Bradford Teaching Hospitals
NHS Foundation Trust

Care Quality Commission (CQC) Compliance Action Plan (2019 inspections/Report April 2020) 'Must Dos'	Date initiated	April 2020
	Date of update	July 2020

Accountability		Executive Responsibility	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Mel Pickup, Chief Executive	Board of Directors	Karen Dawber, Chief Nurse (KLD)	Quality Committee
Karen Dawber, Chief Nurse		Bryan Gill, Medical Director (BG)	Quality Committee
		Matthew Horner, Finance Director (MH)	Finance & Performance Committee
		Pat Campbell, Director of Human Resources (PC)	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 2019 inspections.	1	The Trust must improve governance and oversight of risk in Maternity services.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Board is fully sighted on the key performance indicators (KPI's) relating to compliance.	Monthly
	2	The service must continue to take action to improve performance in national audits to demonstrate effective patient outcomes.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	Clinical Effectiveness subcommittee will have full oversight of the Trust audit plans and the associated KPI's. Reporting through to Quality Committee on a quarterly basis.	Monthly
	3	The service must monitor and control infection risks in theatres consistently well and ensure that mitigating actions (including incident reporting of theatre use) are implemented and closely monitored.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	Infection Control Committee will have full oversight of the KPI's in relation to infection control. Reporting through to Board, via Quality Committee on a quarterly basis.	Monthly

	4	The service must ensure that stillbirths rates are closely and appropriately monitored escalated where required and actions are put in place to improve stillbirth rates.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	Board will be fully sighted on stillbirths on a bi-monthly basis (Board meets bi-monthly), via Quality Committee on a monthly basis and a detailed report provided on a quarterly basis.	Monthly
	5	The service must ensure all staff are engaged with and participate in all steps of the World Health Organisation surgical safety checklist, the checklist is fully completed, and observational and record audits are undertaken to monitor compliance.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	Patient Safety subcommittee will have full oversight of the Trust WHO checklist and the associated KPI's. Reporting through to Quality Committee on a monthly basis. Further detail will be provided on a quarterly basis via the maternity updates.	Monthly
	6	The service must ensure systems and processes are used to safely record the use of controlled drugs in the Maternity service, and compliance is monitored.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	Patient Safety subcommittee will have full oversight and the associated KPI's, via Medicines Safety Group. Reporting through to Quality Committee on a quarterly basis.	Monthly
	7	The Trust must ensure the outcomes/recommendations of any serious case reviews are acted on, and midwives have the opportunity to regularly attend child protection conferences and submit reports to facilitate decision making and safety planning.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	This has been addressed via the system wide Safeguarding Board and is reported biannually to the Trust's Quality Committee.	Monthly
	8	The service must ensure all staff are up to date with mandatory training, including safeguarding children level three training.	The Trust will demonstrate full and sustained compliance with Regulation 18: Staffing.	Monthly monitoring is in place and reports to the Workforce Committee.	Monthly

	9	The service must ensure staff always complete and update risk assessments and applicable key documentation (including modified early obstetric warning scores, and intrapartum 'fresh eyes') for each woman.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Board will be fully sighted on risk processes in Maternity via Quality Committee with detailed report provided on a quarterly basis.	Monthly
	10	The service must ensure a systematic programme of rolling internal and clinical audit (to include documentation audits) is in place to monitor quality and to identify where action should be taken; and robust action plans are in place from audits to facilitate improvement.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Clinical Effectiveness subcommittee will have full oversight of the Trust audit plans and the associated KPI's. Reporting through to Quality Committee on a quarterly basis.	Quarterly
	11	The service must ensure all levels of governance and management function effectively and interact with each other appropriately.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Board will be fully sighted on governance processes in Maternity via Quality Committee with detailed report provided on a quarterly basis.	Monthly
	12	The service must monitor the reporting of staffing related incidents (for example, through the 'safe care' tool) and ensure all opportunities for learning from incidents are taken.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Quality Committee will have full oversight of all staffing incidents and associated learning on a monthly basis.	Monthly
	13	The service must ensure the findings of external incident investigation reviews are duly considered and action plans include all findings to address the issues identified.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Quality Committee will have full oversight of all incidents and associated learning on a monthly basis.	Monthly
	14	The service must ensure regular checks of adult resuscitation equipment are undertaken in Maternity.	The Trust will demonstrate full and sustained compliance with Regulation 18: Staffing.	Patient Safety subcommittee will have full oversight and the associated KPI's. Reporting through to Quality Committee on a quarterly basis.	Monthly

