Airedale NHS
NHS Foundation Trust

Report to:	Overview & Scrutiny Committee				
Date of Meeting:	17 November 2016				
Report Title:	Airedale NHS Foundation Trust response to CQC Inspection.				
Status:	**For information requirement**	**Discussion**	**Assurance**	**Approval**	**Regulatory**
Mark relevant box with X	X	X	X		
Prepared by:	Mrs Helen Kelly, Assistant Director, Healthcare Governance				
Executive Sponsor:	Mr Karl Mainprize, Medical Director				
Appendices (list if applicable):	1. Improvement Plan				

Purpose of the Report
The purpose of this report is to inform the Overview & Scrutiny Committee of the actions the Trust has taken in response to the Care Quality Commission (CQC) Inspection in March 2016 and the plans in place to ensure sustained improvement.

Key points for discussion
The Care Quality Commission (CQC) visited the Trust in March 2016 and performed an assessment as part of their Hospital Inspection Programme. The Quality Report published on 10 August 2016 detailed the overall rating of “Requires Improvement”. The Trust achieved good for all services inspected for the Caring domain and Community Services were rated as “Good” for all domains with the exception of Well-Led where they were rated as “Outstanding”. The Trust developed and provided a detailed improvement plan to the CQC for the identified “must dos” within the report along with those quality issues that will strengthen our compliance with CQC Regulations.

Recommendation
The Overview & Scrutiny Committee is asked to receive this report, note the actions within the Improvement Plan and the ongoing monitoring to achieve improved compliance.

Airedale NHS
NHS Foundation Trust

OVERVIEW & SCRUTINY COMMITTEE – 17 November 2016

Airedale NHS Foundation Trust
Response to CQC Hospital Inspection

1. Introduction

This report provides the Overview & Scrutiny Committee with the key aspects of the CQC findings during their announced hospital inspection on 15 – 18 March and their unannounced visit on 31 March 2016.

Following the inspections in March 2016, the Trust informed the CQC of a serious incident that had occurred on the Critical Care Unit; in response the CQC performed a second unannounced visit on 31 May and also met with the Chief Executive to gain assurance that additional actions had been undertaken to ensure safety.

2. Inspection Ratings

The CQC Quality Report for the Trust was published on 10 August 2016 and the Trust was given an overall rating of "Requires Improvement". Table 1 below details the overall and domain ratings

Ratings	
Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Requires improvement

The individual service ratings for each of the CQC domains have been separated into those for Airedale General Hospital and for Community Services. Tables 2 and 3 below provide the outcomes.

Table 2

Our ratings for Airedale General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Table 3

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	☆ Outstanding	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community End of Life Care services	Good	Good	Good	Good	Good	Good
Overall Community	Good	Good	Good	Good	Good	Good

As the hospital was at REAP level 4, during the CQC visit, the Trust concluded the ratings were a fair reflection of the status of the hospital and community services and was delighted with the good and outstanding ratings for the community services.

3. Quality Improvement Plan (Must Do)

The Trust developed a Quality Improvement Plan in response to the requirements identified within the final report. Each of the 29 Must Do requirements has both an Executive and an Operational Lead. The agreed timeframes for completion are rigorously monitored by a programme of meetings whereby the leads must provide updates in relation to immediate compliance, continued compliance and present the evidence for this.

The Quality Improvement Plan is attached as Appendix 1. However it must be noted; this plan is a live document and consequently is being updated regularly.

4. Action Plans (Should Do)

In addition to the Must Do requirements there were a number of Should Do recommendations made within the report. These are service specific and there are action plans in place that are owned by the General Managers for the Clinical Groups.

The Chief Executive created a Task & Finish Group to monitor the actions within these plans and along with her executive colleagues receive updates every two weeks in relation to progress. These have proved to be very successful, the General Manager attends and details by exception the issues and is supported by key personnel from the specific departments.

These plans are also supported by ward development plans that strengthen the findings from the CQC Inspection.

5. Governance and Assurance

There are a number of key principles underpinning the Trust strategy for supporting the governance and assurance in relation to the achieving of compliance and the sustained improvements required. This is evidenced by all the Must and Should do requirements having

- Executive Director accountability
- Operational / Clinical Manager accountability
- An Improvement Plan that is SMART (specific, measurable, appropriate, realistic and timely) in addition it is evaluated and reviewed.
- Progress reporting to the Executive team
- Non-Executive scrutiny of progress monthly

The Executive Team meets every two weeks and receives progress reports for the must and should do's identified within the report. Challenge is given for the leads to evidence the improvements along with plans for sustained compliance. There is also a Non-Executive led meeting monthly where they received assurance that the must do's within the report are complete, on track for completion and they have the opportunity to raise questions. The Non-Executive chair then reports to the Board of Directors on the progress with the Improvement Plan.

The plan going forward is to introduce a programme of internal peer and self-assessments that will provide a clear picture of the status of compliance and support our path the outstanding.

6. Conclusion

The outcome from the CQC inspection in March 2016 provided the Trust with the opportunity to improve the quality of care we provide to our patients and ensure the changes made are sustained.

7. Recommendation

The Overview & Scrutiny Committee is asked to receive this report, note the actions within the Improvement Plan and the ongoing monitoring to achieve improved compliance.

