CQC Visit Project Plan 2014

Document Purpose: To document the plan for co-ordinating the CQC visit and ensure that all processes and documents are in place and up-to-date
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Revision History			
Version	**Date**	**Name of change owner**	**Description of change**
DRAFT	08/01/2014	Sarah Scott	Working draft
Draft 2	10/01/2014	Helen Goodwin	Addition of PWC actions and updates following project initiation meeting
Draft 3	13/01/2014	Helen Goodwin	Additional tasks and progress updates added
Draft 4	14/01/2014	Sarah Scott	Additional tasks and progress updates added
Draft 5	16/01/2014	Sarah Scott	Additional tasks and progress updates added

THEME	KEY ACTIONS	ACTION LEAD	COMPLETION DATE	PROGRESS	RAG	w/c 6 Jan	w/c 13 Jan	w/c 20 Jan	w/c 27Jan	w/c 3 Feb	w/c 10 Feb	w/c 17 Feb	w/c 24 Feb	w/c 3 Mar	w/c 10 Mar	w/c 17 Mar
Project Initiation	Draft project plan	SSc	10/01/14	Completed												
	Establish a Task and Finish group to lead the visit co-ordination **- include Divisional involvement**	HG		In progress												
	Schedule weekly project group meetings	SSc	10/01/14	Completed												
Logistics	Identify hotel possibilities for Inspectors' accommodation	LW	17/01/14	List prepared and emailed to HG and SS 17/01 - sent to CQC			✓									
	Identify meeting facilities for listening events	BC-S	20/01/14	List prepared and sent to CQC												
	Security requirements identified - Service Evaluation team accompanying the CQC inspection team will have restrictions on what they can observe	FM														
	Identify key stakeholders including non executives and admin staff	HG / AMc	21/01/14	List prepared												
	Validate stakeholder availability for March including non executives and admin staff	SSc		Trust Wide absence reports being obtained via e-Rostering												
	Finalising roles and responsibilities for visit period - key contacts for each site during the Inspection, for each day of visit, for each KLOE, for each Service and for each measurable indicator and ensure they are fully briefed and have appropriate information to hand. (Plus runners.) Produce Calendar of availability, and responsibilities.	HG / SSc														
	Provisionally book meeting rooms on each site	MW		In progress												
	Establish final meeting room requirements and finalise room bookings	MW														
	Identify existing meetings planned from now until the inspection	MW		In progress												
	Provide "How to find us" literature	MW		In progress												
	Ensure taxi information available (Arrow Taxis, Ashford) and Park and ride information	MW	22/01/2014	Completed												
	Car parking?	MW		Discussion with Strategic Development re Car parking changes and dates												
	Food and beverages policy and logistics	MW		Serco listing of food and beverages												
	Specific briefings to Hospital main entrance Reception staff and Car parking Staff	Hospital Managers		Checking with HG whether she has already briefed Estates												
	Ensure Hospital signage up-to-date	FM														
	Ensure access rights to diaries for the project team and action leads for all other stakeholders	SSc														
	Set up access to Qlikview	MF		In progress - request made to the Information Team												

