Bradford Teaching Hospitals
NHS Foundation Trust

Appendix 1

CQC Compliance Action Plan (2018 inspections)	Date initiated	13th June 2018
	Date of update	October 2018

Accountability		**Executive Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Clive Kay, Chief Executive (CK)	Board of Directors	Karen Dawber (KD), Chief Nurse	Quality Committee
Tanya Claridge, (TC) Director of Governance and Corporate Affairs		Bran Gill (BG), Medical Director	Quality Committee
		Tanya Claridge (TC), Director of Governance and Corporate Affairs	Quality Committee
		Pat Campbell (PC), Director of Human Resources	Workforce Committee

Aim	**Objective**		**Expected Outcome**	**Assurance Mechanism**	**Review date**
	Ref				
To effectively and sustainably address areas of non-compliance with the CQC's fundamental standards of quality and safety identified in the 2018 inspections	1.1	To ensure all staff closed mandatory training, including safeguarding training, so they have the skills and competence to undertake their roles.	The Trust will demonstrate full and sustained compliance with mandatory training targets	Key performance indicators incidents involving knowledge and skill based errors related to mandatory training	December 2018
	1.2	To ensure all staff have an annual appraisal.	The Trust will demonstrate full and sustained compliance with appraisal targets for all staff groups	Key performance indicators Staff survey	December 2018
	1.3	To ensure we have a comprehensive system in place to identify policies and guidance approaching their review date.	The Trust will demonstrate full and sustained compliance with procedural document management targets	Key performance indicators relating to compliance	September 2018
	1.4	To ensure that all safety and equipment checks happen consistently, as required, and are acted upon appropriately	All wards and departments will demonstrate full and sustained compliance with checking requirements	Rapid sequence auditing demonstrating whole system compliance	September 2018
	1.5	To ensure all staff are engaged and participate in all steps of the World Health Organisation' (WHO) surgical safety checklist, and that this is consistently utilised.	All teams performing operations across the Trust will demonstrate full and sustained compliance with the WHO checklist	Rapid sequence auditing Cultural assessment ProGRESS review	November 2018

Change team members			
Name	**Job title**	**Contact details**	**Initial**
Dr Janet Wright	**Divisional Clinical Director (W&C)**	**Janet.wright@bthft.nhs.uk**	**JW**
Sara Keogh	**Head of Midwifery (W&C)**	**Sara.keogh@bthft.nhs.uk**	**SK**
Diane Daly	**Acting Divisional General Manager (W&C)**	**Diane.daly@bthft.nhs.uk**	**DD**
Brad Wilson	**Divisional Clinical Director (DOMIC)**	**Brad.wilson@bthft.nhs.uk**	**BW**
Corinne Jeffrey	**Divisional General Manager (DOMIC)**	**Corinne.Jeffrey@bthft.nhs.uk**	**CJ**
Sarah Freeman	**Head of Nursing (DOMIC)**	**Sarah.freeman@bthft.nhs.uk**	**SF**
John Bolton	**Divisional Clinical Director (DADS)**	**John.bolton@bthft.nhs.uk**	**JB**
Collette Cunningham	**Divisional General Manager (DADS)**	**Collette.Cunningham@bthft.nhs.uk**	**CC**
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Lisa Fletcher	**Assistant Director of Human Resources**	**Lisa.Fletcher@bthft.nhs.uk**	**LF**
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Leeanne Elliott	**Medical Director**	**Leeanne.eliott@bthft.nhs.uk**	**LE**
Nicola Cawley	**Obstetric Specialty Lead**	**Nicola.cawley@bthft.nhs.uk**	**NC**
Deborah Horner	**Consultant Anaesthetist**	**Deborah.horner@bthft.nhs.uk**	**DH**