APPENDIX 1 – QUALITY IMPROVEMENT PLAN

Quality Improvement Plan November 2016

	Delivered
	On Track to Deliver
	Partially Met
	Not on Track on to Deliver

See final page for Glossary of Terms

No	Core Service	CQC Domain	Requirement	Action to address requirement	End Date	Progress	Action RAG Status	Operational Lead	Executive Lead
CC3	**Critical Care**	Safe	The Trust must ensure that the remote telemetry monitoring of patients is safe and effective. (Critical Care)	Ensure a nurse allocated to coronary care has responsibility for telemetry. Nurse allocation to be agreed daily with senior team.	11/08/2016	Nurse in charge and the nurse allocated to the coronary care beds are now formally the responsible person(s) for telemetry monitoring and escalation. This new process has been incorporated into the guidance for telemetry.		Senior Nurse for Critical Care	Director of Nursing

CC3.1				Ensure Telemetry is more accessible to Registered Nurses working in the clinical environment. Additional telemetry screens to be acquired and installed.	27/05/2016	5 additional screens acquired and installed.		Senior Matron	
CC3.2				Make Telemetry more accessible to Registered Nurses working in the clinical environment. Audits to be undertaken within one month of installation.	22/06/2016	Two 'Take 5' (5 patient records reviewed each week) spot check audits have taken place to monitor effectiveness. The Nurse allocated to Critical Care is also responsible for monitoring patients on telemetry.			
CC3.3				Telemetry escalation process to be reviewed, agreed and implemented trust wide through the Medical Directorate. Develop a Telemetry, Management Care and Escalation Guideline.	19/08/2016	Telemetry Guideline now incorporates the standard protocol into one document. This has been ratified at PDRG and is available and visible to all on Aireshare		Senior Matron for Medicine	
MC1	**Medical Care**	Safe	The Trust must ensure that the remote telemetry monitoring of patients is safe and effective. (Medical Care)	Telemetry Task and Finish Group to review the two procedural documents, 1 SOP and 1 guideline.	30/09/2016	Critical Care Unit and ward guidelines merged and signed off.		Clinical Director Anaesthetics	Medical Director
MC1.1				Re-register the new Telemetry audits with the Clinical Audit department and audit compliance against the new guidance.	12/09/2016	Telemetry audit registered. The first audit undertaken on 7th September and presented at the Medicine			

						Governance meeting on 12th September 2016.			
MC1.2				Present audit findings at the Medicine Governance meeting with learning, outcomes and actions.	12/09/2016	Audit presented at Medicine Governance on 12th September 2016. Action plan being created to address the outcome and monthly re-audits planned.			
MC1.3				Purchase bleeps for AMU, ward 7 and ward 4 to improve communication between the Critical Care Unit and wards.	31/08/2016	Bleeps purchased and in use.			
CC1	**Critical Care**	Safe	A multi-disciplinary clinical ward round within Intensive Care must take place every day to share information and carry out timely interventions.	Extend weekday MDT meetings to include physiotherapy / microbiology / pharmacy. Nurse Consultant to meet with Lead Consultant and Head of Pharmacy. Monthly review meetings to be reinstated to review progress	31/08/2016	MDT ward round commenced in August 2016.Following handovers both in Theatre and Critical Care subsequent ward rounds take place at the patient's bedside and are conducted by the MDT, including Consultant, Middle grade Doctor(s), Pharmacy, Physiotherapy, Microbiology and Dietetics, Advanced Nurse Practitioner and Nurse at the		Anaesthetic Lead/ Nurse Consultant/ Head of Pharmacy/ Head of Therapies	Medical Director

						bedside.			
CC1.1				Perform a gap analysis and develop an options appraisal to extend the provision of MDT clinical ward rounds at weekends in Critical Care.	31/01/2017	Gap analysis and options appraisal scheduled to be presented at Surgical Services DAG January 2017.		Clinical Director Anaesthetics	
CC4	**Critical Care**	Safe & Well-led	The Trust must review the governance arrangements and identification and management of risks within critical care to ensure that arrangements for assessing, monitoring and improving the quality and safety of the service are effective.	Ensure continued attendance from the Critical Care Lead Nurse and senior nursing team at the group wide Surgical Services Quality and Safety monthly meeting to report and discuss the critical care AEFs and actions taken.	16/06/2016	Critical Care Lead Nurse and senior nursing team now attending Surgical Services Quality and Safety monthly meeting.		Senior Matron	Director of Nursing
CC4.1				Extend the invite to the Critical Care Consultant Meeting and Wednesday lunchtime education programme to include the multi-disciplinary team. Review the ToR of the monthly Critical Care Business Meeting. Nurse Consultant and Anaesthetic Lead to chair and deliver business meetings. Current anaesthetic educational programme to be widely advertised across the MDT	11/08/2016	ToR reviewed to ensure governance is incorporated in the Critical Care Business Meeting. Reviewed and agreed at the meeting in August 2016.		Clinic Lead for Critical Care/ Nurse Consultant	

CC4.2				Ensure that the monthly Critical Care multidisciplinary ward meetings have AEFs / Complaints and PALS learning as standing meeting items. Attendees should include Dietetics, Pharmacy, Physiotherapy, Doctors, Nurses and the Outreach Team. Develop TORs for the monthly MDT meetings and invite core attendees. Ensure an attendance register is kept.	19/07/2016	Monthly MDT ward meetings are now established. First meeting held in July 2016.		Lead Nurse for Critical Care	
CC4.3				Following any incidents the unit, staff will attend all Critical Care unit RCA meetings as well as the Lead Nurse to share learning. Ensure staff are invited and released from duty to attend Critical Care RCA meetings.	31/07/2016	The first RCA meeting took place in July 2016, unit staff attended the meeting and have been invited to attend future meetings.		Senior Matron	
CC4.4				Currently the Critical Care risk register sits within the wider Surgical Services risk register. Critical Care risks need to be received at the Critical Care business meeting with mitigating actions and escalated to the Surgical Services Quality and Safety Meeting	28/09/2016	The Critical Care risk register has been separated out from Surgical Services and is monitored monthly by the Nurse Consultant.		Lead Nurse for Critical Care	
CC4.5				Arrange for an independent (non-surgical services staff) to perform all future KPI assessments.	31/08/2016	Independent KPI assessments started in June 2016 and continues.		Senior Matron	

