WORK PLAN re CQC NoP and NoD

(Visit September 2021 – incorporates CQC Action Plan – May 2021)

ISSUE	REQUIRED ACTIONS IDENTIFIED	RESPONSIBILITY	EVIDENCE (TO BE PROVIDED BY BHC)	PROGRESS UPDATE	TIMESCALE
1) Did not provide Statutory Training in key skills to all staff.	1.1 Statutory and Essential Training must be clearly defined.	HR Manager	Training Matrix in place that clearly identifies essential training for each clinical role.	Essential training confirmed and agreed for Childrens, Family Support and Palliative Home Care Team. Adults to reflect future EoL requirement.	28/2/22
	1.2 BHC must ensure that it can evidence promptly that staff have the qualifications, competence, skills, and experience required to provide care.	HR Manager	Certificates for training available for checking. BHC provide a compliance with training rate to all service leads at the end of every month.	Training Matrix completed detailing Statutory and essential training. Matrix requires certificates to be appended to record evidence date of completion of training.	28/2/22
	1.3 Must ensure that all staff receive safeguarding training for adults and children at the appropriate level – and in line with intercollegiate guidance.	HR Manager DofC			
	1.4 Must ensure that there is a robust process in place that maintains accurate and up-to-date oversight of regular training.	HR Manager	Training Matrix provides evidence that staff have received safeguarding training at the required level.	Regular monthly reports to Senior Leadership team, Quality Safety & Risk Committee, Business Committee, and Management Group.	14/01/22
	1.5 Trustees must complete all required training.	CEO	Training Matrix includes evidence of the training required by Trustees and their completion rate.	BLS training outstanding. A provider has been identified. Staff to do Resus training on ELFH in advance of formal training. Safeguarding training above 90% for Clinical staff and Trustees. Four Domestic staff	28/02/22

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				to receive Level One training in Feb22. Management team can now view training spreadsheets. Certificates now checked and linked to training spreadsheet.	28/2/22
2) Managers did not monitor statutory and Essential Training to ensure all staff completed it.	2.1 Managers must review statutory compliance weekly and follow up staff that are due / overdue to complete training. 2.2 Similar action must be taken with regards to Essential Training. 2.3 There must be a training certificate on file for all training attended. Training certificates must be stored in the correct files. 2.4 Training certificate dates and dates on the training log must be the same. 2.5 Performance monitoring and risk assessment must be completed for staff who have not undertaken all the required training.	Mgmt Team Mgmt Team HR Manager HR Manager HR Manager Mgmt Team	In addition to the above. Managers will have access to the Training Matrix (read only). Managers will report % completion as part of their monthly reporting. Managers will put a remedial plan in place for staff who have not completed all required training within the required timescale. Timescale to be developed and implemented.	Managers to access the Training Matrix weekly to identify any training due. To confirm completion of training certificates are provided to HR. Certificates provided to HR to confirm completion of training. These are then scanned and linked to the individuals training record.	28/2/22
3) Safety incidents not managed.	3.1 Must ensure that incidents (inc meds events) are reported accurately and in a timely manner.	Mgmt Team	KPIs for reporting and investigating must be adhered to.	Incident reports are reviewed weekly.	31/1/22

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	3.2 All parts of the incident form must be completed. 3.3 Incidents must be investigated correctly. 3.4 Incident action plan must be completed. Incident lessons learned form must be completed. Actions and learning is embedded to prevent similar incidents occurring. 3.5 Incident log must be kept up to date. 3.6 Incident log must be reviewed as part of the monthly Integrated Governance Meeting.	Comp Manager Mgmt Team Mgmt Team DofC DofC Mgmt Team Comp Manager Comp Manager Comp Manager	Audit will confirm that all parts of the incident form (that are required) are completed – or action taken to address. The incident log is reviewed weekly and updated with progress – or remedial actions required. Evidence that no incidents are closed without lessons learned. These are shared with staff. Trends are identified and discussed at IGM. Evidence in meeting minutes.	Staff have received and signed to state that they understand the Incident Policies and Incident Procedures. They are also encouraged to report. Incident reports are sent to the Clinical Manager on call. Monthly summary of incidents including lessons learned is shared at Integrated Governance Group and cascaded to Senior Level Team, Quality, Safety & Risk Committee, Business Committee and Management Group. Incident training scheduled for 15th and 24th February to be attended by Clinical staff and Management Team.	24/01/22
4) Lessons not learned or shared from incidents.	4.1 Incidents must be investigated correctly. 4.2 Actions and learning is embedded to prevent similar incidents occurring. 4.3 Learning must be cascaded across all areas.	DofC Comp Manager DofC Mgmt Team DofC Mgmt Team Clinical Lead	Evidence that incidents are investigated correctly. No incidents are closed without lessons learned. These are shared with staff.	Lessons learned are discussed at the Information Governance meeting. These are monitored by Compliance Manager and DofC. Lessons learned are shared with Service Leads through Management Group to discuss with staff as they occur.	31/1/22