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	Book meeting rooms / check availability of HG to conduct briefings on mock inspections w/c 27 Jan	MW														
	Check date of introduction of new parking policy	SSc		New parking policy launches 03 March. SSc will check with Vince Monaghan how many staff are returning their car parking permits which could lead to greater demand for street parking and potential congestion / late staff												
	Ensure translation services adequate	Divs		Particularly Padua and A&E at WHH request translators over the tannoy												
	Agree roles and responsibilities with Communication Team	HG / PG	14/01/14	Initial meeting scheduled between HG, PG, GS & SSc 14 Jan												
	Contact Head of Inspection team to discuss venues and transport links for public engagement	HG	20/01/14	Email sent												
	Prepare a briefing on board assurance framework and oversee processes for NED's to enhance knowledge	AF														
	Provide a weekly project update briefing to each Executive Team meeting	HG		Meetings take place each Wednesday and are in HG's calendar												
	Obtain input from ward staff on content of communication material and format (via email and face to face ward drop ins)	AMc/HoK		In progress												
	Produce literature for briefing staff on CQC Visit Process, including the Quality Assurance process within the Trust, key elements of the Quality Strategy and a checklist of considerations	GS / AMc / SSc		Supported by JP and HG for content. HG reviewing Lewisham version of Staff booklet to be adapted by GS.												
	Establish costs and feasibility of sending out staff booklet with payslips	SSc	15/01/14	Booklet to be printed externally. Distribution might be possible via McKesson (needs following up with Workforce who have been asked to enquire) and if not will cost £600 for Payroll to hire 5 temps for 1 day to staple the booklets to pay slips for Feb payslips.												
	Send out staff briefing booklet to all staff with payslips	AMc		Due to go out with Feb payslips												
	Prepare responses to KLOE and other questions anticipated for the BoD	HG / SSc/ HoK		In preparation and links with material for Mock Inspection programme												
	Brief all Senior team members on visit dates, process, (and expectations from them)	HG		Underway, some ad hoc briefings have taken place and others planned												
	Identify existing meetings to be utilised and identify key people to disseminate face to face briefings to staff	AMc														
	Develop full communication plan to include staff briefings for staff on the three main sites by members of the Executive Team	GS / PG		With involvement from JP and HG. Via staff listening events 19, 21 & 24 Feb, plus road shows organised by the Comms Team for 3, 4, and 5 Feb.												
	Conduct staff road shows on each site	HG		3,4 and 5 Feb												
	Produce Chief Executive presentation and align with the positive and weak areas identified in the data pack	HG / HoK		In preparation												
	Brief HoN on CQC visit and mock inspections required	HoK		Scheduled for Thurs 6 Feb												
	Launch staff communication via Trust News / Intranet	GS		In progress												

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Communication	Conduct face to face staff briefings and feedback	AMc		1. Request support from Crystal McLeod, Chris Hamson and others? 2. OP matron has agreed that her and OP sisters can brief all OP staff. 3. AMc and Vicky to visit wards												
	Request Divisions provide Divisional Reps to conduct mock inspections	HG		Discussed with Divisional Directors 21/01/2014												
	Provide briefings to Div Reps on how to conduct mock inspections	HG / Amc		Material being produced												
	Conduct mock inspections, including checking use of Patient leaflets	Divs														
	Press releases and management in place	PG														
	Brief staff on Trust vision and values, supported by the Shared Purpose Framework and We Care initiatives	Divisional leadership teams														
	Initial Non-executive Director communication on data pack and performance	HG	18/12/13	Undertaken at the BoD meeting in December 2013												
	Undertake briefing for Council of Governors	HG	14/01/14	Scheduled for 14 January 2014												
	Brief Strategic Development on CQC visit purpose and process	HG		Helen G meeting Liz Shutler Wed 29 Jan												
	Brief HR on CQC visit purpose and process	HG		within meeting booked 22 Jan to discuss mandatory training												
	Brief Sally Smith, Kim Manley, & Karen Miles on CQC visit purpose and process	HG		to be covered within CQPS Snr Ops Team Mtg 20 Jan												
	Brief Staff Committee on CQC Visit	PM		January meeting												
	Meet with key lead clinicians for Innovation to discuss their role within the visit	HG														
	Post laminated copies of Summary Quality Communication on all notice boards	GS/AMc		Gemma to confirm We Care branding that should be used on all written communications												
	Ensure Condition specific audit results are published on associated ward notice boards	PY														
	Provide every ward manager with update on outcomes from ward staffing review relevant to them	HoK														
	Include session on CQC visit at Chief Execs Forum in January	TBC		Chief Execs Forum 27 Jan 14												
	Design key questions based on KLOE	HG / Divs		To be part of staff booklet												
	Attend weekly Exec Team mtgs to provide project update	HG		meetings in place in HG's calendar												
	Add Corporate Division "Who does What" structure chart onto intranet	GS/PG?		Already being worked on												
	Conduct Key questions sessions with staff	HG														
	Daily briefing meetings held by Project Team and Snr Mgmt during inspection week	HG		To be set up both morning and evenings each day												
	Set up debriefing meetings for staff	GS														

