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NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors: **11.01.2018**
Agenda Item: **Bo.1.18.28**

CQC Fundamental Standards: Inspections, Compliance and Assurance

Presented by:	Donna Thompson Director of Governance and Corporate Affairs/Deputy Chief Executive	**Author:**	Tanya Claridge Assistant Director of Governance and Risk
Previously considered by:	Quality Committee		

Key points	**Purpose:**
1. This paper provides an overview for the Committee in relation to the CQC's regulatory framework.	To note and gain assurance
2. This paper describes the current position of the Trust in relation to its compliance actions following the inspections in October 2014 and in January 2016.	To note and gain assurance
3. This paper provides an update on progress made against the Internal Audit recommendations.	To note and gain assurance
4. This paper provides an overview of how the Trust assures itself in relation to its overall compliance with fundamental standards.	To note and gain assurance
5. Two compliance requirements have been responded to in full and an assessment made of the effectiveness of that response, these are presented for Committee review and assurance.	To discuss and note

Executive Summary:

The Foundation Trust must ensure that they have appropriate mechanisms in place to satisfy the Care Quality Commission's (CQC) fundamental standards. The CQC has initiated a new phase of their regulatory model.

The Trust received a request to complete its Provider Information Request (PIR) at the beginning of October 2017. This was completed and submitted by the deadline. The Trust will be inspected as per the new phase of the CQC's regulatory model within 6 months of the PIR being made.

The organisational response matrix produced following the outcome, and issuing of compliance actions following the inspections in 2014 and 2016, identify (for each action plan) a suite of key performance indicators. These are monitored on a regular basis to deliver a bi-monthly update to provide oversight of progress, risks and challenges to the CQC Steering Group. An update is provided in this paper. Two actions remain outstanding and beyond their original deadline, one action remains ongoing and within deadline.

The report also summarises the approach and the outcomes of its own internal processes for monitoring and assuring compliance with the CQC Fundamental Standards. The Quality Committee receives regular reports detailing the work of the ProgRESS programme in relation to understanding our compliance with a range of fundamental standards and supporting the identification or risk, opportunities for change, and improvement and areas of good practice.

Financial implications:
Yes – Income & Expenditure

Regulatory relevance:

Monitor:	Risk Assessment Framework
	Quality Governance Framework
	Code of Governance

Equality Impact / Implications:	**Is there likely to be any impact on any of the protected characteristics?** (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☐ No ☒ If yes, what is the mitigation against this?

Other:	

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

CQC Fundamental Standards: Inspections, Compliance and Assurance

1. Introduction

The Care Quality Commission (CQC) monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and then publish what they find, including performance ratings, to help people choose care. The CQC sets out what good and outstanding care looks like, and they make sure services meet fundamental standards below which care must never fall. The CQC have a wide set of powers that allow them to protect the public and hold registered providers and managers to account. The CQC have an enforcement policy that:

- protects people who use regulated services from harm and the risk of harm, and to ensure they receive health and social care services of an appropriate standard;
- hold registered providers and managers to account for failures in how the service is provided.

The CQC's strategy for 2016 to 2021, Shaping the Future, published in May 2016[1] sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation. The CQC completed its Hospital Inspection Programme at the beginning of 2017. Following a system wide consultation[2] (between December 2016 and February 2017) the CQC has now initiated a new phase of their regulatory model. The CQC describes this as 'a more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care'.

1.2 Monitoring

In terms of how the CQC monitors NHS Trusts and decides which core services to inspect and when, the new 'CQC Insight' system is now in place; its initial focus is on existing nationally available data collections. The new, annual Provider Information Requests (PIRs) have now been implemented, and the first batch of NHS Trusts (identified on a risk basis plus those not inspected in the last 12 months) have received a new-style PIR, with targeted inspections likely to follow in the following 6 months after a PIR request. There are also quarterly relationship management meetings with Trusts, which help inform the CQC's regulatory planning.

The CQC is also going ahead with its plan for NHS Trusts to have a well-led assessment and assessment of at least one core service each year (with frequency of core service inspections subject to how services were rated at the last inspection). Trust level well-led assessments will take place approximately once a year. Trusts will be informed of the timing of these following the CQC's internal regulatory planning meetings. The CQC has indicated that the scope/depth of these well-led inspections may vary according to the nature of the individual Trust.

In relation to core services, each year the CQC will inspect all core services rated 'inadequate', half of those rated 'requires improvement', a third of those rated 'good', and a fifth of those rated 'outstanding'. In order to address concerns expressed in the consultation that long gaps between inspections for some core services could prevent Trusts being able to demonstrate improvements, some core service inspections will be triggered by information suggesting that the quality of care has improved.

[1] http://www.cqc.org.uk/sites/default/files/20160523_strategy_16-21_strategy_final_web_01.pdf

[2] http://www.cqc.org.uk/sites/default/files/20170612_next%20phase%20consultation%201%20response_final.pdf

The new assessment frameworks contain revised guidance about what 'outstanding', 'good', 'requires improvement' and 'inadequate' look like for each of the 5 Key Questions. The CQC has committed to setting out clearly in each report how it reached the rating for each question, including factors considered and how this impacted on the CQC's decision-making[3]

The CQC enforcement policy sets out in full the approach that they take to address breaches of regulations. It also reflects how they may work with other organisations to make sure that people are protected from harm, for example, through special measures regimes. The Foundation Trust was inspected in October 2014 and in January 2016. The outcome of both inspections was that the Trust 'Requires Improvement' and the Foundation Trust has implemented an action plan to address the compliance requirements identified.

The Foundation Trust must ensure that they have appropriate mechanisms in place to satisfy the CQCs standards. The Quality Committee receives regular reports detailing the work of the ProgRESS programme in relation to understanding our compliance with a range of fundamental standards and supporting the identification or risk, opportunities for change and improvement and areas of good practice. This paper describes the methods of challenge and review that the Foundation Trust uses in relation to the compliance requirements identified during the inspections referenced above.

2. Current status within the regulatory model

2.1 Provider Information Request (PIR)

The Trust received a request to complete its Provider Information Request at the beginning of October 2017. This was completed and submitted by the deadline. The request was in 3 sections:

- **Trust level request** - This is the main request, which asked about the quality of our services against the five key questions the CQC use to frame their inspections. This includes any changes in quality or activity since our previous inspection:
  Are we safe?
  Are we caring?
  Are we effective?
  Are we responsive?
  Are we well led?
- **Sector request**. This asked us to report on a limited number of key information items for core services that the Trust provides.
- **Community Health Services request** – This asked us for key information about services the Trust provides in the community.

2.2 Inspection preparation

The Trust will be inspected as per the new phase of the CQC's regulatory model within 6 months of the PIR being made. We anticipate that our core services targeted inspection and as a result will be inspected early in the new year (this is two years since our inspection in 2016). The Trust has developed and is implementing a plan that supports preparation for the inspection based on our analysis of the data submitted within the PIR and our experience of previous inspections. This plan is being monitored, challenged and assured through the Director of Strategy and Integration. The plan includes undertaking various additional assurance and challenge reviews across our services; a strategy for increasing staff awareness of the role of the CQC and the relevance of the

[3] https://www.cqc.org.uk/sites/default/files/20171020-healthcare-services-kloes-prompts-and-characteristics-showing-changes-final.pdf

fundamental standards to their daily work; and, assuring the content across, and consistent application of, various strategies.

2.3 Local System review
The CQC has been commissioned by the Secretaries of State for Health and for Communities and Local Government to undertake a local system review in Bradford. The local system reviews are looking at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. They also include an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of the management of resources. The system reviews do not include mental health services or specialist commissioning, but we will look at the experiences of people living with dementia as they travel through the system through case tracking.

The intention is that these system reviews should provide a useful reflection for each of the local areas highlighting what is working well and where there are opportunities for improving how the system works for people using services. On completion of each system review the findings will be reported to the local Authority area's Jealth and Wellbeing Board, with copies to all relevant partners across health and social care. There is an expectation that all system leaders agree to a joint action plan to progress any recommendations made.

The site visit in Bradford is due to take place from Monday 12 to Friday 16 February 2018. At least six weeks before the scheduled site visit the Trust will be required to complete a 'Local System Overview Information Request'.

3. Fundamental standard compliance: Internal Challenge and review

3.1 Compliance actions: Assessment of Key Performance Indicators
The organisational response matrix produced following the outcome, and issuing of compliance actions following the inspections in 2014 and 2016 identify, for each action plan, a suite of key performance indicators. These are monitored on a regular basis to deliver a bi-monthly update to provide oversight of progress, risks and challenges to the CQC Steering Group. The CQC steering group includes Clinical Commissioning Group representation. Any key performance indicators that are identified as being below threshold are reviewed in detail as part of the routine assurance and challenge review at that meeting. An overview of the current position is provided in Appendix 1.