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				Childrens unit has "You said, we did" board that displays incidents and learning. This is updated monthly. Reporting process supported by generic leaning shared through the Information Exchange discussions.	
5) Did not collect safety information and use it to improve the service.	5.1 Incidents must be investigated correctly. 5.2 Actions and learning is embedded to prevent similar incidents occurring.	DofC Comp Manager DofC Mgmt Team	As previous.	Any recurring themes are identified as part of the Integrated Governance Meeting, and the service requested to provide a plan to address. This is to be monitored until complete. Incidents are discussed at the weekly review and Information Governance meeting. Lessons cascaded through minutes and reports. Lessons learned are shared with Service Leads through Management Group. Incident training scheduled for 15th and 24th February to be attended by Clinical staff and Management Team.	31/1/22

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6) No robust oversight of patient outcome monitoring. Findings not used to make improvements and achieve good outcomes for patients.	6.1 Each service must assess, monitor, and improve the quality and safety of the services provided – including the quality of the experience. 6.2 Use of outcome tools must be developed and implemented. 6.3 Use of benchmarking must be developed and implemented.	DofC Mgmt Team DofC Mgmt Team DofC Mgmt Team	There is evidence that each service monitors the quality of the service – including the quality of the experience.	Friends and Family Test has been restarted. Childrens Evaluation Surveys are completed and discharged. Outcome tools for Childrens Services have been piloted and rolled out. Outcome for parents and siblings need to be displayed on the unit. Part of the North East Hospice Networking Group which includes benchmarking.	28/2/22 31/12/21 31/01/22
7) Leaders did not have the capacity, skills, and abilities to run the service. There was sustained absence across the senior leadership team.	7.1 A detailed plan should be in place to cover for leadership absence. 7.2 Explore support from consultant (TW). 7.3 Review leaders skills and abilities.	CEO DofC CEO DofC		Skills audit of Trustees and Managers to be undertaken to identify gaps. Procedure outlining deputising roles (and responsibilities) within each area drafted. On-call rotas (Clinical & Non-Clinical) are available to staff. Appraisals and one to one meetings highlight skills, capacity and ability issues and support provided through PDP and training where required.	28/2/22 31/1/22

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				Overall managers skills, capacity & ability assurance is monitored through content of monthly managers reports.	
8) There remained confusion between senior leaders regarding their roles and accountabilities.	8.1 Senior leaders within the service should be given clear, defined roles and responsibilities that support delivery of the service. 8.2 Detailed, formalised arrangements should be in place to cover for leadership absence.	CEO CEO DofC		Deputising arrangements formalised. Skills audit to be completed in February 22. " Meet the Team" board under development.	31/1/22 28/2/22
9) Systems were not used to manage performance effectively.	9.1Governance processes must be robust. 9.2 Risks must be identified, and actions taken to reduce their impact.	Trustees CEO / SLT Comp Manager Mgmt Team		Risk Register reviewed and updated monthly and shared with teams. Clinical In Patient unit displays top three risks. Reporting structure in place with regular monthly reports	28/2/22
10) Relevant risks were not always identified and escalated – and actions identified to reduce their impact.	10.1 Risks relating to the health, safety, and welfare of patients, and others who may be at risk, must be assessed, monitored, and mitigated.	DofC Mgmt Team Comp Manager	Risk Assessments are robust and in place. There is evidence that R/As are reviewed annually.	Current Risk Assessments have been identified. Risk Assessment log being finalised. Annual review to take place.	31/12/21 28/2/22
11) Gaps in documentation were evident.	11.1 Documentation audits must be completed monthly and actions taken to address deficits.	DofC Clinical Lead Mgmt Team	Monthly audits will identify any issues and that action plans have been developed,	Monthly documentation/ record keeping audits are being completed. Action plans	31/1/22

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	11.2 Risk assessments – for example, MUST – should be completed.	DofC Clinical Lead Mgmt Team	and monitored until complete.	are developed and monitored until they are complete. Audits to continue and actions to be monitored until completed by Service Leads.	
12) No evidence of DBS and there was the potential for staff to have unsupervised access with vulnerable adults and children.	12.1 Review DBS checklist. 12.2 Review DBS Policy. 12.3 Review all staff against DBS checklist to ensure that all required staff have a current DBS – and identify and document staff who do not require a DBS.	SLT HR Manager HR Manager	Monthly report will evidence that compliance rate is 100%.	DBS Policy revised and ratified this includes Reception staff. Reminders are sent to staff three months ahead. DBS monitored monthly as part of reporting process. Staff will be transferred to DBS update service for annual checks.	31/12/21 31/1/22 31/01/22
13) Patient choice with regards to administration of medicines was not recorded – and the policy did not reflect this.	13.1 Review Medication Policy. 13.2 Review Medication Procedures. 13.3 Patient choice with regards to administration of medicines must be recorded.	DofC Clinical Lead H/Physicians ANP	Medication policies and procedures have been reviewed. Audit confirms that a medication care plan is in place for all patients.	Controlled Drug Procedure drafted. End of Life project will incorporate full policy review for Adult services. Childrens service procedures embedded in care delivery.	31/3/22
14) Systems and processes were not used to safely monitor and record medication – particularly with regards to those taken PRN.	14.1 There must be a comprehensive medication care plan in place for all patients.	Clinical Lead RNs Clinical Lead RNs	Audit confirms that a medication care plan is in place for all patients. Audit confirms that PRN protocols are detailed.	Childrens medication care plans embedded. Adult services to be reviewed as part of End of Life plan.	4/2/22 1/6/22