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	Send out patient communication on visit to elective patients due to be in attendance during CQC Visit period	GS/PG		Comms Team will be contacting the Surgical Division to support this communication being sent												
	Initial Debriefing meetings for staff	GS														
Validation of data and processes	Reconcile Trust audit activity with National Audit Programme and produce summary of future actions	RU / PY		In progress												
	Collect and validate data on the areas identified as alerting in the PWC data pack	LP/MF		In progress												
	Review Intelligent Monitoring report and horizon scanning for updates	LP/MF		In progress												
	Validate all data used in clinical coding, including depth of coding and diagnostic and procedure coding accuracy	Head of Clinical Coding		Meeting booked with Denise Blackman 29 Jan												
	Conduct Assessment of Trust against all CQC KLOE as well as the key ones highlighted by PWC as areas of concern and revise on the basis of updated data	HG		To be completed by project group												
	Ensure all policies and documentation are up-to-date	PM		Accuracy of Q3 report is in question and needs resolving - liaise with Workforce												
	Check whether Patient leaflets library is up-to-date	AMc / HGon		Audit tool prepared and all ward clerks contacted												
	Checks on use and availability of patient leaflets in clinical areas	AMc/SSc		Patient Leaflet library up-to-date. All Ward Clerks being asked to review patient leaflets in use.												
	Investigate an IT communication re TV and PC wallpaper screens in use within the Trust	GS		Gemma to talk to David Nicholls												
	Review current process and data validation for data transfer to NRLS to ensure this is timely	SC/MB		Validation in progress												
	Appoint junior doctor patient safety leads to increase incident reporting by junior doctors	MWe		In progress - list of 14 junior doctors prepared												
	Ensure that FFT performance data up-to-date and fully reported and provide response plan (from PWC data report)	SS		In progress												
	Validate PROMS data and ensure robust process in place to respond to data (from PWC data report)	NW		PROMS meeting with Noel 21 Jan 14 - Noel will ensure that governance process implemented and documented, and response to CQC available.												
	Validate current infection prevention and control measures and update action plans and collaboration with PHE	JN/SR		In progress												
	Ensure E-rostering team provided with Ward staffing review action plan and business case action plans	HoK														
	Follow up on Ward Staffing vacancies report with Marc Farr	HoK														
	Ensure Year 2, Q3 Quality Strategy Update published and disseminated	SSc / SS		Draft completed, due to be reported to the Strategic Group meeting 5 Feb												

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	Ensure Year 3 Quality Strategy in development	SS / HoK/ SSc		Initial meeting took place 8/1/14, Yr 3 Strategy to be developed												
	Prepare response to # NoF concerns (from PWC data report) - how are we improving the number of patients receiving surgery within 36 hrs?	PS		Helmut Zahn and Shelagh O'Riordan involved - #NOF meeting 22/01/2014												
	Prepare response to GMC Serious educational concerns (from CQC Intelligent Monitoring report Oct 2013)	HG/PS		Letter sent to GMC - no response												
	Ensure that the minutes of all Governance & Board meetings, and Divisional Risk Registers, are available centrally electronically (SharePoint?)	SSw														
	Ensure there are clear plans in place to fill all vacancies	Div leads														
	Ensure the Francis Action Plan is up-to-date	AF		There are various action plans in place - need to check with AF/SSw/PM and ensure available to all staff on SharePoint												
	Ensure the Keogh Action plan is up-to-date	PM														
	Ensure Mandatory training reports available and action plans in place where levels insufficient	HL		Emailed HL 14/1/14												
	Mattress audit to be completed (as per normal procedures)	SR		In progress												
	Equipment audit conducted (as per normal procedures)	CH / HoK		Avril met Carol Howell 17 Jan, HoK also following up												
	Ensure process for commissioning translation services clear	Divs														
	Compile action points to address patient feedback concerns from Patient Opinion and other sources	SS														
	Review compliance against Essential Standards for Quality and Safety	HG / AMc														

KEY

SSC = Sarah Scott, Quality Improvement & CQUINS Programme Manager

RU = Robin Ufton, Clinical Audit Service Manager

HG = Helen Goodwin, Deputy Director Of Risk, Governance & Patient Safety

AMC = Avril McConnachie, Standards Compliance Manager

GS = Gemma Shillito, Communications Manager

PG = Peter Gilmour, Director of Communications

HoK = Helen O'Keefe, Associate Chief Nurse

SS = Sally Smith, Deputy Chief Nurse and Deputy Director of Quality

NW = Noel Wilson, Medical Director, Surgical Division

PS = Paul Stevens, Executive Medical Director

RAG	KEY for Project Plan
	Action COMPLETED and CLOSED
	Action Completed
	On Target to achieve
	Timescale has slipped, but in progress
	No action progressed in past week
	No Progress at all