Communications plan				
What?	**Who?**	**By whom?**	**How?**	**How frequently?**
Action plan support	Clinical Divisions	Divisional Clinical Directors	Divisional Quality meetings-action plan	Monthly
Action Plan Oversight	Quality Committee/Workforce Committee	Executive Directors	Committee Meetings: action plan and assurance update	Every meeting
Action Plan Management	Executive Mangement Team Operational Meeting	Director of Governance and Corporate Affairs	Team meetings-exception report	Every meeting

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Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

	Objective	1	To ensure all staff closed mandatory training, including safeguarding training, so they have the skills and competence to undertake their roles.						
	No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
Trust Wide	1.1	To fully implement the Board approved core and high priority training policy	BG	01/04/2018	31/5/2018	**Closed**	31/5/2018	Policy is fully implemented	Policy compliance evidence as described by the policy
	1.1	To undertake a Trust wide review of mandatory training compliance that is not meeting the agreed standards by subject, professional group and individual to highlight areas of concern	AH	01/06//2018	31/7/2018	**Closed**	31/7/2018	Comprehensive new system in place: started April 2018. Good performance across majority of subject areas. Improvements being made in previously highlighted areas:	Trust wide mandatory training profile
	1.2	To implement a programme of trust wide mandatory training day which provides individuals the ability to ensure they can achieve 100% on completion	AH	01/06/2018	6/08/2018	**Closed**	10/7/2018	Fully implemented from July 2018 with ongoing bi monthly dates. Full engagement from subject matter experts and divisional practice educators.	Programme of training days Programme for training days
	1.3	Education to continue to work directly with divisions to identify individual staff members in whom their training compliance is sub-optimal to target attendance at training days	AH	01/06/2018	6/08/2018	**Closed**	31/08/2018	Attendance at new mandatory training days has targeted individuals and departments/staff groups with lowest levels of compliance. Attendance and feedback is positive	Trust wide mandatory training profile
	1.4	To continue to review the training delivery plans for all mandatory training subjects to ensure that: • they align to the core skills training framework • the provision of training matches the demand • training is provided in a variety of methods to increase capacity and to suit different staff needs	AH	01/052018	31/8/2018	**Closed**	31/08/2018	This work is closed. Now working regionally on implementation of the core skills framework to allow transfer of mandatory training.	Outcome report of the review Minutes of Workforce and Education meeting
	1.5	To provide training on the use of the training database tool to allow them to review and understand their own teams mandatory training compliance	AH	01/06/2018	30/09/2018	**Closed**	30/09/2018		Training % of line managers
	1.6	To align compliance with mandatory training to divisional performance management processes	AH	01/06/2018	31/07/2018	**Closed**			Divisional performance review profiles/minutes
Maternity	1.7	To monitor divisional compliance and assurance using the 'maternity assurance tracker'	DD	10/7/2018	31/12/2018	**Open**			Use of maternity assurance tracker Notes of monthly executive led meeting
	1.8	To routinely report levels of compliance and any risks/associated mitigation to the monthly executive led maternity oversight meeting	JW SK	10/7/2018	31/12/2018	**Open**			Notes of monthly executive led meeting

	Objective	2	To ensure all staff have an annual appraisal.

	No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
Trust wide	2.1	Divisions/Corporate Areas to provide list to HR of managers currently undertaking appraisals and for which organisation cost centres & staff.	DD, CC. CJ	25/6/2018	16/07/2018	**Closed**	16/07/2018		Provision of required information
	2.2	An expected ratio of appraiser to appraisee will be defined and guidance provided to all divisions	RP	16/07/2018	30/7/2018	**Closed**	30/7/2018	The issue was discussed raised at TOG on 3 September for Divisions to consider appraisals ratios within their teams and what would be practically manageable and also to provide me with idea of the current staff ratios with a view to ensuring as part of the appraisal season next year Sept-Nov, full guidance is in place.	Guidance Communication to Divisions
	2.3	Workforce Information to produce a monthly report (adding to the existing monthly workforce data report) detailing all staff within the next quarter that are eligible and require an appraisal for divisions and corporate areas. This report will be reviewed and updated during existing divisional and corporate performance meetings	RP	25/6/2018	30/07/2018	**Closed**	30/7/2018		Monthly report
	2.4	Using the information provided above divisions will develop a trajectory for compliance with mandatory training standards	DD CC CJ	16/7/2018	30/7/2018	**Closed**	30/7/2018		Trajectory
	2.5	Establish a list of reporting leads for appraisal completion within divisions and corporate areas who will run (through ESR Business intelligence) an agreed fortnightly report with respect to appraisal progress. This report will be reviewed by the Division and Corporate Management teams and the Deputy Director of HR	RP LH	25/6/2018	20/7/2018	**Closed**	20/7/2018		Report Evidence of review and action Evidence of grip and control by Deputy Director of HR
	2.6	Additional appraisal workshops for managers to be added to the OD delivery schedule for Q2 and Q3 to equip managers with the skills and knowledge to carry out an effective appraisal. Bespoke workshops targeted at areas which require additional support.	LH	10/7/2018	13/07/2018	**Closed**	13/07/2018		Workshop content Work shop evaluation Workshop attendance records
	2.7	Regular communication of the importance of having an effective appraisal using examples of best practice across the Trust; direct managers to the time2talk appraisal intranet hub for information and guidance; continue We are Bradford work to develop our culture of continuous improvement, including developing and managing performance through effective appraisals.	LH	10/7/2018	30/9/2018	**Closed**	30/9/2018		Portfolio of initiatives used
	2.8	Promote use of ESR Manager Self-Service to record and manage appraisal data, to ensure accurate and up to date information.	LH	10/7/2018	31/12/2018	**Closed**	31/8/2018		Evidence of intervention Evidence of increased utilisation
Maternity	2.9	To hold monthly divisional compliance and assurance meetings using the 'maternity assurance tracker' but with a specific focus on appraisal	DD	10/7/2018	31/12/2018			The first 'Be the Best' workforce steering group held where compliance with appraisals shared with all managers and those staff whose compliance is out of date. Action required discussed. Appraisal rate improved slightly across the Division on 18.8.18 to 79%, all departments manager e-mail an update and informed of those staff who require an appraisal or who will be out of date over the next two months. As of 29.8.18 appraisal rate 83%.	Notes of meetings
	2.10	To routinely report levels of compliance and any risks/associated mitigation to the monthly executive led maternity oversight meeting	JW SK	10/7/2018	31/12/2018			1.8.18 = 76%, 18.8.18 = 79%, 23.8.18 increased to 83% and see information above.	Notes of monthly executive led meeting