	15	The service must ensure clinical guidance for staff is clear and not contradictory, particularly with regards to foetal growth monitoring.	The Trust will demonstrate full and sustained compliance with Regulation 15: Premises and equipment.	Clinical Effectiveness subcommittee will have full oversight of the Trust clinical guidance and the associated KPI's. Reporting through to Quality Committee on a quarterly basis.	Monthly
	16	The service must ensure traceability registers for nasal endoscopes are always completed correctly and that compliance is monitored through periodic audit.	The Trust will demonstrate full and sustained compliance with Regulation 12: Safe care and treatment.	Patient Safety subcommittee will have full oversight and the associated KPI's. Reporting through to Quality Committee on a quarterly basis.	Monthly
	17	The service must ensure checks of emergency equipment are completed in accordance with Trust policy and that compliance is monitored thought periodic audit.	The Trust will demonstrate full and sustained compliance with Regulation 15: Premises and equipment.	Patient Safety subcommittee will have full oversight and the associated KPI's. Reporting through to Quality Committee on a quarterly basis.	Monthly
	18	The service must ensure there is a formal system is in place for security of prescription pads.	The Trust will demonstrate full and sustained compliance with Regulation 17: Good Governance.	Patient Safety subcommittee will have full oversight, via Medicines Safety Committee, and the associated KPI's.	Monthly

Change team members			
Name	**Job title**	**Contact details**	**Initial**

Communications plan				
What?	**Who?**	**By whom?**	**How?**	**How frequently?**
Action plan support	Care Group	Care Group triumvirate	Care Group Core Group Meetings.	Monthly.
Action Plan Oversight	Quality Committee/Workforce Committee/ Board of Directors	Executive Directors	Committee Meetings: action plan and assurance update.	Every meeting, bi-monthly or quarterly depending on action.
Action Plan Management	Moving to Outstanding*	Chief Nurse	Updated action plans and exception reports.	Every meeting.

*Note to be constituted in April 2020, delay due to COVID-19, plan for late summer/early autumn

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

Objective	**1**	**The Trust must improve governance and oversight of risk in Maternity services.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1.1	Establish regular meetings with Chief Nurse and Medical Director and Women's Services CBU.	CN/ CMO	November 2019	November 2019	**C**	November 2019	In place and meeting every 2 weeks initially now 4 weekly.	Diary, reports submitted to CN and CMO.

1.2	Schedule a Quality Summit.	KLD	January 2020	May 2020	**OC**	TBC	Unavoidable delays due to COVID-19. OMS programme mandate signed off by Board in May 2020.	Senior team development session 23 July. OMS clinical summit / launch 27 August 2020
1.3	Undertake a diagnostic review of Labour ward, focussing on patient experience and staff culture.	KLD	December 2019	May 2020	**OC**	TBC	23/12/2020 - Piece of work commissioned with the Improvement Academy, cultural surveys plus patient level experience surveys using the Patient Experience Toolkit. This will be worked up as part of the wider Maternity improvement programme and is planned to be later in the year to avoid "doing to" - want to be inclusive in our decision making. Will be sequenced to follow Quality Summit.	Action superseded by OMS programme
1.4	Review reporting structures within the CBU, review terms of reference, roles and responsibilities within the teams in relation to still births and how this is reported.	KLD	December 2019	31/12/2019	**C**	30/12/2019	Reviewed with clinical teams and changes implemented.	
1.5	Review reporting of Maternity services to Board of Directors.	KLD	December 2019	January 2020	**C**	January 2020	Reports to both Quality Committee and Board changed to provided assurance to each meeting.	Board and Committee minutes and papers

Objective	2	The service must continue to take action to improve performance in national audits to demonstrate effective patient outcomes.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
2.1	CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	December 2019	January 2020	**C**	January 2020	Reports provided on a monthly basis.	Minutes and reports.
2.2	Establish regular meetings with Chief Nurse and Medical Director and Women's Services CBU.	KLD / BG	November 2019	November 2019	**C**	November 2019	In place and meeting every 2 weeks initially now 4 weekly.	Diary, reports submitted to CN and CMO.