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JJ = Jan Jerram, E-Rostering Manager
PM = Peter Murphy, Director of HR
LB = Lesley Bourne, Personal Assistant And Project Co-ordinator
To Helen O'Keefe
MW = Margaret Withey, Administrative Assistant IG
BC-S - Bruce Campion-Smith
MF - Marc Farr, Deputy Director of Information
AF = Alison Fox, Trust Secretary
PY = Pat Young, Clinical Audit Manager
CH= Carol Howell, Medical Devices Coordinator
HGon = Harry Goncalves, PI coordinator
SSw = Sarah Swindell, Assistant Trust Secretary
JN = Dr James Nash, DIPC
SR = Sue Roberts, Deputy DIPC
FM = Fin Murray, Director of Estates and Facilities
MWe = Dr Michelle Webb, Associate Medical Director (Patient Safety)
LP = Louise Pallas, Head of Information
Management

HL = Heather Loader, Workforce Information Manager

KEY RISKS:			
Key risks to obtaining a Good or Outstanding Rating from the March 2014 CQC visit		**Mitigation**	RAG
1	Funded establishment may not be reflected in ward staffing due to vacancies, sickness and outcome of ward staffing review not yet fully implemented	1. get rosters up-to-date reflecting outcome from ward staffing reviews 2. include in staffing briefings, specific data on each unit's establishment	
2	Head of Patient Experience is newly appointed and is currently in induction phase of role and therefore may not have extensive knowledge of historical challenges in patient complaints	Ensure additional support is available to ensure Head of Patient Experience has full knowledge of historical challenges, existing action plan and next steps	
3	Additional pressure of visit on staff during winter pressures could result in increased sickness / poor performance / demotivated staff	1. positive campaign around opportunities visit generates 2. regular, accurate and meaningful communication with ALL staff groups 3. Staff support available pre and during visit - Chaplains?	
4	Mixed sex accommodation challenges exist	Trust responding to CCG requirements to address mixed sex accommodation challenges	
5	Strategic Development Senior Structure has vacancies / newly filled posts which may be interpreted as a weakness in Leadership		
6	Head of Clinical Coding is a vacant post which could lesson leadership within the Dept		
7	Mandatory Reporting contains inacccuracies leading to lower compliance being reported than is true	Mandatory Training reports content being reviewed	
8	Sharepoint does not currently contain 100% up-to-date policies, and not all policies currently up-to-date	Divisions must be asked to ensure all their policies are up-to-date and posted on Sharepoint	

Focus on 'Safe'
Possible KLOEs and detailed prompts

1. Are there effective mechanisms in place to monitor safety and address concerns, including from staff?
2. What is the Trust's track record on safety? How well does the Trust learn from mistakes and improve standards of safety?
3. Are services adequately and appropriately staffed to provide safe and effective care to patients?

Questions to consider

- What action has been taken to address increased levels of falls resulting in harm and catheter-related UTIs?
- How does the Trust protect patients from pressure ulcers and VTEs?
- What is understood by the causes of HCAI rates higher than the national average and what actions are being taken to address them?
- How does the Trust learn lessons from Never Events and patient safety incidents to ensure continuous improvement?
- What has the Trust done to understand the timeliness of reporting patient safety incidents and the implications of delays?
- What mechanisms are in place to ensure that lessons are learnt are shared throughout the Trust?

