The Leeds Teaching Hospitals NHS
NHS Trust

ACTION PLAN - CQC INSPECTION (March 2014) v3.0 17 11 14

Recommendation	Regulation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date	Future monitoring and assurance
		QC	WC	RC						
Actions that MUST be taken to improve quality and safety										
1. Staffing										
1.1 Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical elderly care wards children's wards and surgical wards, including anaesthetist availability and medical cover out of hours and weekends.	**Regulation 22**		✓		**Chief Nurse** **Chief Medical Officer**	**Jill Asbury/ Graham Johnson**	Investment in nurse staffing approved by Trust Board; included on Corporate Risk Register with summary of controls and mitigating actions. 496 Registered nurses in pipeline (June 2014), assurance provided to Workforce Committee 19 June 2014. Report to Board provided in line with Hard Truths (January 2014). Bi-monthly Board report on nurse staffing Bi-monthly progress reports on medical staffing at Workforce Committee	Comprehensive review of medical staff cover including consultant staff presence and out-of-hours began in April 2014, reporting to Workforce Committee. Specific improvements to be implemented in (i) elderly care - improved RMO cover (nights/weekend) to start October 2014 (ii) Hospital at Night programme in children's services to be implemented (iii) Surgical ward cover to be enhanced by use of ANPs from October 2014 (iv) detailed work programme has commenced in relation to 7 day working across the Trust to be completed by 1st April 2015.	31 Oct 2014 31 Mar 2015	**Initial review completed.** Report on nurse staffing to be provided to Trust Board (bi-monthly) in line with recommendations in Hard Truths report. Specific risks re nurse staffing to be reviewed and discussed at Risk Management Committee and at performance review meetings with CSUs. Medical cover (7 day working) programme to be delivered by established group, overseen by Medical Directorate. Medical staffing assurance report to be provided to Workforce Committee.
1.2 Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.			✓		**Chief Nurse**	**Jill Asbury**	Refer to above (1.1). Review of skill-mix and acuity undertaken October 2013. Care of deteriorating patient identified as priority QI goal, supported by Haelo and Improvement Academy.2013	Skill-mix to be reviewed again in Q3 2014/15.	31 December 2014	**Completed.** Report on skill-mix review went to Trust Board (Jan 2014); further review to be undertaken in Q3. Report to Trust Board. Quality Improvement programme established, focusing on care of deteriorating patient and interventions/escalation. Overseen by Faculty, supported by Haelo, progress reports to be provided to Quality Committee.
1.3 Review the arrangements over the oversight of L39 High Dependency Unit at Leeds General Infirmary to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.	**Regulation 10**			✓	**Chief Medical Officer**	**David Berridge**	Review of medical cover completed and confirmed by Trauma and Orthopaedics CSU, focusing on supervision of junior doctors on the ward.	Joint review of medical cover arrangements with Critical Care CSU to be undertaken	30 September 2014	**Completed.** Medical Director (Operations) co-ordinating review with critical care and trauma. Joint meeting held 4/814 and action plan produced by CSU. Progress report provided to Risk Management Committee and Quality Committee. Incorporated into Trust HDU improvement plan.
2. Training										
2.1 Ensure that staff attend and complete mandatory training, particularly for safeguarding and maintaining their clinical skills.	**Regulation 23**		✓		**Director of HR**	**Karen Vella**	Plan for the provision of mandatory training in place, includes monthly report to managers to monitor uptake and compliance. Built into staff appraisal process and included in documentation for sign off. Safeguarding Training Officer appointed to increase capacity for Level 1 and 2 training. Plan agreed for delivery in conjunction with Organisational Learning.	Mandatory training to be fully integrated into performance management framework. Training at 31 October 2014 (safeguarding) *Safeguarding L1: 92% Safeguarding Adults L2: 76% Safeguarding Children L2: 62%	30 September 2014	**Review completed and incorporated into performance review process.** Progress to be reported at Workforce Committee and Executive Management Committee. Specific risk areas reviewed at Risk Management Committee. Report provided for each CSU to monitor progress. Mandatory Training 90% 31 10 14,