Objective	3	The service must monitor and control infection risks in theatres consistently well and ensure that mitigating actions (including incident reporting of theatre use) are implemented and closely monitored.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
3.1	Infection Control Committee will have full oversight of the risks in relation to maternity theatre.	KLD	December 2019	January 2020	**C**	January 2020	Process reviewed and is enhanced. Although routine ICC has been suspended due to COVID there is oversight and continued monitoring in place • Weekly datix's are completed for the number of times theatre 2 is used during that week. • An excel spread sheet is in place which is monitoring if women are readmitted with a postnatal wound infection or have a positive wound swab culture on ICE for women that birthed in January and February 2020 • A working group was set up in January 2020 to look at improving current standards and monitoring for post –operative surgical site infections • Benchmarking of the 'OneTogether' tool has taken place and an action plan has been developed for areas of non-compliance • Surveillance of Surgical	Minutes and reports. Quarterly infection control report

							Site Infection (SSI) following Caesarean Section Delivery commenced on 1st March for all women.	
3.2	Care Group will set up a group to oversee the implementation of theatre rebuild.	KLD	December 2019	January 2020	**C**	January 2020	Meeting in place and chaired by Care Group Director.	Minutes.
3.3	IGRC will have ongoing oversight of the risk in relation to the strategic risk register.	KLD	December 2019	December 2019	**C**	December 2019	Risk will continued to be raised as part of exception report to Board of Directors. IGRC not meeting due to COVID19 SRR continues to be updated and and presented to Board	Minutes and reports.
3.4	CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	December 2019	January 2020	**C**	January 2020	Reports provided on a monthly basis.	Minutes and reports.

Objective	4	The service must ensure that stillbirths rates are closely and appropriately monitored, escalated where required and actions are put in place to improve stillbirth rates.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
4.1	CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	December 2019	January 2020	**C**	January 2020	Reports provided on a monthly basis. Due to COVID19 QC has not met but a monthly report has been presented to Regulation Committee or Trust Board	Minutes and reports.
4.2	Establish regular meetings with Chief Nurse and Medical Director and Women's Services CBU.	KLD / BG	November 2019	November 2019	**C**	November 2019	In place and meeting every 2 weeks initially now 4 weekly.	Diary, reports submitted to CN and CMO.

Objective	5	The service must ensure all staff are engaged with and participate in all steps of the World Health Organisation surgical safety checklist, the checklist is fully completed, and observational and record audits are undertaken to monitor compliance.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
5.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	April 2020	May 2020	**O**	May 2020	Maternity Improvement plan now includes all actions in relation to CQC QC not met due to COVID 19 – Regulation Committee in place as substitute to have oversight	Minutes and papers to Board and Regulation Committee

Objective	6	The service must ensure systems and processes are used to safely record the use of controlled drugs in the Maternity service, and compliance is monitored.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
6.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	April 2020	May 2020	**O**	May 2020	Presented to Board and regulation committee on a monthly basis	Minutes and papers

Objective	7	The Trust must ensure the outcomes/recommendations of any serious case reviews are acted on, and midwives have the opportunity to regularly attend child protection conferences and submit reports to facilitate decision making and safety planning.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
7.1	This has been addressed via the system-wide Safeguarding Board and is reported biannually to the Trust Quality Committee.	KLD	April 2020	April 2020	**C**	April 2020	As per System-wide assurance.	Action plans and Board minutes.

Objective	8	The service must ensure all staff are up to date with mandatory training, including safeguarding children level three training.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
8.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	BG	April 2020	May 2020	**OC**	May 2020	Presented to Board and regulation committee on a monthly basis Although compliance achieved this will undoubtable fall due to COVID 19 and cessation of mandatory training	Action plans and Board minutes.