KLoE	Key Questions and/or Sources of Assurance	WARD LEVEL
S1. What is the provider's track record on safety?	Can staff articulate how to report an incident, never event or allegation of abuse? When they do report such an instance do they receive feedback?	
	Can staff describe the main components of both the Adult and Children's Safeguarding Policy?	
	Can staff describe how a patient may make a complaint if they wish to do so?	
	Is Safety Thermometer information or other Harm reporting tools openly displayed on the Ward Noticeboard ? Are they up to date and are staff aware of the content?	
	Can staff describe the various ways in which patients and carers may provide feedback on the care provided?	
S2. How well does the provider learn from mistakes and improve standards of safety?	Do staff feel that the Trust takes reduction in harm seriously? Can they provide examples of how this manifests itself on their ward?	
	Can staff name a recent initiative which contributed to reducing harm and the impact that it had on their ward?	
	Can staff provide examples of where clinical practice has changed as a result of an incident , complaint or patient feedback?	
	Can staff describe the ways in which they can voice their concerns? If staff have raised concerns previously do they feel that they were listened to and taken seriously? Did they receive feedback in relation to the outcome of their concern?	
	Are staff aware of incidents or complaints fin other areas and has their clinical practice changed as a result of such issues elsewhere within the organisation?	
S3. Are behaviours, processes and systems failure free over time ?	Do staff feel that they are made aware of when new policies are introduced or existing policies updated? Are they encouraged and performance managed to read, confirm understanding and implement any new requirements?	
	Are staff aware of the Mental Health Act 2005 and in particular how it relates to them in terms of assessing the capacity of patients?	
	Do staff feel that there is sufficient equipment in pace for them to carry our their duties? Are there issues in relation to old /broken equipment or different makes/models of equipment to carry out similar functions?	
	Are there appropriate arrangements for obtaining, recording, handling, using, safekeeping, dispensing and disposal of all medicines, including medical gases?	
	Are you aware of the Infection Control Policy and how is compliance against the policy maintained?	
	Where electronic systems are in place (e.g. e-prescribing, electronic records) do staff feel they have received appropriate training to use the system confidently?	
S4. Is care safe today?	What is the one thing that staff are concerned about as an individual and how are they assured that the organisation is aware of this and is taking this seriously?	
	Do staff feel empowered to raise concerns and can they do so without fear of being penalised, bullied or harassed?	
	Do staff feel that there is a good climate of multi-disciplinary team working, including seeking specialist advice where necessary? Can they provide a recent example of where this has worked appropriately?	
S5. How confident are we that care will be safe in the future?	Has the area recently experienced cost savings and if so do staff believe that patient care quality has been maintained, improved or reduced?	
	Do staff feel that there Is a culture of continuous improvement re patient care? Can staff provide an example of a recent change hat has improved patient care?	
S6. Do staffing arrangements enable safe practice?	Do staff know what the level and mix of staffing should be on their ward? Is this information openly available and published?	
	Are there occasions when staff feel that they have insufficient staff to safely care for patients on their ward? Are concerns raised? If so what happens ?	
	Do staff feel the impact of staff shortages in other areas such as portering, catering, housekeeping, laundry? How does this manifest itself?	
	Are staff satisfied with the quality of work and patient care they are able to deliver?	
	Are staff up to date in terms of their statutory and mandatory training and any professional updating etc? If not why not?	

Focus on 'Effective'
Possible KLOEs and detailed prompts

4. Can the Trust demonstrate that it manages the quality of its care and treatment in a manner which ensures high quality services that provide the best outcomes for patients?
5. Are services, treatment and care delivered by suitably qualified and competent staff who are well supported and developed?

Questions to consider

- Can the Trust demonstrate effective use of data to improve performance and quality, including in investigating areas flagged by statistical indicators?
- Does the Trust use recognised clinical standards and guidelines, and current best practice?
- Is there collaborative working across disciplines and providers to ensure that patients' needs are properly managed and met?
- How does the Trust ensure that clinical staff have suitable qualifications, competencies and support?
- How does the Trust review outlier mortality data (e.g. cardiology, trauma and orthopaedics and paediatrics) and use the findings to improve the effectiveness of clinical practice?
- How is the Trust reviewing and improving the rate of patients receiving surgery for fractured neck of femur within 48 hours?
- How is the Trust ensuring that its data is accurate? What action has it taken in response to the PbR audit and depth of coding findings?

