice Policy	Policies are relevant, comprehensive and current.
		Documentation • Standardise discharge documentation across the Trust, including a process for auditing its implementation.		31 October 2014	Standard Discharge Form	
		Monitoring • Roll out 'real time bed state using the Electronic Patient Record. • Joint discharge analysis (OUH & Oxford Health) including the analysis of patient feedback regarding their discharge experience. • Linkage of the Real Time bed state		1 September 2014 31 July 2015 31 July 2014 and	Analysis and monitoring of bed management processes including transfers out of hours, multiple moves and delayed discharges.	Unnecessary moves within the hospital are avoided and patients are discharged to appropriate care settings, receive the care they require and are

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		with the safe staffing analysis • Audit the implementation of the Corporate Bed Management Policy including transfers of patients at night and multiple moves (Quarterly basis)		ongoing		not delayed in this process.
		Transportation • CCG's hold the contract for provision of transportation of patients with the South Central Ambulance Service. The eligibility criteria is currently out for consultation. • Hold monthly operational meeting with the CCG to review issues • Increase the number of crews to an additional one between 5p.m. and 1a.m. (from July 2014) and a further crew from 5p.m. – 12p.m. for winter provision).	**Executive Director lead:** Director of Clinical Services Operational lead: Deputy Director of Clinical Services	With effect from 30 June 2014	Reviewed contract and KPI's Minutes of monthly monitoring meetings Incident monitoring levels	Patients are provided receive the correct mode of transport in a timely way.
		Communication • Reviewed and updated patient discharge information • Development of 'Keep well, choose well, plan well' winter campaign and re-launch for Winter 2014	**Executive Director lead:** Director of Clinical Services Operational lead: Deputy Director of Clinical Services	31 December 2014 and ongoing	Patient information leaflets Materials relating to the Keep well, Choose Well campaign	Patients receive the information they require to make choices relating to their discharge and to fully understand the process.
STAFF ENGAGEMENT AND SUPPORT (WELL LED DOMAIN)						
SD	**Staff engagement and support (HGH)**	Regular visits to be scheduled by Divisional Director, Divisional General	**Executive Director lead:**	30 September 2014	Schedule of visits	Horton staff feedback that

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
13	The hospital trust should improve support to local staff so they feel more included and less isolated.	Manager and Executive Directors	Director of Organisational Development and Workforce Operational lead: • Divisional Director • Divisional General Manager			they feel more included and less isolated, monitored via staff 'pulse' survey results
		Introduce regular workforce and HR surgeries at the Horton, for staff to be able to access to discuss relevant issues	**Executive Director lead:** Director Workforce & OD Operational lead: HR Business Partner	30 September 2014	Schedule of surgeries and number of attendees, list of themes and issues raised from these surgeries	Positive staff feedback through surveys
		Schedule Listening into Action event, led by the workforce directorate	**Executive Director lead:** Director of Workforce & OD Operational lead: HR Business Partners	30 September 2014	Report from the Listening into Action meeting with recommendations and actions to take forward	Positive staff feedback through surveys
SD 22	**Staff engagement and support (NOC)** The trust should work to improve engagement with staff (particularly the consultant body) within the hospital in order that	The Trust is working on a range of initiatives to further improve staff engagement and support. This is a significant and long term undertaking involving focus group meetings and the development of specified proposed	**Executive Director lead:** Director of Workforce &OD	On going	Schedule of meeting dates Report on findings and proposed actions to address this issue	Improved engagement with staff so that staff feel consulted with and listened to

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	they are consulted about changes within the hospital and to ensure that they feel their views are listened to.	actions.				
SD 37	**Staff engagement and support – Surgery (JR)** The trust should take further steps to engage with staff and investigate reasons for disempowerment and low morale within the surgical domain.	Human resources business partners to undertake a deep dive to ascertain reasons and identify remedies	**Executive Director lead:** Director of Workforce & OD Operational leads: HR Business Partners	30 September 2014	Report on findings and proposed actions to address this issue	Improved moral and empowerment acknowledged through local staff survey
SD16	**Preceptorship for midwives (HGH)** Support for newly-qualified midwives (through their preceptorship programme) should be improved along with management of the maternity services.	***Compliance Action response CA5.2***				
SD 27	**Cross team working (JR)** Some specialist departments should work more co-operatively with the A&E team.	***Compliance Action response CA1.1***				