CC5	**Critical Care**	Safe	The Trust must ensure there are sufficient numbers of intensivists deployed in accordance with national guidance.	Perform a review and gap analysis in line with GPICS and D16 recommendations including benchmarking against other District General Hospital Critical Care providers.	31/10/2016	Clinical Director has started this review and gap analysis.		Clinical Director Anaesthetics	Medical Director
CC5.1				Develop options appraisal including the affordability to address the gaps identified.	31/10/2016	Clinical Director has started the options appraisal.			
CC5.2				Update current risk assessment in response to the gap analysis.	07/11/2016	Risk assessment will be updated on receipt of gap analysis			
CC5.3				Present outcome of options appraisal to Surgical Services DAG.	31/01/2017	This will be presented in January 2017.			
CC6	**Critical Care**	Safe & Well-led	The unit must ensure a minimum of 50% of nursing staff have a post registration qualifications in	Obtain advice from the Critical Care Network to clarify exactly what constitutes " a post registration qualifications in critical care". Nurse Consultant to seek advice from the Critical Care Network.	31/08/2016	Network and UKCCN alliance confirms that this is a post registration university course.		Nurse Consultant for Critical Care	Director of Nursing

			critical care.						
CC6.1				To support the on-going training rotation of band 5 and band 6 Critical Care nursing on the university module for Critical Care. 9 Nurses to be released for training in the academic year 2016/17.	30/06/2017	Already identified as part of the GPICS action plan (March 2016). Currently, the unit employs 7 staff with a post graduate qualification in Critical Care and an additional 4 staff with an acute cardiac post graduate qualification. 3 staff are booked onto the Critical Care post graduate advanced course commencing October 2016. 3 further staff are booked onto the Critical Care post graduate advanced course in January 2017. A further 3 staff have been identified to attend the Critical Care post graduate advanced course spring 2017. This will result in 50% of nursing staff with a post registration qualification in Critical Care.			

CC10	**Critical Care**	Well-led	The unit must ensure a minimum of 80% of nursing staff within critical care have been appraised.	Nurse Consultant to meet with all band 7 and band 6 staff to ensure eligible and available staff have received their performance review and appraisal.	31/10/2016	The Nurse Consultant has met individually with staff and as at September 2016 81% of eligible staff have received their performance review and appraisal. There are dates scheduled for the remaining eligible staff to receive a performance review and appraisal.		Nurse Consultant for Critical Care	Director of Nursing
MC2	**Medical Care**	Safe & Well-led	The Trust must review the timeliness and effectiveness of controls and actions on the local and corporate risk register, in medical care (Integrated Care Group).	Migrate the local risk register to the new corporate database.	31/08/2016	Risk Register migrated and excel spread sheet archived.		General Manager - Medicine	Chief Operating Officer
MC2.1				Review the corporate risk register, identify all medicine risks and ensure they are flagged and ownership has been transferred.	31/08/2016	Corporate Risks reviewed. Medicine Governance Group is the reviewing committee for these risks. Each risk has an identified lead who has the responsibility for ownership and leadership.		Resilience and Governance Manager	
MC2.2				Update the procedure for the review of all risks identified within Medicine. (Integrated Care Group)	12/09/2016	Risk process drafted and circulated to the Clinical Management Team for comment and to be presented to Medicine Governance in September.			

MC2.3				Regular review of the Medicine Risk Register by the Clinical Management Team and governance lead.	31/08/2016	Twice yearly meetings now in place.			
MC2.4				Risks graded 9 and over are to be escalated to DAG with further escalation to EAG.	31/08/2016	All risks of 9 and above are reviewed at DAG and EAG.			
CYP2	**Services for Children and Young People**	Safe & Well-led	The Trust must review the timeliness and effectiveness of controls and actions on the local and corporate risk register, in children and young people's services.	Increase the frequency of the Paediatric Governance meeting to monthly.	08/08/2016	Governance meetings are now held monthly.		General Manager - Women and Childrens Health	
CYP2.1				Embed the routine review of the risk register at the Paediatric Governance Meeting.	31/08/2016	The agenda for the Paediatric Governance Meeting now has review of risk register as standing agenda item.			
CYP2.2				Discuss emerging and on-going risks and mitigation of risks at the Clinical Management Team meeting as part of the standing agenda.	31/08/2016	Clinical Management Team meeting has the risk register review as a standing agenda item.			
CYP2.3				Risks graded 9 and over are to be escalated to DAG with further escalation to EAG.	31/08/2016	All risks of 9 and above are reviewed at DAG and EAG.			

UE2	**Urgent and Emergency Services**	Safe & Well-led	The Trust must ensure that resuscitation and emergency equipment including neonatal resuscitaires, is checked on a daily basis in line with trust guidelines.	Emergency Department Matron and Team Leader to review current checking and recording procedures.	31/08/2016	Current checking and recording procedures completed. Daily checks now form part of the routine quality and safety checks.		Matron - Emergency Department	Director of Nursing
UE2.1				Awareness sessions to be undertaken with all staff to ensure they are aware of the Trust guidelines.	12/09/2016	Awareness sessions have begun via the Emergency Department handover brief.			
UE2.3				Team Leader/Matron to undertake weekly review of documentation to ensure compliance.	Weekly reviews	Weekly reviews began 8th August 2016. This continues to form part of the monthly nursing KPIs.			
UE2.4				Ensure recording procedures are a standing agenda item on the Emergency Department Clinical Governance meeting.	31/08/2016	The agenda for the Emergency Department Clinical Governance meeting now has recording procedures as a standing agenda item. The next meeting is on 21st September 2016		Matron - Emergency Department and Senior Matron for Medicine	
UE2.5				Review and revise the current SOP for opening a ward when additional beds are required.	23/09/2016	A review of the Opening a Ward SOP is underway to include a clear process for completion of checking and recording procedures and formal		Resilience & Governance Manager	

						notification to the Medical Director, Director and Deputy Director of Nursing and Senior Matrons. Details of any opened wards will be included at the bed meetings.			
UE2.6				Ensure revised SOP is communicated, published to AireShare and visible to all staff.	30/09/2016	Will be completed following revision of the SOP			
UE2.7				Matron responsible for Ward 15 to undertake daily spot checks to ensure compliance with SOP.	09/09/2016	Matron is currently undertaking daily spot checks on ward 15.			
MG2	**Maternity and Gynaecology**	Safe & Well-led	The Trust must ensure that resuscitation and emergency equipment including neonatal resuscitaires, is checked on a daily basis in line with trust guidelines.	To develop a SOP for daily checking of the resuscitation equipment.	30/04/2016	SOP developed for daily checking of the resuscitation equipment.		Head of Midwifery	
MG2.1				Ratify SOP at WIGG and through the Trust process.	30/04/2016	SOP ratified, published to AireShare and is visible to all staff.			
MG2.2				Monitor the compliance with daily checking of the resuscitation equipment via the Matron check list and a monthly report at WIGG.	30/04/2016	Compliance with daily checking of the resuscitation equipment is now monitored via the Matron check list and a monthly report at			

						WIGG.			
UE8	**Urgent and Emergency Services**	Safe	The Trust must ensure it meets national guidance for medical staffing in the emergency department.	Increase the Medical staffing numbers in the Emergency Department.	31/10/2017	A Business Case for additional Consultants in the Emergency Department was approved by the Board in January 2014, to increase the team to 10 WTE. There is further recruitment planned to fully achieve the recommended number. A Consultant returns to work from Maternity Leave on 31/10/2016 and a newly appointed Consultant also commences on 31/10/2016This takes the number to 8 WTE.Further recruitment is planned with adverts to be placed in February and July 2017 to coincide with the completion of speciality training.		General Manager - Medicine	Medical Director

UE8.1				Complete a risk assessment.	15/09/2016	Risk assessment in place detailing mitigation for the remaining two WTE Consultant Emergency Department vacancies. This is monitored through the Medicine Governance meeting.		Resilience & Governance Manager	
MG12	**Maternity and Gynaecology**	Safe	The Trust must ensure intravenous fluids are stored in a locked cupboard on the Labour Ward.	Ensure fluids are stored in a lockable cupboard by making alterations to the worktop in the Labour Ward utility room.	09/09/2016	External contractors have completed the required alterations and intravenous fluids are safely stored.		Head of Midwifery	Chief Operating Officer
S1	**Surgery Care**	Safe & Well-led	The Trust must ensure that where the responsibility for surgical patients is transferred to another person, the care of these patients is effectively communicated.	Audit post-take ward round (PTWR) against internal standards derived from a literature review.	30/06/2016	The June re-audit was presented at the Surgical Services Clinical Governance meeting on 8th July 2016 and demonstrated clear improvements in all aspects of the morning handover after interventions, when compared to data from the previous audit done earlier in 2016.		Clinical Director	Medical Director

S1.1				Respond to the recommendations following the conclusion of the audit.	30/06/2016	Handover logbook introduced and in use. Where possible sister / charge nurse is present for each handover.			
S1.2				Re-audit the efficacy of the handover of patients from PTWRs and implement the findings.	31/12/2016	Re-audit scheduled for November 2016.			
S1.3				Extend the current process to include all handovers.	30/01/2017	The formal handover process for Urology is implemented, the sister / charge nurse attends each handover when available. The afternoon / early evening is formally documented and the attendance log is completed. The re-audit scheduled for November 2016 will include all handovers. The November audit outcome will be presented to Surgical Services Clinical Governance meeting in January 2017.			

S2	**Surgery Care**	Safe & Well-led	The Trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.	Ensure there is a consistent application of all steps of the WHO checklist lead by the Clinical Lead for anaesthetics and General Manager	30/06/2016	Audit results presented to the CQC Task and Finish group for April , May , June 2016. Continuous improvement delivered with 100% compliance in June 2016. Audit to monitor performance agreed and undertaken on a monthly basis.		Anaesthetic Clinical Lead	Medical Director
S2.1				Undertake weekly 'Take 5' audit (5 patient records reviewed each week) with published results. Results taken to Surgical Services Quality and Safety Meeting and distributed to specialty Clinical Audit meetings.	30/06/2016				
S2.2				Individuals or specialities with recurrent non-compliance will be challenged to deliver immediate improvement by the relevant Clinical Lead/Director.	30/06/2016	Any non compliance identified has been escalated to the relevant Clinical Director/Lead.		General Manager - Surgery	
S2.3				Clinical Leads/Clinical Directors to escalate any issues requiring support to the Chief Operating Officer/Medical Director.	30/06/2016	The escalation process now in place.			
S2.4				Mandated silent cockpit in all theatres	30/06/2016	Silent cockpit posters redesigned and implemented.			
S2.5				Redesigned visual aids/documentation to support the WHO process.	30/06/2016				

CYP1	**Services for Children and Young People**	Safe & Well-led	The Trust must ensure an effective system is in place to ensure that community paediatric letters are produced and communicated in a timely manner.	Reduce the backlog of dictation for community paediatric letters. Ensure the letters are produced in a timely manor. Recruit a locum consultant in Community Paediatrics to backfill the Consultant time to address backlog of dictation.	01/08/2016	Locum in post to support the post holder 18th March 2016. Backlog of dictation for community paediatric letters has been reduced and a monitoring process is in place.		General Manager - Women and Childrens Health	Chief Operating Officer
				Monitor backlog weekly overseen by the General Manager.	01/08/2016	Weekly monitoring of backlog and reporting overseen by the General Manager			
Q1	**Quality**	Safe & Well-led	The Trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.	Ensure staff are trained in the skills/competency required to undertake NEWS and escalate as per NEWS guidance. Address any training needs identified through audits and or appraisal.	30/06/2016	Staff have been reminded via briefings in clinical areas to escalate in accordance with the guidance. During staff appraisal training needs are identified.		Senior Matron	Director of Nursing
Q1.1				Standard approach and documentation for the NEWS where appropriate across all wards and departments. Matrons review the use of the NEWs tool in clinical areas, audit the outcomes and report to the DAG meetings.	30/06/2016	NEWS is now included within the monthly nursing KPIs. Where KPIs fall below the accepted standard, weekly 'Take 5' audits will be undertaken to target the education and training required to ensure improvement.			

Q1.2				Medical Staff are made aware to escalate any concerns they have re NEWS management to the relevant Matron. Clinical Directors asked to inform all relevant medical staff, and escalate any concerns on an on-going basis to matrons in the clinical areas.	30/06/2016	Medical Staff informed and escalation process in place.			
Q1.3				Regular audit of the process to determine if NEWS is being used consistently. Incorporate Take 5 audit questions into the KPIs from May 2016. KPIs have been reviewed, and a peer review approach has been taken.	30/06/2016	Assurance sought from matrons at the monthly Quality Safety meetings. Monthly report on audit outcomes collated by Deputy Director of Nursing and reported to the CQC Task and Finish Group. Action delivered June 2016 . Audit programme in place to monitor compliance.			
Q2	**Quality**	Safe	The Trust must ensure records are stored and completed in line with professional standards, including an individualised care plan.	Undertake a risk assessment of the current records storage solution and detail the necessary actions required.	05/09/2016	Risk Assessment completed to describe mitigation for the decision to not purchase locked trolleys for the storage of medical records in in-patient wards and departments. E-mail reminder re: safe storage of medical records sent to all Clinical Directors,		Senior Matrons	Director of Nursing

						Ward Clerks, Matrons & Ward Leaders. Matrons include safe storage of medical records into their daily walkrounds.			
Q2.1				Ensure all staff are aware of the requirements in relation to Information Governance Standards	31/03/2017	At 30th September 2016 72% of eligible staff have completed their annual Information Governance mandatory training update. Human Resources issue monthly training compliance reports to Managers for monitoring and action.			
Q2.2				Continue with the monthly KPI audits of nursing documentation. The audits include compliance checks with the documentation NMC professional standards	01/09/2016	Monthly KPI process reviewed. Audits will continue monthly by peer ward leaders. Quarterly KPI audits will be performed by the corporate nursing team. The nursing documentation is currently under review by a working group established in May 2016.			

Q2.3				Signature sheet to be introduced into the Nursing Documentation to enable clarity of escalation. This will be ratified at the Health Records Group in September 2016.	12/09/2016	Signature template successfully piloted on Harden Ward at Castleberg Hospital. The template will be ratified through the Trust governance processes and implemented to in patient areas. Will be monitored through the nursing KPI's.			
Q3	**Quality**	Safe & Well-led	The Trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.	Widespread recruitment plan for registered and non registered nursing staff in place and on-going. This includes International nurse recruitment which happened in July 2016. Job offers were made and staff will start taking up posts at end of August 2016.	31/08/2016	32 job offers made to international recruits, additional interviews via Skype are planned. New recruits now working in the organisation and are undergoing and induction programme.		Senior Matrons	Director of Nursing
Q3.1				Undertake a bottom up review of staffing for all wards. Explore the implementation of band 4 roles by possibly recruiting retired registered nurses who can demonstrate competency at the level of band 4 .	30/09/2016	Job Description has been developed for band 4 Assistant Practitioners (underpinning qualification retired nurse), deployment form signed and agreed, awaiting table top exercise for AfC, advert developed and will be placed once on the 17 October 2016. Nov update - 5 applicants, recruitment process		Deputy Director of Nursing	

						to follow.			
Q3.2				Explore the role of the Associate Nurse as part of a pilot project in conjunction with other organisations.	30/09/2016	The Trust participated in the submission of a national Health Education England bid in partnership with Trusts from Leeds and Bradford. The bid was successful and 5 trainees will be recruited by December 2016 and commence training in January 2017 with a 2 year training contract.		Senior Matrons and Deputy Director of Nursing	
Q3.3				Review the nursing establishment and collate quality and safety for each ward. Present for discussion to the corporate nursing team in September.	30/09/2016	A formal peer meeting with Deputy Directors of Nursing from other Trusts took place on 21st September. The outcome of the meeting will be presented to EDG in November 2016 and be included in the 24 month Group Plans 2017 - 2019.		Deputy Director of Nursing	
Q3.4				Apprentice scheme for 2016 agreed with Executive Directors in July 2016, ensure that this is implemented to the time line agreed	31/10/2016	The recruitment selection process stared t in September 2016 and an advert was placed, there was a good response and staff were be recruited by 31st		Deputy Director of Nursing and Assistant Director Medical Directors Unit	

						October 2016. Offers were made to 16 students and the usual employment checks are underway. The apprentice scheme will start in Jan 2017.			
Q3.5				Continue to undertake twice yearly review of nurse staffing plus monthly reporting of nurse staffing. Develop the reports related to this for the Board of Directors by including where relevant any adverse variance against the NICE nurse indicators. MIAA commissioned to undertake a review and assure the Trust that planned vs actual nurse staffing is accurately reported to the Board. Director of nursing to review the format of the reports. Reports to include the recommendations from the recent MIAA audit report.	30/09/2016	The format of the reports is under review, with input from the recently developed Workforce Healthcheck. The first draft of the report will be presented to the Board of Directors on the 28th September 2016 and the SOP for Hard Truths Report is in place. The second draft report was presented to Board of Directors on the 26th October and was well received, further development of the final report continues.		Director of Nursing	
Q3.6				On a day to day basis ensure Matrons and Senior Matrons are supporting ward teams with any issues relating to gaps in their available staff. Template capturing the staffing situation produced by end of March 2016 and circulated following each bed meeting. This is in SBAR format.	31/03/2016	Template completed each day and circulated via email for action as required.		Matrons	

Q3.7				Ensure e-rostering is rolled out to all wards and departments and determine what reports are required to support effective deployment of staff. E-rostering to be implemented by August 2016.	30/08/2016	E-rostering being used in all ward areas.		Senior Matrons	
Q3.8				Implement a Ward Development programme across the wards. Template produced and being completed and individualised by the Ward Sisters supported by the Matrons during August 2016	28/10/2016	Initial meetings completed in September 2016 with progress plans developed and completed by the Matrons and Ward Sisters in October 2016.			
Q3.9				Produce an updated Nursing and Midwifery strategy. Consult with the clinical workforce. Produce a draft strategy for formal consultation by the end of September 2016.	31/10/2016	Initial consultation events with the nursing forum, sisters and ward nurses took place in September 2016, this was expected to October 2016 to ensure all the ward staff unable to attend earlier events got the opportunity to input. The draft strategy was has been produced and will be circulated in November 2016 as part of the consultation process.			

Q4	**Quality**	Safe & Well-led	The Trust must ensure the safe storage of medicines (general)	Review relevant policies and procedures relating to safe storage of medicines to ensure compliance with legislation and national good practice.	31/08/2016	Relevant medicines management policies are in date. They have been reviewed and reflect the requirements of legislation and best practice relating to safe storage of medicines.		Lead Pharmacist Clinical Governance and Senior Matrons	Medical Director
Q4.1				Ratify changes to policy and SOPs.	31/08/2016	No changes proposed at this time.			
Q4.2				Audit storage of medicines as part of existing pharmacy-led audit cycle.	15/11/2016	Next quarterly controlled drugs audit and safe handling of medicines audit to be undertaken by 31st October 2016. Report to NMLG and Medicines Safety Group mid-November. Any actions emerging from the audit will be delivered by the operational teams and monitored at local governance groups.			

Q5	**Quality**	Safe & Well-led	The Trust must ensure the safe storage of medicines (fridges)	Display reminder poster 'how to re-set thermometers' on fridge doors.	01/08/2016	Action completed.		Matrons	Medical Director
Q5.1				Display reminder screen 'to check medicine fridge temperature' as part of Trust-wide rolling screen saver communication tool.	30/09/2016	Action completed.		Lead Pharmacist Clinical Governance	
Q5.2				Audit practice via weekly medicines audit for CQC Task & Finish Group. Matrons weekly spot checks are monitoring compliance.	01/04/2016	Weekly audits of compliance in place. Any training issues which emerge are being addressed.		Matrons	
Q5.3				Identify the medicine fridges unable to hold the required temperature.	19/09/2016	Fridges have been identified and replaced.		Lead Pharmacist Clinical Governance	
Q5.4				Obtain costings for replacement fridges.	30/09/2016	Medicine fridges in clinical areas have been replaced via Supplies where the previous model was demonstrated to be functioning incorrectly.		Lead Pharmacist Clinical Governance	
Q5.5				Explore alternative methods to support maintenance of medicine storage temperatures.	30/09/2016	Estates and facilities department have considered air conditioning of clean utility rooms. This option currently		Lead Pharmacist Clinical Governance	

						unviable due to cost.			
Q5.6				Work with Estates Dept to increase monitoring of ambient temperature in clean utility rooms where medicine fridges are located to inform the risk assessment	30/11/2016	This is a further action to gain more data to assess the risks to stored medicines.		Lead Pharmacist Clinical Governance	
Q5.7				Update risk assessment of medicine storage temperatures in clinical areas with proposed actions to mitigate risks to medicines	30/11/2016	The risk assessment will be updated when further data available on ambient temperatures.		Lead Pharmacist Clinical Governance	
Q5.8				Develop flow chart to aid decision making by nursing staff in response to fridge temperatures being outside of the required range	07/12/2016	The flow chart is currently under development and will be approved at Medicines Process Review Group on the 7th December 2016.		Lead Pharmacist Clinical Governance	
Q6	**Quality**	Safe & Well-led	The Trust must ensure the safe storage of medicines (discharge)	Review nurse discharge checklist and associated procedure.	31/08/2016	Action completed.		Senior Matrons and Lead Pharmacist Clinical Governance	Medical Director
Q6.1				Confirm nursing staff have read relevant policy and procedures and understand their role and responsibility.	31/08/2016	This is part of the annual appraisal process and induction for new starters.			

Q6.2				Confirm pharmacy staff have read relevant policy and procedures and understand their role and responsibility.	31/08/2016	Action completed.			
Q6.3				Display reminder poster on inside of door to patients medicines lockers to prompt nurse to check fridge for discharge medicines.	31/08/2016	Action completed.			
Q6.4				Display reminder screen to check fridge for discharge medications as part of Trust-wide rolling screen saver communication tool.	30/09/2016	Action completed.			
Q6.5				Monitor practice via the weekly medicines audit. Matrons to undertake spot checks on safe storage of medicines and staff knowledge of their roles and responsibilities.	30/08/2016	Weekly audits of compliance in place. Any training issues which emerge are being addressed.		Matrons	
Q7	**Quality**	Safe	The Trust must ensure the safe storage of medicines (Controlled Drugs)	Ensure compliance with relevant policies and procedures. Expired controlled drugs to be removed from the clinical areas. Confirm nursing staff have read and understand relevant policy and SOPs including respective roles and responsibilities.	30/08/2016	Process is part of the annual appraisal process and induction for new starters. Local operational group will monitor compliance.		Senior Matrons and Lead Pharmacist Clinical Governance	Medical Director

Q7.1				Confirm pharmacy staff have read and understand relevant policy and SOPs including respective roles and responsibilities.	31/08/2016	Action completed.		Lead Pharmacist Clinical Governance	
Q7.2				Display reminder poster on the inside of controlled drugs cupboard door with prompt 'to write expiry date on liquid controlled drugs bottles'.	31/08/2016	Action completed.			
Q7.3				Display reminder screen 'to write expiry date on the liquid controlled drugs bottles' as part of Trust-wide rolling screen saver communication tool.	30/09/2016	Action completed.			
Q7.4				Audit practice via weekly medicines audit for CQC Task & Finish Group, Matrons' spot checks and pharmacy-led Quarterly controlled drugs audits.	31/08/2016	Weekly audits of compliance in place. Any training issues which emerge are being addressed.		Senior Matrons and Lead Pharmacist Clinical Governance	
Q7.5				Ensure compliance with standards for controlled drugs record keeping, if the controlled drugs records are corrected they must be signed. Audit practice via existing audit cycles. Matrons spot checks and pharmacy-led Quarterly controlled drugs audits.	15/11/2016	Next quarterly controlled drugs audit to be undertaken by 31st October 2016. Report to NMLG and Medicines Safety Group mid-November. Action plans from the Quarterly audits will be delivered and monitored at the local governance		Senior Matrons and Lead Pharmacist Clinical Governance	

						groups.			
Q8	**Quality**	Safe & Well-led	The Trust must ensure the safe administration of medicines	Review relevant policies and procedures relating to safe administration of medicines to ensure compliance with legislation and national good practice.	31/08/2016	Relevant medicines management policies are in date. They reflect the requirements of legislation and best practice relating to safe storage of medicines.		Senior Matrons and Lead Pharmacist Clinical Governance	Medical Director
Q8.1				Ratify changes to policy and SOPs.	31/08/2016	No changes proposed at this time.			
Q8.2				Matrons to confirm nursing staff have read and understand relevant policy and SOPs including respective roles and responsibilities.	31/08/2016	This is part of the annual appraisal process and induction for new starters. For example, medicines management session is part of the induction programme for the new international recruits and will then be followed up within their preceptorship period.		Senior Matrons	
Q8.3				Monitor incidents relating to administration of medicines.	31/08/2016	Medicine related incidents are monitored at the medicine safety group. Any particular issues are devolved to the operational governance groups		Senior Matrons and Lead Pharmacist Clinical Governance	

						for further action.			
Q9	**Quality**	Safe & Well-led	The Trust must improve compliance in medicines reconciliation.	Review existing operating practices and map process.	16/08/2016	Presented findings to Pharmacy Leadership Team. Agreed to produce a weekly tracker to monitor on-going performance, review the SOP for medicines reconciliation and produce an operational improvement plan including a stepped target trajectory.		Senior Project Pharmacist	Medical Director
Q9.1				Confirmed current performance (50%) and agreed initial target KPI (80%) with focus on Acute Medical Unit (AMU) weekdays. Trajectory for stepped improvement (60% by end October 2016).	31/10/2016	Medicines reconciliation target aligned with NICE guidance (NG5) and emerging Regional medicines reconciliation definition (Yorkshire & Humber Chief Pharmacists Group meeting which took place on the 2nd September 2016).			
Q9.2				Meet target of 70% medicines reconciliation (on AMU on weekdays) by 31st December 2016 .	31/12/2016	60% was achieved by 31st October 2016.			

Q9.3				Meet target of 80% medicines reconciliation (on AMU on weekdays) by 31st March 2017.	31/03/2017	60% was achieved by 31st October 2016.			
Q9.4				Produce weekly tracker to show % achievement of medicines reconciliation undertaken in agreed clinical areas.	05/09/2016	Action completed.			
Q9.5				Review and improve the pharmacy SOP for medicines reconciliation.	30/09/2016	Action completed.			
Q9.6				Produce an operational improvement plan showing how phased target trajectory will be monitored and delivered. To include proposals for recruitment, skill mix and deployment of ward-based pharmacy staff and optimal use of EPMA.	30/09/2016	Action completed.			
Q10	**Quality**	Safe & Well-led	The Trust must ensure that guidelines are up to date and meet national recommendations	Review and revise out-of-date guidelines.	30/09/2016	All Core Services have reviewed and revised their guidelines.		General Managers	Medical Director

Q10.1			within NICE guidance or guidance from similar bodies.	Ratify them through the Trust processes.	30/09/2016	All Core Services have ratified their guidelines.		General Managers	
Q10.2				Publish them to Aireshare for all staff to view.	31/10/2016	All the ratified Guidelines are now published to Aireshare; any remaining guidelines are being fed through to the Health Information Service for publishing by the 30 October 2016.		Assistant Director Healthcare Governance	
Q10.3			The Trust must ensure that guidelines meet national recommendations within NICE guidance or guidance from similar bodies.	Clinical leads for each specialty to provide detail of guidance relating to other relevant national organisations such as Royal Colleges.	31/10/2016	Clinical leads are working with their groups and will share the final lists with the Health Information Service.		Clinical Director	
Q10.4				Compile list of relevant national guidance.	31/10/2016	Initial identification of national guidance completed by Assistant Director Healthcare Governance & Senior Health Information Specialist.			
Q10.5				Issue list of service specific national guidance to the Health Information Service to enable the monthly horizon scanning.	31/10/2016	A list of national guidance for Medicine has been issued to the Health Information Service, awaiting the list from the remaining clinical groups.			

Q10.6				Develop a process for the dissemination of relevant guidance to clinicians (similar to current NICE process) to include development of tracker for each speciality.	31/10/2016	Clinical Audit Manager is extending the current NICE guidance dissemination process to include all guidance. This will then be subject to the current monitoring processes in the Trust.		Assistant Director Healthcare Governance	
Q11	**Quality**	Well-led	The Trust must improve engagement with staff and respond appropriately to concerns raised by staff.	The Trust's People Plan sets out actions that are planned for 2016-17. In addition, there will be a planned series of Board Director listening sessions and walk-rounds commencing by end September 2016. There will also be a series of corporate conversations led by Directors, the first of these will be on 'Right Care the next 5 years'. Develop schedule for Board Director walk-rounds.	15/09/2016	Board Director walk-rounds schedule has been developed. Exec Team weekly Walkarounds commenced October 2016. Individual Exec walkarounds and listening sessions planned for next year - one per director per month. CEO briefing sessions to take place in October. Regular CEO/Exec led briefings of senior leaders takes place weekly.		Director of Human Resources	Director of Human Resources
Q11.1				Consult on the new clinical leadership and accountability arrangements between August and November 2016, prior to implementation from April 2017. Ensure the clinical leadership and accountability arrangements have been shared through a formal	30/11/2016	Consultation document issued and meetings arranged with key groups of staff. Meetings completed with key staff groups; and consultation shared across the Trust via			

				consultation.		team leaders and staff brief. Consultation closed on 30 September 2016.			
Q11.2				Monitor the process to ensure meaningful engagement and delivery of the leadership and accountability framework.	31/03/2017	Consultation underway and running to planned timescale.			
Q11.3				Implement 'Consistently Good People Management Conversations'. Guidance and Communication.	31/10/2016	Resource allocated and work commenced on format and guidelines. Draft guidelines and communications produced.		Workforce Development Manager	
Q11.4				To review the Dignity at Work Policy. To publicise the Dignity at Work and Raising Concerns policies via Trust communications through staff side and a lunchtime session for medical staff co hosted with the LNC. Appoint the Freedom to Speak Up Guardian.	31/10/2016	Review of Dignity at Work commenced. Draft Freedom to Speak Up Guardian job description developed for consultation with staff side. Review of Dignity at Work policy completed with staff side and will now go through Trust ratification processes before communicating widely across the Trust. Freedom to Speak up Guardian JD finalised and post will be advertised w/c 10 October.		Human Resource Business Partner	

Q11.5				Develop the Pulse Survey through November 2016. Consider delivery options including internal or outsourced options and implement new surveys and reports from January of 2017.	30/01/2017	Arrangements in other Trusts have been considered and discussions have begun with outsourced provider.		Workforce Development Manager	
Q12	**Quality**	Well-led	The Trust must ensure that staff complete their mandatory training including safeguarding training.	Improve the overall Trust compliance with mandatory training to achieve the 80% target. This includes reviewing the mandatory training matrix for staff groups, developing a workbook for specific groups and running bespoke events for staff groups who can be difficult to reach through the standard offer. Agree a new set of actions to achieve a consistency in compliance across staff groups and mandatory training subjects and set an overall stretch target for the Trust of 90%.	31/08/2016	The workbook developed, matrix reviewed and new stretch target and actions agreed.		Workforce Development Manager	Director of Human Resources
Q12.1				HR Business Partners, ward and departmental managers all share up to date and accurate information.	30/09/2016	Information on Mandatory Training compliance is provided to line managers, senior managers at business groups and at EAG. The clinical management teams are preparing plans to achieve compliance against the 90% stretch target.			

Q12.2				HR Business Partners to test the validity of ward / department plans to check these are realistic and whether additional support is required to realise the plan.	01/10/2016	Reviews competed - actions and additional support underway			
Q12.3				Develop and offer alternative methods of delivering training where appropriate for the subject matter, including extending access to the mandatory training workbook for all staff and further developing the workbook content.	30/03/2017	Workbook developed . Mandatory Training Facilitators developing action plans to improve the content and delivery based on local risk assessments. Additional elements added to the Workbook and Workbook made available to all staff from 7 October.			
Q12.4				Line managers to check compliance at PDR/appraisal before signing off objectives and incremental progression.	30/09/2016	Guidance for 2016/17 PDRs included the requirement to check mandatory training compliance before signing off the PDR and incremental progression. This is being monitored by the Workforce Development Team and managers are being asked to put action plans in place where there are mitigating circumstances. Guidance to be further strengthened			

						for 2017 PDR/appraisals.			
Q12.5				Consider options for exploring the use of e-learning technology to deliver mandatory training and secure funding.	30/09/2016	An options appraisal has been developed based on best practice at other Trusts and work is currently underway to secure funding from within existing budgets. . Options appraisal considered at EDG and funding arrangements agreed linked to training funds and the VR process.			

Glossary of Terms

AireShare	Airedale NHS Foundation Trust Intranet	**NEWS**	Nursing Early Warning Score
AEF	Adverse Event Form	**NICE**	National Institute for Health and Care Excellence
ANP	Advanced Nurse Practitioner	**NMC**	Nursing and Midwifery Council
AMU	Acute Medical Unit	**NMLG**	Nursing and Midwifery Leadership Group
CCU	Critical Care Unit	**PALS**	Patient Advice and Liaison Service
DAG	Delivery Assurance Group	**PDR**	Performance Development Review
EAG	Executive Assurance Group	**PRDG**	Procedural Documents Ratification Group
EPMA	Electronic Prescribing and Medicines Administration	**PTWR**	Post Take Ward Rounds
GPICS/D16	Critical Care standards / guidance	**RCA**	Root Cause Analysis

HR	Human Resources	**SBAR**	Situation, Background, Assessment, Recommendation
KPI	Key Performance Indicators	**SOP**	Standard Operating Procedure
LNC	Local Negotiating Committee	**ToR**	Terms of Reference
MDT	Multidisciplinary Team Meeting	**UKCCN**	UK Critical Care Network
MIAA	Mersey Internal Assurance Audit	**WIGG**	Womens Integrated Governance Group
MPRG	Medicines Process Review Group	**WTE**	Whole Time Equivalent