KLoE	Key Questions and/or Sources of Assurance	WARD LEVEL
E1. Can the provider demonstrate that nationally/internationally recognised guidelines and other recognised guidance and and current recognised best practice are used	Can staff describe how patients are provided with information and supported to help them make decisions about or agree to care and treatment? How is informed consent assured? If people are deemed to not have capacity, how are their best interests assessed?	
	Can staff describe how they are assured that nutritional/hydration patient needs are met?	
	Can staff describe how patients are engaged in their pain management and how they [the staff] assess that pain management treatment is appropriate?	
E2. Can the provider demonstrate that it supports collaborative, multi disciplinary working across all the services within the organisation and with external stakeholders?	Does every patient have an expected date of discharge and can staff describe how this is used to proactively manage discharge arrangements and liaison with external	
	Can staff describe how care and treatment plans secure multi-disciplinary involvement, involvement from the patient and their relatives, carers or those close to them where appropriate?	
	How are staff assured that multi-disciplinary arrangement practices are appropriate and effective? Could these arrangements be improved in any way?	
	Can staff describe an occasion where multi disciplinary handover has worked well with good outcomes and one where the process could have been improved?	
	Do staff regularly liaise with in-reach staff from other organisations including healthcare, social care and voluntary groups?	
E3. Can the provider demonstrate that services, treatment and care, are delivered by suitable qualified and competent staff who are supported in their development and in role?	Have all staff interviewed received an appraisal within the last 12 months and have they an agreed set of objectives and Personal Development Plan in place to improve their	
	Other than Statutory/Mandatory training what additional training have staff had to ensure continuing professional development?	
	Are staff clear in relation to the standards of care that are expected and can they describe the culture of performance management within the organisation?	
	Are staff backfilled and covered appropriately in order to release them for training, and appraisal time away from patient fronting duties?	
	Do staff feel valued and invested in? Do opportunities exist for advancement if they so wish?	
	How is clinical practice monitored, including variability of practice and how is poor practice managed?	
	How are staff involved in strategic and operational decision making about service development and delivery?	
E4. Can the provider demonstrate that it manages the quality of its care and treatment in a manner which ensures that it delivers high quality care that provides the best outcomes for people?	Can staff describe a range of indicators of quality of care care and experience that is routinely captured by the organisation and fed back to them at ward team meetings re	
	Can staff identify Trust Board members and Senior Clinical Leaders? When was the last time that a Board member [other than the Medical/Nurse Director] visited their ward?	
	Have staff partook in clinical audit activity recently or as a minimum seen such activities taking place within their ward? What was the activity and have they seen the results?	

Focus on 'Caring'
Possible KLOEs and detailed prompts

6. Do patients feel safe, comfortable and treated with dignity and respect?
7. Do staff develop trusting relationships and communicate effectively so that patients and their families understand what is happening to them and why, at all stages of their treatment and care?

Questions to consider

- How does the Trust share learning from patient feedback, particularly good practice from wards that score well on FFTs?
- What action does the Trust take in wards that have lower FFT scores ?
- What improvements has the Trust made to ensure that the privacy and dignity of patients are maintained?
- Can the Trust demonstrate improvements to the care of patients at the end of their life, including working with local partners?
- How does the Trust ensure patients receive appropriate care in relation to nutrition and hydration?
- Do staff build trusting relationships, communicate effectively with patients and families and involve them as partners in their care in all areas of the hospital?
- How is the Trust seeking to understand and improve low response rates from the Friends and Family Test?
- How does the Trust disseminate learning form patient opinions, such as from PALS and NHS Choices?

