Appendix 1: Action Plan for all outcomes (Amber and Red Risks)

Monitoring Group	Outcome Prompt	RAG rating	Action Required	Responsibility of	Completion Date	Progress Status	Progress Comments
Patient Experience Group CQC Steering Group	1A	Amber	**The full CQC action plan from the June 2013 inspection addresses concerns raised around meeting patient's privacy and dignity needs.** Amend the comfort round form to have a separate statement to record the nurse has checked call bells are in reach. Check call bells are accessible as part of CQC mock inspection. Plan a dignity day. Also consider showing a privacy and dignity DVD at induction / open staff meeting. Review the work plan of the Privacy and Dignity Group to ensure it reflects findings from the CQC report.	Mary Lewis (Associate Director of Nursing, Quality and Patient Safety) Julie Stone (Matron) Anne Plaskitt (Senior Nurse, Quality Improvement) Rob Eliot (Lead for Quality Assurance)	31 October 2013	Blue	Actions complete and reported to Quality Board in October 2013. A fundamentals of care day will also be held in November 2013 on the 6C's (Care, Compassion, Competence, Communication, Courage, Commitment) which will also include a focus on nutrition and hydration, privacy and dignity, pressure ulcers and safeguarding.
CQC Steering Group	4A, 21A	Amber	**The full CQC action plan from the June 2013 inspection addresses concerns raised around patient assessments and documentation.** Further guidance has been provided to staff on how they can access Millennium and an overview of nursing documentation requirements including timescales for assessments. Hourly briefing sessions will also be held with a senior sister responsible for each ward regarding the use of Millennium for recording patient assessments and as a	Anne Plaskitt (Senior Nurse, Quality Improvement) Rob Eliot (Lead for Quality Assurance)	30 November 2013	Amber	Results from the ward audit results show improvements in the completion of nursing documentation but further improvement is still required. Audit results continue to be undertaken on a weekly basis and presented at the CQC Steering Group, Professional Nurse Forum and Senior Nurses

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			management tool for overseeing compliance with key assessments. These are scheduled to be complete by mid November 2013. The filing and storage of records has been reviewed. New nursing files are being introduced which include a standardised index of documentation. New bed boards are also being launched during November 2013 which allows staff to highlight key patient requirements such as patients at risk of falls, pressure ulcers and patients requiring assistance to eat and drink. Completion of key documentation including Millennium assessments and the assessment of patients' care needs, are audited on a weekly basis by the wards and matrons and results monitored through the CQC Steering Group and at other forums for senior nursing staff with the Director of Nursing. In addition to this, compliance with ensuring patients have a fluid or hydration chart, and comfort round forms are monitored by the Senior Nurse for Quality Improvement on a fortnightly basis and timely completion of assessments on Millennium are also reviewed at least monthly.				meetings. Results from the audits carried out by the Senior Nurse for Quality Improvement in October 2013 also show improvements in the completion of nursing documentation. *N.B. The progress has been RAG rated as 'Amber' to reflect the continuing focus on documentation and further improvements that are required.*
CQC Steering Group Divisional Clinical Governance Meetings	4B	Amber	**The full CQC action plan from the June 2013 inspection addresses concerns raised around governance.** A formal template has been developed for governance meetings and for team meetings that will include reporting on clinical incidents and lessons learned. It will be rolled out across	Jo Miller, Assistant Director of Nursing, Medicine Sharon Bonson, Assistant Director of Nursing, Surgery	30 November 2013	Green	In progress.