Objective	9	The service must ensure staff always complete and update risk assessments and applicable key documentation (including modified early obstetric warning scores, and intrapartum 'fresh eyes') for each woman.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
9.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	April 2020	May 2020	**C**	May 2020	Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation committee on a monthly basis

Objective	10	The service must ensure a systematic programme of rolling internal and clinical audit (to include documentation audits) is in place to monitor quality and to identify where action should be taken; and robust action plans are in place from audits to facilitate improvement.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
10.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	April 2020	May 2020	**C**	May 2020	Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation committee on a monthly basis

Objective	11	The service must ensure all levels of governance and management function effectively and interact with each other appropriately.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
11.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement	KLD	April 2020	May 2020	**C**	May 2020	Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation committee

	plan.							on a monthly basis

Objective	**12**	**The service must monitor the reporting of staffing related incidents (for example, through the 'safe care' tool) and ensure all opportunities for learning from incidents are taken.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
12.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	April 2020	May 2020	**C**	May 2020	Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation committee on a monthly basis

Objective	**13**	**The service must ensure the findings of external incident investigation reviews are duly considered and action plans include all findings to address the issues identified.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
13.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	KLD	April 2020	May 2020	**C**	May 2020	Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation committee on a monthly basis

Objective	**14**	**The service must ensure regular checks of adult resuscitation equipment are undertaken in Maternity.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
14.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The	CN	April 2020	May 2020	**C**	May 2020	Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation

	action plans will cover all areas of the improvement plan.							committee on a monthly basis

Objective	**15**	**The service must ensure clinical guidance for staff is clear and not contradictory, particularly with regards to foetal growth monitoring.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
15.1	Maternity CBU will provide a monthly update to Quality Committee in relation to Maternity action plans; these will be reviewed within the service. The action plans will cover all areas of the improvement plan.	CN	April 2020	May 2020	**O**		Presented to Board and regulation committee on a monthly basis	Presented to Board and regulation committee on a monthly basis

Objective	**16**	**The service must ensure traceability registers for nasal endoscopes are always completed correctly and that compliance is monitored through periodic audit.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
16.1	Planned Care Group will develop a process to track all endoscopes in the OPD setting.	SES	April 2020	June 2020	**C**	June 2020	The clinician who is performing the procedure should add the procedure in the comment box on EPR, the flexi scope number and the Tristel cleaning wipe number. We will audit 10 patients every three months to get the process embedded. First Audit End of August 2020 We will then move to 20 patients every six months which would mirror the JAG	The audit records will be kept centrally by Decontamination Team Manager – as electronic copies. A record will also be kept locally as evidence of compliance by any

							& CQC requirements as used in Gastro. There are two components to audit: Tracking of an individual scope's reprocessing (from the Tristel record book) and then Tracing of the scope's use – by examining the patient records on EPR and comparing with the Tristel record. Decontamination records are usually kept for 11 years unless the patient is a minor ; in which case they should be kept until they are 21 (or 11 years if they are older than 11). The guidance tend to change frequently. I will confirm if it has changed recently.	external examiners /auditors. The decontamination logbooks are kept locally in the clinical area as required. The patient use records are recorded on EPR at the time of the procedure.

Objective	**17**	**The service must ensure checks of emergency equipment are completed in accordance with Trust policy and that compliance is monitored though periodic audit.**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
17.1	Planned Care Group will develop a process for the checking and audit of equipment in the OPD setting.	SES	April 2020	June 2020	**OD**		Emergency equipment is checked and a spot check process has been implemented. A monthly audit will be completed by the sisters overseen by Amanda Greenwood.	

Objective	18	The service must ensure there is a formal system is in place for security of prescription pads.

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
18.1	Planned Care Group will develop a process for the security and checking and of prescription pads.	SES	April 2020	June 2020	**C**	June 2020	FP10 Prescription Pads: The pharmacy support team co-ordinate the distribution of FP10 pads. A person requiring an FP10 pad needs authorisation from the Director of Pharmacy who ensure that they have the legal ability to prescribe and also that the CBU is supportive of the request and can provide a cost centre for any medication prescribed to be charged to. Prescription pads are ordered from the official supplier, currently Xerox, by the support team. They are received into pharmacy a log of the prescription numbers made and then stored securely. When a duly authorised person attends to collect the pad, they produce identification and a record is made of the pad supplied and the serial numbers it comprises of. The person collecting the pad is responsible for its security and is mandated to	Audit logs are held in the Pharmacy Support team officers

							report any loss to pharmacy for our onward external escalation.	