KLoE	Key Questions and/or Sources of Assurance	WARD LEVEL
C1. How does the provider involve patients and members of the public to shape services, and to gather and use their experiences of care?	How does the organisation routinely involve patients, the public and their representatives to understand their views and experiences of care?	
	Does the ward receive, continuously review and act on the feedback from patients, the public and their representatives about the quality of care?	
	Can staff provide examples of changes that have occurred as a result of receiving such feedback?	
C2. Are patients and their families or those close to them 'partners' in their	Can staff describe how patients and their families are routinely involved in planning their care and in making decisions about the choices available in their care?	
	Can staff describe how patients are supported to be involved in their care when they lack capacity or need advocates to speak on their behalf?	
	How are patients and their families involved in planning their discharge and are they given sufficient information and time to help them plan for discharge?	
C3. How do staff develop trusting relationships and communicate effectively so that patients and their families or those close to them understand what is happening to them and why, at all stages of their treatment and care?	Do patients have a named nurse with whom a two way relationship and understanding can be developed?	
	Can staff describe the support available for patients and their families to meet their different communication needs such as through language	
	Is there evidence on the ward of appropriate written information tailored to patient needs (including easy to read information)?	
	Can staff describe an appropriate culture of openness, honesty and transparency to patients and families if they need to share bad news or if something has gone wrong?	
	Can staff describe how patient confidentiality is respected, both in terms of verbal communication and written records? Can they provide examples of good practice that they have been involved in or have experience of?	
C4. Do patients receive the support they need to cope with their treatment and hospital visit/stay?	Can staff describe how services take into account the cultural, ethical and spiritual needs of patients and their carers/families?	
	Can staff describe how patients are supported to remain in contact with family and those close to them to avoid isolation during a hospital stay? Can staff provide examples of	
	Can staff describe if patients are able to take part in social activities to support their recovery or long term care in line with their needs? Can staff provide examples of where this has worked well/not so well?	
C%. Do patients feel safe, comfortable and are treated with dignity and respect?	Is there zero tolerance to any disrespectful/discriminatory/abusive behaviour or attitudes towards patients, their families and carers? How are staff made aware of this and	
	Do staff feel that the care environment make patients feel safe, comfortable, and private? Are there any changes that they would recommend?	
	Are there appropriate arrangements for single sex accommodation?	
	How does the ward identify and signpost to staff those patients that require support with eating, drinking and toileting?	
	How do staff make sure they support patients and their families appropriately when there have been safety or safeguarding concerns?	

Focus on 'Responsive'
Possible KLOEs and detailed prompts

8. Is the Trust effectively planning and managing the provision of services to ensure that the needs of the local population are met?
9. Can the Trust demonstrate that it effectively assesses and responds to individual patient needs?
10. How does the Trust seek and respond to views from patients about their experiences?

Questions to consider

- What steps have been taken to understand and improve A&E waiting times?
- How is the Trust ensuring that patients can be safely discharged as soon as they are ready?
- How are patients' needs met at each stage of their care, especially those in vulnerable circumstances?
- How does the Trust care for patients who have dementia and ensure their views are taken into account?
- How are concerns and complaints acted on and learnt from?
- How is the Trust developing its services to enable access from all its communities?
- Does the Trust provide appropriate staffing out of hours across all specialties?
- What is understood by the causes of readmissions and how are they monitored and managed?
- What actions are being taken to address the dip in admitted RTT performance in trauma and orthopaedics?

KLoE	Key Questions and/or Sources of Assurance	WARD LEVEL
R1. How does the provider plan its services on the basis of the needs of the local population?	Are you aware of the organisation engaging with voluntary groups, and other stakeholders to help improve care on your ward and ensure that it is appropriate for the patient	
	Do you regularly witness external bodies coming on to the ward to proactively plan and assist with discharge arrangements?	
R2. How does the provider enable people from all its communities to access services in response to their needs?	Can staff describe what approaches the ward takes to ensure that it is accessible for all disabilities including information, physical and cultural barriers?	
	What actions is the ward taking to minimise the time patients wait for diagnostic services, treatment or care? Does the ward monitor 'non intervention' days?	
	Do staff believe that bed capacity and management issues are dealt with in an appropriate manner and with sensitivity towards patients?	
	Do staff believe that outlier patients are seen as poor practice and patients are repatriated as soon as practicable?	
R3. How are patient's individual needs met at each stage of their care, especially patients who are in vulnerable circumstances?	Are patients asked about their spiritual, ethical and cultural needs as well as their medical and nursing needs	
	Do staff believe that care provided that is appropriate and sensitive to patient's gender, age, race, religion or belief, sexual orientation and any disability that may impact on	
	Are staff assured that the needs and wishes of patients with a learning disability or who lack capacity being assessed and monitored appropriately?	
R4. Do patients leave hospital when they are well enough and with the right support in place?	Are the discharge arrangements agreed with patients and their families early in their care planning, especially patients in more vulnerable circumstances	
	Are patients and their families or those close to them involved in decisions about their readiness for discharged?	
	How do patients and their families receive the appropriate information and support when they are discharged?	
	Do staff believe that Expected Dates of Discharge are meaningful, have impact and are realistic in terms of their expectations?	
R5. How does the provider act on concerns and complaints and learn from complaints?	Is there an easy to use complaints procedure which is known and used?	
	How do you and the wider ward encourage feedback and complaints from patients/carers and act upon it to improve service quality?	
	Is the provider open and transparent with you about how they have dealt with complaints, concerns and whistle-blowers?	
	Are you aware of any instances where clinical practice or care has been revised due to patient feedback? Id so. Please provide examples	

Focus on 'Well-led'
Possible KLOEs and detailed prompts

11. Can the Trust demonstrate that there is effective governance and a patient-centred vision and culture throughout the organisation?
12. Is there effective and visible leadership of quality improvement in the Trust?