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			the Trust at a specialty, ward and departmental level from 28 October 2013 by the Heads of Divisions.				
CQC Steering Group	4C	Amber	Audit completion of the discharge checklist on a weekly basis	Matrons	Ongoing	Green	Improved completion of the discharge checklist was noted at the CQC Steering Group on 25 October 2013.
Privacy and Dignity Group	4F	Amber	Continue to monitor compliance through the same sex accommodation task force. Two of the surgical wards have been made into single gender wards to address patient perception of being cared for in single sex accommodation. These patients were previously cared for in single gender bays.	Sharon Bonson, Assistant Director of Nursing, Surgery	Ongoing	Green	
Nutrition and Hydration Steering Group	5A	Amber	**The full CQC action plan from the June 2013 inspection addresses concerns raised around nutrition and hydration.** Agree work plan and membership of the Nutrition and Hydration Steering Group. This will include a review of training (including MUST) and standards / performance data around nutritional assessments and meal times. Meal time observations to also be carried out. Nutrition week / fundamentals of care week to be arranged – event to be held on 12 November 2013. Monitor compliance with the Nutrition Support Record through the Nutrition and Hydration	Mandy Rumble (Matron)	30 November 2013	Green	A progress report was discussed at length at the CQC Steering Group on 25 October and it was agreed that the Nutrition and Hydration Steering Group should meet fortnightly to move the CQC actions forward with the next meeting to take place on 6 November 2013. Rob Eliot has met with Mandy Rumble and revised the Nutrition Group work plan. This will be discussed at the next nutrition group and meal time observation audits

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			Steering Group. Refinement to fluid balance chart (last updated 2008) and hydration chart to add in guidance about its use Compliance with ensuring every patient has a fluid or hydration chart and comfort round forms to be monitored by Anne Plaskitt on a 2 weekly basis (to be agreed at Steering Group).				planned. The nutrition and hydration policy also needs to be agreed.
Safeguarding Adults Forum	7E	Amber	There is a training action plan for Safeguarding Adults. Training attendance is reviewed at the Safeguarding Adults Forum.	Jane Davies (Senior Nurse for Quality Improvement & Adults at Risk)	Ongoing	Amber	The RUH has training targets for the CCGs for safeguarding adults. The RUH remains below the target.
Safeguarding Adults Forum CQC Steering Group	7H	Amber	The CQC identified in the June 2013 inspection to the Trust that there was not always documented evidence in place for patients where the 'Safe Wandering Technology' was used. An action plan has been put in place to address these findings	Jane Davies (Senior Nurse for Quality Improvement & Adults at Risk) Sue Leathers, Matron	Ongoing	Green	This has included the launch of the new 'Safe Wandering Technology Policy' and revised documentation and checking. Additional training is also being provided to increase staff awareness of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA).
Safeguarding Adults Forum	7P	Amber	Develop Rapid Tranquilisation flow chart, using NICE guidance – raise who will take this forward at the Safeguarding Adults Forum	Jane Davies (Senior Nurse for Quality Improvement &	31 December 2013	Green	

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				Adults at Risk)			
Medical Equipment Committee (MEC)	11D	Amber	The POCT (Point of Care Test) committee is currently a sub-committee of the MEC. The CPA (Clinical Pathology Accreditation) has recommended that they report directly to the Board. This is unlikely to be approved with the current Trust governance structure. The Consultant Biochemist who chairs the POCT committee has had discussions with the Associate Medical Director for Quality Improvement. It is proposed that governance reporting from POCT will be direct to Operation Governance Committee. The CPA also identified that some staff were inappropriately using Blood Gas Analysers without proper authorisation or training. The POCT sub-committee chair has been invited to attend the MEC so that the details can be discussed at a higher level.	David Hyde (Electromedical Equipment Manager)	30 April 2013	Green	
Medical Equipment Committee (MEC)	11F	Amber	The audit of ward competency folders showed 36% compliance with the requirement for recording staff member's competence in the use of their ward equipment. The reasons for such a low compliance have been recorded as including: • Lack of time to conduct competence assessments • Lack of time to gather and record results	David Hyde (Electromedical Equipment Manager)	30 April 2013	Green	Development of the database has begun, but is currently on hold due to a vacancy. A replacement developer will start in December, and the first prototype has been scheduled for late January 2014 (Reference Chris Ruddick, Deputy CRS Manager).

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			• Inconvenient nature of the paper format of record • Low motivation of ward managers to manage staff member's competence status • Low motivation of staff members • Lack of centralised training and assessment availability. One action is to draw up a proposal for an improved model for medical equipment training (and by implication assessment) for the RUH. The Medical Equipment Specialist Nurse (MESN) has started work on this. An action previously identified was the lack of a central electronic database of staff competence for medical equipment, including POCT equipment. Such a system would allow closer monitoring of recording, which would in turn allow more rapid feedback and encourage compliance with requirements. It would also allow planning for training needs, which would in turn increase motivation towards compliance. The Information Services Department have committed to development of a central database. A specification has been submitted by the Clinical Engineering Department. The project will be sponsored by the Head of Clinical Engineering.				Once staff are trained in the use of the system, and records are updated then it will be possible to closely monitor compliance with the requirement to be trained and competent to use POCT and medical equipment. A basic measure will be the percentage of recorded competence against staff and equipment numbers. Managers and staff will be expected to utilise the system as part of annual appraisal.
CQC Steering	16A	Amber	**The full CQC action plan from the June**	Jo Miller, Assistant	31	Green	In progress.

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Group			**2013 inspection addresses concerns raised around governance. These are also covered in the Quality Governance Framework action plan.** A formal template has been developed for governance meetings and for team meetings that will include reporting on clinical incidents and lessons learned. It will be rolled out across the Trust at a specialty, ward and departmental level from 28 October 2013 by the Heads of Divisions. Funding has been released from October 2013 for ward sisters to have more time to work in a clinical leadership supervisory capacity which will allow greater monitoring of patient care. Revised Job Description are being developed for Ward Senior Sisters and Charge Nurses clearly stating their responsibility and accountability for standards of nursing care and leading on quality improvement. From November 2013, senior nurse unannounced visits will take place out of hours to check on nursing standards. Any issues of concern or poor performance will be discussed promptly and directly with the Director of Nursing. Ward scorecards will be launched from December 2013 aligned to the new CQC domains (Safe, Effective, Caring, Responsive, Well Led). These will include documentation	Director of Nursing, Medicine Sharon Bonson, Assistant Director of Nursing, Surgery	December 2013		

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			audit results and these scorecards will be accessible to all staff. Success measures (Key Performance Indicators) identified from the Ward level scorecard will form part of the job description for ward senior sisters and charge nurses, outlining expectations of the role and enabling performance to be measured. The Matrons and Assistant Director of Nursing will closely monitor ward level scorecards. Matrons will meet with Senior Sisters/Charge Nurses monthly to identify issues and where improvements need to be made and this will form part of their 'Ward to Board' quarterly reports and will also be monitored and discussed at the Trust's Senior Nurses Forum chaired by the Director of Nursing.				
	17A	Amber	Improvement in the timescales for complex complaint responses. Providing evidence that actions identified in each complaint are completed. Improving the service to be more responsive and available need to be considered to align with Patient Association recommendations and Friends and Family Programme. Greater access to the Datix system to ensure accurate efficient reporting to allow greater control of the Complaints process by Divisional and senior managers as well as the Complaints Team.	Sue Griffin, Patient Experience Manager	31 January 2014	Green	The timescales for complex responses will be reduced by the greater use of the Datix database and exception reporting. A greater use of the Datix system and its reporting function will allow exception reporting to be generated for the divisions which will highlight incomplete actions. This will be monitored by the Complaints Team. An external review of the complaint process starts

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							on 05/11/13 that will consider if restructuring of the current service is required to ensure that a gold star service can be delivered. The Trust was focussed and had made changes to achieve the NHSLA level 2. Progress on this activity will also be considered. Recent recommendation both from the Patient Association and the Clwyd report (October 2013) will drive the changes. This is being delivered by the Qulturum Team supported by the Director of Nursing. The number of licenses available for using the Datix system is to be reviewed as well as considering if the alternative platform for the database needs to move from client to web based is in progress. This is being considered by the Risk Team and the Qulturum

RAG Rating	
Yellow	Evidence available at the time of assessment shows that the outcome is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Impact on people who use services, visitors or staff is low. Action required is minimal
Amber	Evidence available at the time of assessment shows that the outcome is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Impact on people who use services, visitors or staff is medium. Action required is moderate
Red	Evidence available at the time shows that the outcome is at risk of not being met or there is no available evidence that the outcome is met. Impact on people who use services, visitors or staff is high/significant. Action is required quickly

Progress Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Completed