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2.2 Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.	**Regulation 9**			✓	**Chief Medical Officer**	**Hamish McLure**	Review undertaken by Theatres and Anaesthetics CSU	Finalise plan, including development of assistant practitioners (anaesthetics), resident consultant job plans	30 September 2014	**Completed:** Resident Consultant Anaesthetist in place (from April 2014) providing increased support and supervision out of hours. Progress to be overseen by Medical Directorate through Deanery trainee improvement plan; report to Workforce Committee
2.3 Ensure that doctors are able to attend teaching sessions and this includes specialist medication regimes and other clinical areas they cover for including children's services			✓		**Chief Medical Officer**	**Bryan Gill**	Training programmes in place for junior doctors; trainees linked to designated consultant in theatres to provide supervision and support	Comprehensive review of training records of junior doctor attendance at training sessions to be undertaken by Post Graduate Medical Education, Review of Deanery QM visit (March 2014) to be undertaken and establish Task & Finish Group to review recommendations	31 August 2014	**Completed:** reviewed by Medical Directorate and CD forum. Deanery re-visit July 2014 - report received; task & finish group established and action plan developed. Progress to be overseen by Medical Directorate through Deanery trainee improvement plan; report to Workforce Committee
3. Risk and Safety										
3.1 Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and *appropriate* recording practices.	**Regulation 9**			✓	**Chief Nurse**	**Jackie Whittle**	Process in place for risk assessment relating to tissue viability and hydration and incorporated into care planning documentation. Training programme and risk assessment process refreshed by tissue viability. Monitored monthly in ward healthcheck	Further tissue viability training to be provided June/July 2014. Audit of compliance to be undertaken to provide assurance	30 September 2014	**Review completed:** Tissue viability actions in place, education ongoing and assessment process clear. Nursing specialist assessment and metrics reviewed to include specific link to hydration. Progress to be monitored through Clinical Effectiveness and Outcomes Sub-Committee, including results of audits undertaken.
3.2 Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.	**Regulation 10**	✓			**Chief Medical Officer**	**Craig Brigg**	Process in place, incorporating web-based incident reporting (datix-web), implemented July 2013. Staff supported to report incidents by risk management team, training provided. Quality and safety briefings issued fortnightly to raise awareness of serious incidents and highlight actions staff need to take to reduce risks. Discussed at weekly quality review meeting with Chief Nurse and CMO	Sharing learning Task & Finish group to complete programme of work and issue guidance to staff. Recruit and appoint 4 Patient Safety and Quality Managers to support CSUs in safety, risk and governance	30 September 2014	**Completed:** Sharing learning Task & Finish group progressed; methods for sharing learning identified. Patient Safety and Quality Managers appointed (3) to support CSUs in sharing learning (4th to be appointed in November 2014). Progress on sharing learning to be reported to Quality Committee.
4. Governance										
4.1 Review the clinical audit and auditing of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.	**Regulation 10**	✓			**Chief Medical Officer**	**Julia Roper**	Clinical audit programme in place and integrated into CSU governance arrangements; compliance reported to Clinical Effectiveness and Outcomes Sub-Committee and Quality Committee. Internal Audit review undertaken (July 2014)	Learning from audit to be further embedded in CSU governance. Review process for auditing national best practice and local guidelines.	30 September 2014	**Review completed:** Importance of sharing learning from audit was reinforced by Clinical Audit Forum, September 2014. Process for auditing national best practice and local guidelines to be included in way forward agreed with CD forum (see 4.2 below), and will form part of the collaborative audit improvement programme. This will form a key part of the collaborative audit improvement programme to be launched in December 2014. Progress will be overseen by the Clinical Audit Forum, and reported to the Clinical Effectiveness and Outcomes Sub-Committee.

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4.2 Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.	**Regulation 10**	✓			**Chief Nurse**	**Julia Roper**	Policy Task & Finish Group established 2013, leading on programme of work to review process for the development and approval of Trust policies. CSUs have received guidance on implementation of Trust Policies/Procedures and associated governance, dated May 2013. Specific risk policy reviews included in Trust internal audit programme	Guidance to be issued to CSUs to clarify the process for implementation and audit of Trust-wide and local policy/procedure/guidance.	30 September 2014	**Review Completed:** Guidelines Group has considered the gaps in existing guidance. Way forward to be agreed at CD Forum, and further guidance issued. Policy Task & Finish Group completed review of policy/procedure process. Report to Quality Committee, November 2014. Progress to be monitored through Quality Committee.
4.3 Ensure that there is a coherent and clear auditing system in place for the participation of national clinical audits and auditing of trust guidelines and that there is an appropriate recording system in place to capture this. Review the involvement of junior doctors in the audit process		✓			**Chief Medical Officer**	**Julia Roper**	Annual clinical process in place, reporting to Clinical Effectiveness and Outcomes Sub-Committee. Clinical Guidelines group has an established process for reviewing and updating guidelines.	Review and communicate the process for participation in national audit and the mechanism for capturing and sharing learning. Review the involvement of junior doctors in clinical audit and develop a plan to ensure greater engagement.	30 September 2014	**Review Completed:** Discussed at Clinical Audit Forum and with Informatics. Will be progressed as part of the collaborative audit improvement programme to be launched in December 2014. Progress will be overseen by the Clinical Audit Forum, and reported to the Clinical Effectiveness and Outcomes Sub-Committee. Discussed at Clinical Audit Forum in September. Views of junior doctors and specialty leads surveyed. Involvement of junior doctors will form part of the collaborative improvement programme and be supported by 4 junior doctor leadership fellows.
5. Communication										
5.1 Review the nursing and medical handover to ensure that the appropriate information is passed to the next shift of staff and recorded.	**Regulation 9**	✓			**Chief Nurse/ Chief Medical Officer**	**Jackie Whittle/ Graham Johnson**	Handover procedure revised and updated 2013, utilising S-BAR communication tool. Incidents relating to handover reviewed; learning shared through Quality and Safety briefing.	Handover to be integrated into annual audit programme, for assurance	30 September 2014	**Completed:** Audit tool based on the transfer policy developed, led by corporate nursing team. Progress to be monitored through Clinical Effectiveness and Outcomes Sub-Committee, including results of audits undertaken.
5.2 Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.	**Regulation 9**	✓			**Chief Nurse**	**Dawn Marshall**	Transfer procedure revised and updated. Performance information produced by CSU relating to time patients have waited on a trolley for a bed. Escalation process in place.	To be incorporated into CSU performance management process; risk assessment process to be established and communicated to staff	30 September 2014	**Completed:** Monthly report provided to the CSU and reviewed at the operational and governance meeting. Escalation process agreed with CSUs, to be consistently applied out of hours/weekends.
6. Human Resources										
6.1 Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.	**Regulation 23**		✓		**Director of HR**	**Karen Vella**	Annual appraisal process revised - agreed period for all appraisals to be completed April-June, linked to pay progression. Chief Nurse led session on completion of appraisal with senior staff, supported by HR. Performance reports produced by CSU and corporate service to monitor compliance.	Chief executive to issue communication on appraisal process and time scales for completion (Sept 2014). To be incorporated into performance management process	30 September 2014	**Completed:** Communication from CEO issued July 2014; Chief Nurse led session on appraisal with HR, July 2014. Appraisal completion rate at 31 October 2014: Medical appraisal 92.6% Non-Medical appraisal 95% Progress to be monitored through reports to Workforce Committee, exceptions to be reported to Risk Management Committee.
7. Mental Health										

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7.1 Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff are clear about the Mental Capacity Act and implement and record this appropriately.	**Regulation 18**	✓			**Chief Nurse**	**Jeffrey Barlow**	Procedures relating to MHA and MCA circulated to all staff; training provided to direct staff to these procedures.	Further communications and education, including Quality and Safety briefing to be issued. Audit process to be reviewed and established.	31 August 2014	**Completed:** Training provided in conjunction with Health & Social Care providers; Quality and Safety briefing issued September 2014; audit tool produced. Progress to be monitored by Risk & safety Sub-Committee, reporting to Quality Committee.
7.2 Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.		✓			**Chief Nurse**	**Jeffrey Barlow**	Procedures relating to Deprivation of Liberty Safeguards circulated to all staff; training provided to direct staff to these procedures.	Further communications and education, including Quality and Safety briefing to be issued. Audit process to be reviewed and established.	30 September 2014	**Completed:** Training provided in conjunction with Health & Social Care providers; Quality and Safety briefing issued September 2014; audit tool produced. Progress to be monitored by Risk & safety Sub-Committee, reporting to Quality Committee.
8. Equipment										
8.1 Introduce a rolling programme to update and replace ageing equipment particularly on the critical care units.	**Regulation 10**			✓	**Director of Estates and Facilities**	**Darryn Kerr**	Capital programme for 2014/15 reviewed in conjunction with CSUs and corporate team.	Undertake a review of priority equipment requirements against Trust capital programme. Liaise with CCG/TDA where up-front investment may be required to support this. Investment support agreed with TDA.	31 August 2014	**Completed:** Capital programme (equipment) review undertaken, including investment in critical care; reviewed at Risk Management Committee, September and October 2014. Progress to be monitored and overseen by Trust capital programme group, reporting to Trust Board.

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