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	14.2 PRN protocols must be detailed to support staff in the safe administration of medicines.				31/01/22
15) The plan for recommencing EoL services comprised of a list of actions for the service but was not measurable, and lacked an underpinning strategy and aim.	15.1 Meet with Christina Thompson NT&H FT. 15.2 Develop and implement project plan with clear actions and milestones.	CEO DofC CEO DofC CT	The project plan will detail the required actions and whether milestones/targets are being met.	PID developed. Weekly meeting take place. linking with Tees Valley Palliative End of Life Exemplar project to identify appropriate service model.	7/1/22 17/12/21 1/3/22
16) EHCP had a different dose for epilepsy management to protocol. These discrepancies had not been identified within the internal audit or the external pharmacy audit or the care plan audit.	16.1 Audit tools to be reviewed to ensure that they identify issues, so that they can be addressed and resolved. 16.2 If issues are unable to be resolved, these must be escalated, and reported as an incident.	DofC Clinical Lead H/Physicians ANP Clinical Lead RNs H/Physicians ANP	Evidence that staff escalate any issues that they are unable to resolve. Audit tool will identify any issue.	Discussed with staff that they must escalate any issues that they are unable to resolve – that we must be able to evidence that we have done everything possible. A statement is included in transcribing procedures as to what to do if there are exceptions to EHCP (i.e. difference in medication dosage). An Emergency Healthcare Plan Procedure has been written and is awaiting ratification.	31/1/22
17) Potential for 3 CQC action plans to be running concurrently: May Action Plan NoP/NoD Action Plan	17.1 Review all action plans, and cross reference to ensure actions are not missed. 17.2 Close completed actions.	Trustees SLT DofC Mgmt Team		Developing action plan based on Key Lines of Enquires. Currently undertaking in children's and inpatients to	7/2/22

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September Action Plan	17.3 Add ongoing actions to one master work (action) plan. 17.4 Ensure that all staff are aware of the current work plan.	Compliance Manager		ensure all aspects of regulations are covered.	
Ongoing From May 2021 18) Progress required P&Ps, and R/As.	18.1 Continue to review P&Ps as required. 18.2 Policies to be ratified as per procedure. 18.3 Draft schedule for ongoing planned review of policies. 18.4 Medication Policy and Procedures to be reviewed as part of EoL Project. 18.5 Clinical procedures to be reviewed as part of EoL Project. 18.6 Clinical R/As to be reviewed as part of EoL Project. 18.7 Agree process for annual review of R/As – in particular: MCA & consent to treatment; Moving & Handling; PEEPs; Falls; Skin integrity / pressure damage; IPC; Nutrition & hydration;	SLT DofC Clinical Lead H/Physician	V-Drive. Staff know where to locate policies.	Policy Log in place. Policy Log reviewed monthly. Procedure Log developed. Policies available on the Public Drive. Risk Assessment Log developed.	31/3/22

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	VTE.				
19) Review Pharmacy (Lloyds) Provider Contract.	19.1 Arrange to meet with relationship manager. 19.2 Look at alternative pharmacy options to ascertain best provider based on quality, safety, and cost.	DofC CEO DofC		Decision made to review as part of EoL Project. Will be actioned as part of the EoL Project. Covered a s part of End of Life Project	TBC
20) Review of Strategy.	20.1 To be undertaken due to CQC inspection and covid-19 pandemic affecting timescales.	CEO Trustees SLT		Trustee planning day schedule.	28/02/202
21) Develop clinical equipment asset register.	21.1 Include annual or manufacturer service schedule / PAT testing. 21.2 Where relevant secure training re use of equipment. Conduct periodic equipment audit. 21.3 Provide service with summary sheet of clinical equipment and service date/due date.	Operations Manager		Clinical Equipment Asset Register complete. Equipment training identified through statutory training, risk assessments and competencies.	14/2/22
22) Business Continuity Plan.	22.1 Review significant risks in the event of an emergency that threatens continuity of service. 22.2 Identify mitigations to key risks. 22.3 Develop action plans in event of emergency that threatens service continuity.	Comp Manager CEO		Business Continuity Plan currently being reviewed by SLT and Management Group. Risk register reviewed and updated monthly	28/2/22
23) Procure Vantage System to include R/A systems.	23.1 Work has commenced on the implementation of Vantage.	Comp Manager		Data collection for the first module, incident reporting is complete.	31/3/22

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				Awaiting test site from Vantage to enable testing of first module	
24) Procure SystmOne for care records.	24.1 Develop project plan 24.2 Consider option of using iCare as an alternative. Complete options appraisal and mapping exercise.	Comp Manager Operations Manager		Awaiting feedback on Great North Care Record as alternative to System One.	TBC

NOTES: