CQC Update for Division of Clinical Support Services

WORKING DRAFT VERSION

Introduction

This pack is currently in the development phase. The pack aims to offer a monthly standardised report for each division to track progress and provide assurance of delivery of the conditions and actions set forth in the Trust's CQC report published in July 2019.

The information contained in this pack for the Division of Clinical Support Services is for illustrative purposes as the exact position of the division's programme of work could not be validated in time for submission. It is expected a full and correct report will be available for November 2019.

A similar report, subject to feedback and amendments, will be produced monthly by the Programme Management Office (PMO) for the following areas:

(a) Division of Surgery
(b) Division of Medicine
(c) Division of Women's and Children's
(d) Division of Clinical Support Services
(e) Corporate – Strategic

A robust and detailed information pack will be provided for each division complete with templates and milestones for each condition, must-do and potentially prioritised should do's. Summary documents from these packs will then be presented to Hospital Management Committee – Quality with highlight and exception reporting. Further reduced summary documents will be provided to Quality & Performance Committee and Trust Board. In taking this approach; all reports will be generated from a single base document ensuring a streamlined monitoring function with a single source of data and information.

A key action is to now agree the schemes to be prioritised for delivery over the next 6-month period (as per slide 4)/

Proposal to redefine monitoring of milestones

- In order to ensure the Board and relevant committees have effective oversight of each action, it is proposed that a strengthening of the monitoring function for the programme be introduced. An example of a 6-set category is detailed below for consideration.
- This would then provide a single and clear definition across all conditions and actions.

Status Rating	Description
Not started	Work on condition or notice has not commenced however a start date has been identified.
On plan	Milestones are being met for the reporting period stated and there are no risks identified to completion of the condition or notice.
At risk	Milestone has not been achieved within 10 working days of expected delivery date; however clear actions are being taken to support condition or notice being achieved by stated completion date.
Behind Plan	Milestones have not been achieved and condition or notice will not be achieved by stated completion date. In this case, a revised plan will need to be agreed and approved by the relevant
Embedded	All milestones for the condition or notice have been achieved and no further milestones are required.
Embeded with evidence	Evidence is being collected to assure the milestones are delivering the expected key performance indicators.

Prioritisation plan for conditions, must do's & should do's

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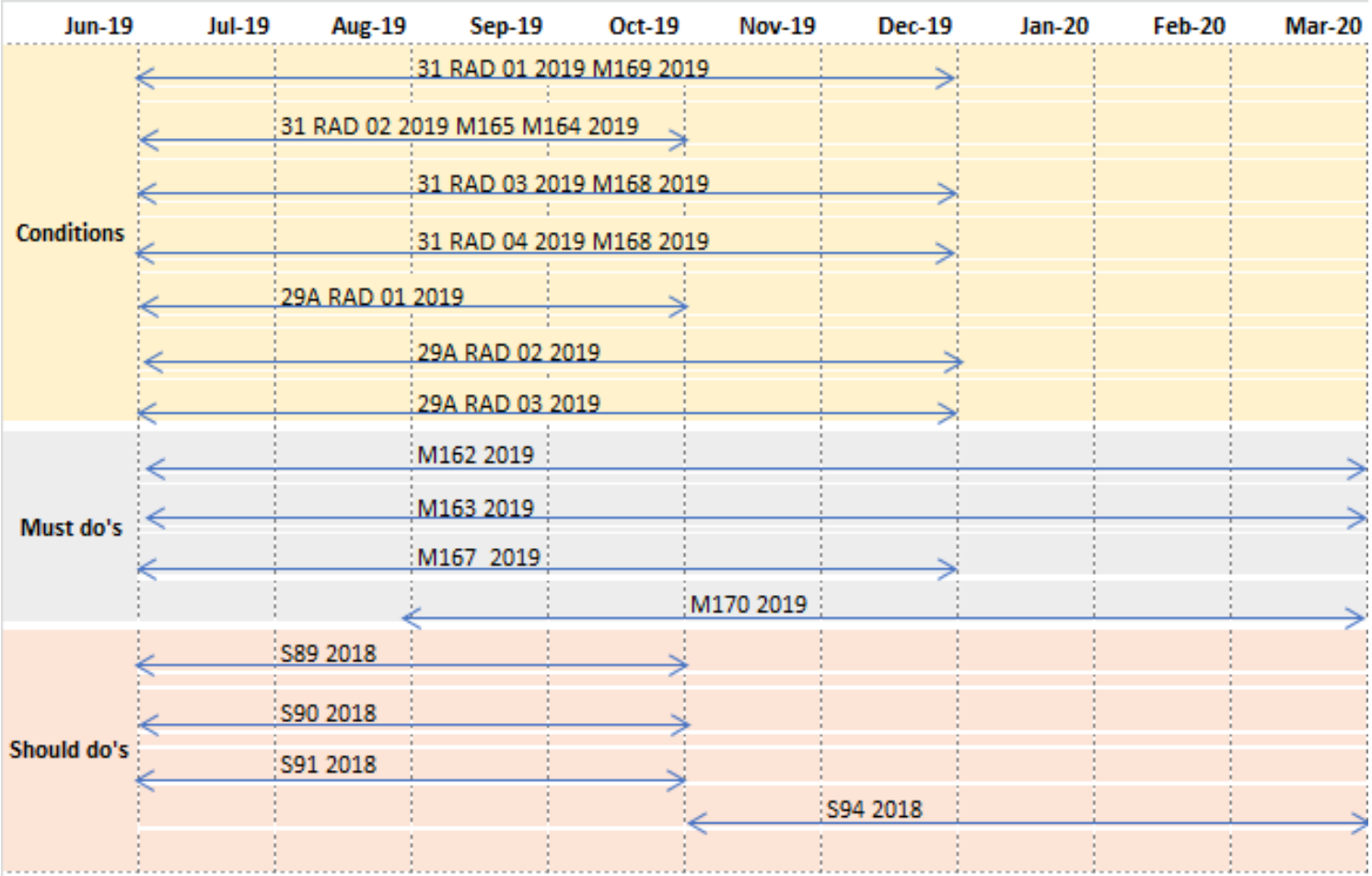
- The following sets out the current trajectory for achievement of the conditions, must do's and should do's for the Division of Clinical Support Services.
- For other divisions, a **prioritisation exercise** should be undertaken to ensure the time and capacity focus is concentrated on the most required actions over the next 6-month period. A similar mapping exercise will then produce a timetable, as per the example provided herein.



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Embedded					5		6			4
% embedded					33.3%		73.3%			100%

Division of Clinical Support

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- A sample overview slide that can be used for Trust Board to set out the Trust wide programme position as well as each individual division.

Progress update from last reporting period

Category	Total	Not Started	On Plan	At Risk	Behind Plan	Embedded	Embed with evidence
Conditions							
Must do's							
Should do's							

Focus of effort ahead of next reporting period

Behind Plan Schemes and supporting commentary

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- A slide focused on those conditions, must do's & should do's that are behind plan - meaning not to be achieved within original plan timescales. This slide will provide committee members and Board members with an overview of schemes that require additional oversight and scrutiny to reset delivery timetables.

Ref	Source	CQC Domain	Applicable To	Milestone Description	Overall RAG Status	Commentary on mitigating actions
2.6.1	31 RAD 01 2019	Safe	Diagnostic Imaging	We will ensure that relevant clinical policies and guidelines are in place across the diagnostic imaging department to support operational activity. This includes policies related to scope of practice and patient care.	R	
2.6.2	31 RAD 02 2019	Safe	Diagnostic Imaging	We will ensure that all Patient Group Directions (PGDs) are fit for purpose and all staff working under a PGD have received the appropriate training and competency assessments. This includes annual competency assessments.	R	
2.6.3	31 RAD 03 2019	Safe	Diagnostic Imaging	We will ensure that an effective system is in place for the regular oversight of the appropriate escalation of significant findings. This will include diagnostic imaging undertaken out of hours to ensure that any patients at risk are escalated appropriately.	R	
2.6.4	31 RAD 04 2019	Well Led	Diagnostic Imaging	We will ensure that there is robust system in place to facilitate effective clinical governance within the diagnostic imaging department. This will include oversight of training, compliance to scope of practice, learning from incidents and escalation processes.	R	

Sample

Description of specific actions being taken to bring condition or scheme back to plan

Active Section 31 Conditions

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- A slide focused on the Section 31 conditions and the overall RAG status

Section 31 DIAGNOSTIC IMAGING

Ref	Source	CQC Domain	Applicable To	Milestone Description	Milestone Owner	Links	Overall RAG Status
2.6.1	31 RAD 01 2019	Safe	Diagnostic Imaging	We will ensure that relevant clinical policies and guidelines are in place across the diagnostic imaging department to support operational activity. This includes policies related to scope of practice and patient care.	Head of Radiology	M169 2019	
2.6.2	31 RAD 02 2019	Safe	Diagnostic Imaging	We will ensure that all Patient Group Directions (PGDs) are fit for purpose and all staff working under a PGD have received the appropriate training and competency assessments. This includes annual competency assessments.	Head of Radiology	M165 2019 M164 2019	Sample
2.6.3	31 RAD 03 2019	Safe	Diagnostic Imaging	We will ensure that an effective system is in place for the regular oversight of the appropriate escalation of significant findings. This will include diagnostic imaging undertaken out of hours to ensure that any patients at risk are escalated appropriately.	Head of Radiology	M168 2019	
2.6.4	31 RAD 04 2019	Well Led	Diagnostic Imaging	We will ensure that there is robust system in place to facilitate effective clinical governance within the diagnostic imaging department. This will include oversight of training, compliance to scope of practice, learning from incidents and escalation processes.	Radiology Clinical Governance Lead	M168 2019	

Active Section 29A Conditions

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- A slide focused on the Section 29A conditions and the overall RAG status

Section 29A DIAGNOSTIC IMAGING

Ref	Source	CQC Domain	Applicable To	Milestone Description	Milestone Owner	Links	Overall RAG Status
2.7.1	29A RAD 01 2019	Safe	Diagnostic Imaging	We will ensure staff are clear about their scope of practice. Staff within cross sectional imaging will not be working outside of the existing Patient Group Direction (PGD) and administering contrast to children. We will ensure staff know where to access guidance. We will ensure all staff are up to date with basic life support and anaphylaxis training.	Head of Radiology		
2.7.2	29A RAD 02 2019	Safe	Diagnostic Imaging	We will ensure staff in diagnostic imaging are clear of the escalation process to ensure the correct escalation of patients with significant findings on diagnostic imaging.	Head of Radiology		
2.7.3	29A RAD 03 2019	Safe	Diagnostic Imaging	We will ensure Incidents in the diagnostic imaging department are appropriately reported or escalated. We will ensure there is evidence of themes identified and lessons learned. We will ensure lessons learnt from incidents are shared effectively.	Head of Radiology		

Sample

Active Must Do actions

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- A slide focused on the must do actions and the overall RAG status

MUST DO ACTIONS

Ref	Source	CQC Domain	Applicable To	Milestone Description	Milestone Owner	Links	Overall RAG Status
3.6.14	M162 2019	Safe	Diagnostic Imaging	We will ensure that staffing levels are adequate to provide safe care and treatment to patients in a timely way.	General Manager		
3.6.15	M163 2019	Safe	Diagnostic Imaging	We will be assured that the out of hours staffing arrangement is sustainable and robust to provide safe care and treatment to patients.	General Manager		
3.6.16	M167 2019	Safe	Diagnostic Imaging	We will ensure that appropriate personal protection equipment is used when administering care to patients to prevent the spread of infection.	General Manager		
3.6.4	M54 2018	Safe	Diagnostic Imaging	We will ensure staff lock computer screens to protect patient information when leaving them unattended in the breast care unit.	General Manager		
3.10.2	M170 2019	Well Led	Diagnostic Imaging	Leaders will ensure they are visible and improve relationships between staff and managers.	Divisional Director		

Sample

Active Should Do actions

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- A slide focused on should do actions and the overall RAG status

SHOULD DO ACTIONS

Ref	Source	CQC Domain	Applicable To	Milestone Description	Milestone Owner	Links	Overall RAG Status
3.6.8	S89	Safe	Diagnostic Imaging	We will ensure the secure storage, prescription and administration of medicines. This includes ensuring that appropriate patient group directives (PGD) are in place for the safe administration of medicines, including the safe administration of saline.	General Manager		
3.6.9	S90	Safe	Diagnostic Imaging	We will ensure that resuscitation equipment in the breast care unit is easily accessible to all staff.	General Manager		
3.6.10	S91	Safe	Diagnostic Imaging	We will ensure effective processes are established for the cleaning of clinical rooms and equipment in the radiology department.	General Manager		
3.9.10	S94	Responsive	Diagnostic Imaging	We will review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.	General Manager		

Sample

Completed conditions and actions

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- A slide focused on the completed conditions and the overall RAG status

COMPLETED ACTIONS

Ref	Source	CQC Domain	Applicable To	Milestone Description	Milestone Owner	Links	Overall RAG Status
3.6.4	M54 2018	Safe	Diagnostic Imaging	We will ensure staff lock computer screens to protect patient information when leaving them unattended in the breast care unit.	General Manager		Completed

Section 31 RAD 01 2019 Milestone Plan

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- This is a sample document that captures milestones and key risks for one of the section conditions. This level of information provides assurance against key milestones to ensure delivery against target is on track.
- It is expected this form is completed by the PMO for each condition as well as some should do actions.

Link Reference	M169 2019

Recommendation Reference Number	31 RAD 01 2019	Must or Should Do Action	Must do	CQC Domain	Safe
Division	Clinical Support Services	Strategic Priority	Governance Assurance		
Executive Lead	COO - Denise Smith	Divisional Director	Nicola Burns		
General Manager	Nicola Leighton Davies	QIP Lead	David Barron		
CQC Recommendation	31 RAD 01 2019 - We will ensure that relevant clinical policies and guidelines are in place across the diagnostic imaging department to support operational activity. This includes policies related to scope of practice and patient care. M169 2019 - We will ensure that policies and guidelines are in line with national guidance, legislation and best practice. Regular audit will take place to ensure compliance.				
What is achievable in 2019/20	Full achievement of both conditions within this financial year.				

Action plan to achieve the Recommendation

No.	Action	Due Date	Executive Lead	Action Lead	Expected Outcome	KPI	Current KPI Performance	Source of Evidence & Measuring & Monitoring Methodology	Progress to Date	Action RAG Status	KPI RAG Status
31 RAD 01 2019.1	Ratification of all 8 remaining out of date document by 31/12/19	31/12/2019	COO - Denise Smith	Chris Dales	100 % Compliance with in date documentation	100 % Compliance with in date documentation	94% Compliance with in date documentation	Local documentation management spreadsheet	June Compliance 87% - September Compliance 94%	G	G
31 RAD 01 2019.2	Integrate check and compliance audits into department audit plan	31/10/2019	COO - Denise Smith	Chris Dales	Updated active audit plan				Audit Plan presented in CNOG update for August.	A	A
31 RAD 01 2019.3	Launch new department document shared folders structure	31/10/2019	COO - Denise Smith	Chris Dales / Adele Abbott	New folder system for staff to access department documents and policies	A single electronic location where all department documents are accessible for staff				A	A
31 RAD 01 2019.4	Review and implement devolved model of document ownership by modality leads	31/12/2019	COO - Denise Smith	Nicola Leighton-Davies	Modality leads take ownership and responsibility of reviewing local policies and procedure documents	Identified documents are owned and reviewed by modality leads	All Documents are managed and monitored by Deputy Service Manager	Local documentation management spreadsheet	Radiology Manager post vacant as of 08/10/2019 No progress to date with current model progression.	R	A

Risks

No.	Risk	Likelihood	Impact	Risk Score	Mitigating Actions	Responsible	Due Date	Residual Likelihood	Residual Impact	Residual Score
1	If current capacity is not maintained to review out of date radiology documents THEN the department's trajectory to be 100% compliant by the end of 2019 may not be achieved.	2	4	8	All 8 documents identified and authors contacted with timescale to update. Progress monitored at weekly section Notice meeting	Chris Dales	31/12/2019	1	4	4
2	If radiology documents are not presented at clinical governance in high quality final version format THEN the department's trajectory to be 100% compliant by the end of 2019 may not be achieved.	2	4	8	All 8 documents identified and authors contacted with timescale to update. Progress monitored at weekly section Notice meeting	Chris Dales	31/12/2019	2	4	8
3	• IF devolved ownership of document management to modality Leads does not progressed THEN the sustainability of document compliance may not be achieved	4	4	16	No current Mitigations Radiology Manager post vacant as of 08/10/2019	Nicola Leighton-Davies	31/12/2019	4	4	16

Key Risks and decisions to escalate

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- A slide setting out key decisions required

Reference	Risk	Likelihood	Impact	Risk Score	Mitigating actions	Responsible	Due Date	Residual Likelihood	Residual Impact	Residual Score
31 RAD 04	If the department does not hold robust and effective clinical governance meetings THEN effective clinical governance may not be achieved.	4	5	20	None	Nicola Leighton-Davies	31/12/2019	4	5	20
31 RAD 01 M168 2019	If devolved ownership of document management to modality Leads does not progressed THEN the sustainability of document compliance may not be achieved	4	4	16	No current Mitigations Radiology Manager post vacant as of 08/10/2019	Nicola Leighton-Davies	31/12/2019	4	4	16

No	Decision Required	By Whom	Programme Implications (Safety, timescale, financial, other etc)
1			
2			
3			