	Objective	3	To ensure we have a comprehensive system in place to identify policies and guidance approaching their review date.						
	No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
Trust-wide	3.1	To undertake an immediate risk assessment on all policies that are out of date and ensure that any risks are mitigated and appropriate action is taken	TC	21/6/2018	31/7/2018	**Closed**	31/7/2018	Review closed, risk assessment closedd and prioritisation of review and update to be provided to EMT in September 2018	Closedd proforma for all out of date policies
	3.2	To closed a formal review and benchmarking of all Trust-wide policies, procedures and guidance. The review to focus on relevance, compliance and comprehensiveness	TC	21/6/2018	31/8/2018	**Closed**	31/8/2018	Review closed, recommendations to be made in a paper to EMT in October 2018	Benchmarking report
	3.3	To ensure that all policies have a named accountable executive director and nominated operational lead	TC	21/6/2018	2/7/2018	**Closed**	2/7/2018		Audit of compliance with procedural document policy
	3.4	To continue to monitor compliance with Trust wide policy and clinical guidance through executive management team meetings, with a direct escalation for non-compliance to the Chief Executive Officer	TC	21/6/2018	30/9/2018	**Closed**			EMT/TOG minutes
	3.5	To undertake a formal review of Trust-wide procedural document management system to ensure effectiveness and make recommendations where opportunities for change and improvement are identified	TC	21/6/2018	30/9/2018	**Closed**			Report of review
	3.6	To increase the required compliance with local procedural documentation policy to demonstrate an optimum of 100%	TC	21/6/2018	22/6/2108	**Closed**		Closedd, BRAG rating amended on dashboard to reflect changes	Monthly compliance reporting
	3.7	To ensure that compliance with local procedural documentation policy is reviewed and performance managed through divisional performance reviews	TC	21/6/2018	31/7/2018	**Closed**		Proposal made to Chief Operating Officer for inclusion, accepted. Quarterly performance data to be provided.	Divisional performance reviews
	3.8	To undertake a formal review of divisional governance conduct in relation to the management of local procedural documents and make recommendations where opportunities for change and improvement are identified	TC	21/6/2018	30/9/2018	**Closed**			Outcome report of divisional governance review
Maternity	3.9	To undertake a review of all local procedural documents and ensure all are fit for purpose and relevant	JW	21/6/2018	31/8/2018	**Closed**		Closedd, with a comprehensive list of guidelines and their status available.	Local procedural document compliance report
	3.10	To participate in the review (3.8) and ensure that all recommendations are considered and opportunities for change and improvements addressed	JW	21/6/2018	31/10/18	**Closed**			Outcome report of divisional governance review
Medical care	3.11	To undertake a review of all local procedural documents within all specialties and ensure all are fit for purpose and relevant	BW	21/6/2018	31/8/2018	**Closed**			Local procedural document compliance report
	3.10	To directly performance manage specialties where compliance with the Trust wide standard is sub-optimal	BW	21/6/2018	31/8/2018	**Closed**			Local procedural document compliance report
	3.12	To participate in the review (3.8) and ensure that all recommendations are considered and opportunities for change and improvements addressed	BW	21/6/2018	31/10/2018	**Closed**			Outcome report of divisional governance review

	Objective	4	To ensure that all safety and equipment checks happen consistently, as required, and are acted upon appropriately						
	No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
Trust wide	4.1	To formally map all safety and equipment checks across the Trust carried out in patient care environments	TC	25/6/2018	11/7/2018	**Closed**	11/7/2018	A mapping exercise was closedd with a working group of matrons	Portfolio of safety and equipment checks
	4.2	Input generic and area specific bolt on checks into a standardised check checklist agreed by divisional representatives	TC	10/7/2018	20/7/2018	**Closed**	31/7/2018	Checklist developed and was piloted during August 2018. Final version being rolled out w/c 3/9/2018	Standardised safety and equipment checklist
	4.3	Develop educational and awareness campaign 'Cliffboard' including learning matters (to support staff understanding the rationale for checking), splash screen publicity and inter ward and department competitions	TC	25/6/2018	20/7/2018	**Closed**	15/8/2018	Closedd and initiated as new checklist implemented w/c 3/9/2018	Promotional material Learning maters publications
	4.4	Implement a 2 month programme of Trust wide rapid sequence compliance audits	TC	20/7/2018	30/9/2018	**Closed**	3/9/2018		Audit outcome report
	4.5	Add compliance with safety and equipment checks to the divisional performance meeting profiles and ward and department safety information-for reporting from August 2018	TC	25/6/2018	11/7/2018	**Closed**	03/07/2018	Request for addition to portfolio made to Head of Informatics	Divisional performance profile
	4.6	To build qualitative review of compliance with safety and equipment checks into peer ward and observational review programme-for use from August	TC	25/6/2018	11/7/2018	**Closed**	11/7/2018	Ward assurance and	Observational checklist with appropriate amendments
	4.7	Implement a further 2 month programme of Trust wide rapid sequence compliance audits	TC	01/12/2018	31/1/2019	**Open**			Audit outcome report
	4.8	Revise and strengthen maternity checklists to include action taken, by whom and management of escalation of concerns.	SK	25/6/2018	20/7/2018	**Closed**	30/8/2018	To adapt the Trust wide pharmacy form for local use as the form has insufficient space to record escalations and actions. 30/08/2018. Revised checklists designed and will all be in use by 03/09/2018 In place but monitoring to continue therefore will remain open until assured of compliance. Trialling the revised Trust checklist from end of July before roll out across the Trust. An escalation process is now included on the back of the checklists, the Directorate will monitor completion and whether appropriate action was taken where an issue highlighted. 30/08/2018. Trust checklists have been modified to include the additional safety checks unique to maternity within the Trust template. These will be rolled out from 03/09/2018.	Revised checklist
	4.9	Increase matron review and challenge of compliance checks, with weekly reporting of compliance to the Head of Midwifery and routinely report levels of compliance and any risks/associated mitigation to the monthly executive led maternity oversight meeting	SK	25/6/2018	31/7/2018	**Closed**		In place but monitoring to continue therefore will remain open until assured of compliance. Any issues will be reported at the Be The Best Board.	Notes of meetings

	Objective	5	To ensure all staff are engaged and participate in all steps of the World Health Organisation' (WHO) surgical safety checklist, and that this is consistently utilised.

	No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
Maternity	5.1	To undertake an assessment of safer surgery steps compliance including staff engagement and understanding of any barriers to its completion through direct observation.	NC CD	25/6/2018	30/9/2018	**Closed**		Weekly audit of 10 cases commenced. Observational work undertaken in partnership with anaesthetics	Observational assessment report
	5.2	To improve debrief in theatres by developing a glitch book and associated action log	SR	25/6/2018	31/8/2018	**Closed**		During 'work as one week' from 13 August a glitch book will be trialled, no glitches reported as of 28.8.18. However, staff are able to report previously glitches as examples of what would be recorded where appropriate. 30/08/18. Glitches books in situ in both theatres and are now in use.	Glitch book and utilisation
	5.3	To deliver scenario based education to the multidisciplinary team using specialty clinical governance sessions	DH	25/6/2018	31/12/2018	**Open**		Education plan being devised to be delivered across work as one fortnight, this included posters and information to highlight the importance of the WHO checklist.	Content of scenario based education Evaluation of intervention Attendance at intervention
	5.4	To deliver education on the five steps to safer surgery for Obstetric staff and also include within PROMPT training to include the multidisciplinary team	DH NC	25/6/2018	31/12/2018	**Open**		As above and the PROMPT training will be revised from Oct 18 to include information on WHO checklist.	Content of training Evaluation of training Attendance at training
	5.5	To ensure that the Trust has confidence that obstetric theatres have fully implemented the five steps to safer surgery through a detailed assurance review using ProgRESS methodology	TC	25/6/2018	31/12/2018	**Open**			ProgRESS report
	5.6	To ensure all new starters working within theatres are educated on the five steps to safer surgery and the trusts guidance and procedure by adding expectations into theatre induction and junior doctor induction into the service	CD NC	25/6/2018	31/12/2018	**Open**		Induction package will include WHO education and will be used for rotational staff moving to Labour Ward.	Induction programme Induction evaluation
	5.7	To implement a programme of senior divisional clinical and managerial leadership through walkarounds focussed on the five steps to safer surgery	JW SK	25/6/2018	31/7/2018	**Closed**		Full programme to be agreed, first walk around planned for 30.8.18 ongoing programme to be developed.	Report from walkarounds Divisional Governance minutes
	5.8	To participate fully in the Trust wide safer procedures collaborative to ensure that use of NatSSIP guidance is optimised within the Service	NC CD	25/6/2018	31/12/2018	**Open**		A safer procedure document for fetal blood sampling has been devised; this needs Directorate approval via the governance meeting and will then be implemented.	Collaborative attendance Implementation of Natssips
	5.9	To develop an audit programme designed to assure weekly compliance with the WHO surgical safety checklist and routinely report levels of compliance and any risks/associated mitigation to the monthly executive led maternity oversight meeting	JW SK	25/6/2018	20/7/2018	**Closed**		Weekly audit of 10 cases commenced, 1.8.18 achieved 100%	Notes of meetings