Questions to consider

- How effectively does the Board communicate the quality and safety expectations of the organisation and how well does this correlate with outcomes and behaviours in clinical areas?
- Are the governance framework and processes coherent, complete, well understood and functioning? Is delegation of responsibility and accountability effective ?
- How is assurance gained that risks are being managed proactively and effectively, and that information is accurate and complete?
- What do staff, including consultants, say are the main challenges to providing high quality patient-centred care?
- How does the Trust provide a supportive learning environment for junior doctors? How has feedback from junior doctors in the NTS survey been responded to?
- What steps are being taken by the Trust to understand and improve the results of the latest National Staff Survey?
- How does the Trust ensure that staff have appropriate training and appraisal (including consultants)?
- How is leadership developed and maintained at all levels?

KLoE	Key Questions and/or Sources of Assurance	WARD LEVEL
R1. How does the provider plan its services on the basis of the needs of the local population?	Are you aware of the organisation engaging with voluntary groups, and other stakeholders to help improve care on your ward and ensure that it is appropriate for the patient	
	Do you regularly witness external bodies coming on to the ward to proactively plan and assist with discharge arrangements?	
R2. How does the provider enable people from all its communities to access services in response to their needs?	Can staff describe what approaches the ward takes to ensure that it is accessible for all disabilities including information, physical and cultural barriers?	
	What actions is the ward taking to minimise the time patients wait for diagnostic services, treatment or care? Does the ward monitor 'non intervention' days?	
	Do staff believe that bed capacity and management issues are dealt with in an appropriate manner and with sensitivity towards patients?	
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	Are you aware of any instances where clinical practice or care has been revised due to patient feedback? Id so. Please provide examples	

No	Key Observations to undertake	WARD LEVEL
1	Check each qualified nurse on duty knows what the staffing level for the ward is and what to do if it is not correct	
2	Check the observed skill mix/nursing numbers comply with expectations	
3	Check that senior nursing leadership is visible on the ward floor	
4	Check through all patients notes for patient information sheet	
5	Check through all patient notes for completeness of record keeping – consent / fluid balance /MUST	
6	Check that there are no patient identifiable documents/papers within easy access of patients/carers/public	
7	All oxygen and suction equipment in place by each bed space and check portable oxygen and suction functioning (including tubing)	
8	Ensure drugs fridge temperatures have been recorded today	
9	Ensure drug trolley in place and all room and cupboard doors are closed	
10	Sufficient stock in clean utility room / sluice	
11	Check bed pan macerator working and what to do if not	
12	Check patient information leaflets available	
13	Ensure ward kitchen is stocked and housekeeper is aware of patient numbers/ preferences	
14	Check all appropriate waste disposal bins in place and ward area is tidy.	
15	Resus trolley in place. Checked and accessible.	
16	Ensure equipment checklist has been completed today and kept for archiving	
17	Ensure vital signs recording equipment is in place and working such as Sphygmanometer/ Dynamap, Thermometers, ECG Machine(s)	
18	Check each trained nurse knows how to escalate deteriorating patients – what VIEWS score	
19	Check each nurse on duty knows how many Sphygmanometer/ Dynamap, Thermometers , ECG Machine the ward should have	
20	Ensure each nurse / ward clerk knows how to report broken equipment	
21	Check all commodes for cleanliness	
22	Stock hand gel dispensers (wall and bed end) and gloves and aprons.	
23	Check all staff are using hand gel	
24	Red trays appropriately assigned and patients receive assistance	
25	Check that call bells are within reach of patients and are water jugs full on bedside tables	
26	MCA / DOLs – applied to appropriate patient – NIC aware	
27	Check that all patients have an EDD, Named Consultant and Named Nurse clearly visible	
28	Check that the ward noticeboard is accessible to the public and contains the full array of quality KPIs and is up to date, readable and informative	