3.2 Assurance and challenge reports: Quantitative indicators
Once the action plan leads identify that they believe that an action plan is complete a formal review of the action plan is undertaken. The action plan is assessed, reviewed and evidence gathered in order to obtain a level of confidence of implementation. The CQC Steering Group reviews the assessment and confirms the rating. It is then sent to the executive lead for discussion at the responsible committee where it is either signed off or any follow up actions are agreed. Two completed action plan assurance profiles can be found in appendices 2 (use of patient group directives) and 3 (Ward 24 infection control). The outcome of the discussion is fed back to the CQC Steering Group, who maintains an overview of all CQC completed action plan outcomes and subsequent risk and assurance. Once the organisation is satisfied the summary of the action and the assurance mechanism used are provided to the CQC for their review and decision in relation to evidence of compliance.

3.3 Daily compliance alert triggers-'@55'
The risk and complaints team horizon scan all reported incidents, claims and complaints on a daily basis. A trigger tool has been developed and was implemented in January 2017 that supports the identification of any issues relating to previous CQC compliance actions, previous serious incidents, NPSA alerts or incident themes and trends. Issues of concern are brought for discussion

and escalation if required to a 'daily horizon scanning' huddle. Incidents are also coded with @55 and a weekly report is generated to enable an oversight of any potential indication within the risk management system that there is sub-optimal compliance with CQC fundamental standards or themes across the Trust. These are escalated, as required, to the Quality of Care Panel; Incident Performance Management Group; or, the Learning and Surveillance Hub for discussion and the identification of appropriate mitigation.

3.4 ProgRESS reviews: Quantitative and Qualitative indicators
ProgRESS is our **PROG**rammed **R**eview of **E**ffectiveness, **S**afety and **S**ensitivity in the Trust which helps us to identify where there might be difficulties, risks, opportunities for change and improvement, or, areas of best practice in the way that we deliver our services. The programme uses a variety of qualitative tools, theories and techniques for assessing quality and service design using staff, volunteers, and patient reviewers. The reviews also look at quantitative indicators to give an overall level of confidence of compliance. Outcomes are reviewed and tracked by the CQC Steering Group. Reviews can be commissioned to provide additional assurance in relation to the effectiveness of action plans designed to address the compliance actions.

The Quality Committee receives a separate, regular update in relation to ProgRESS.

3.5 CQC scrutiny and challenge
The Foundation Trust holds regular, senior engagement meetings with the area CQC inspectors, these meetings are attended by the Director of Governance and Operations, the Chief Nurse and the Assistant Director of Governance and Risk. In addition the Assistant Director of Governance and Risk and the Deputy Chief Nurse meet monthly with the Trust's key inspector to deal with operational issues and provide assurance in relation to any issues that the CQC may have identified through their intelligence systems.

Since the last report to the Qality Committee in June the CQC have attended the Infection Prevention and Control meeting and visited Ward 24 to observe improvements made to the governance, facilities and infection prevention and control practice following the Trust's completion of the related compliance action.

The CQC have indicated that they are currently assured in relation to our response to, and progress with, their compliance recommendations from both the 2014 and 2016 inspections.

The CQC visited the Trust in November and undertook a formal review of our Duty of Candour process and outcomes. They reviewed a sample of incidents and the Trust tool for the management of the Duty of Candour. The review was undertaken in the context of the Trust's declaration of a breach in its Duty of Candour in August 2016. The Trust is awaiting the findings from the review.

3.6 NHS Improvement 'Moving to Good' programme
In October 2017 the Trust were selected by NHS Improvement as a Trust with the potential and aspiration to move from 'requires improvement' to 'good'. The support has so far involved members of the Executive Team and senior managers attending two events in Leeds with NHSI and other Trusts.

As part of the support NHSI also provided a team of Peer reviewers and on Wednesday 6th December 2017 which enabled the Trust to conduct a 'Mapping our ProgRESS in a day' event. The event enabled the Trust to review several core service areas and domains, these were:

- Governance – Corporate, Divisional, Medicines Management and Infection Prevention and Control
- Theatre Safety

- Critical Care
- Palliative Care
- Paediatrics (excluding Neonatology which have just undertaken a peer review)
- Responsive domain

These areas were selected by the CQC Steering Group to test improvements made to the services since the CQC inspection in 2016 and to assess the Trusts self-assessment of improvements to core services prior to a potential inspection.

On the day ward observations were also undertaken on the majority of wards at Bradford Royal Infirmary and at St Luke's Hospital. Community sites will be reviewed during December 2017.

4. Internal audit: assuring our own internal assurance processes

As part of the Internal Audit Plan the Foundation Trust requested work to be conducted to review our approach to assurance in relation to the Fundamental Standards. The overall finding was of significant assurance. The report had two recommendations, progress against these are detailed in Appendix 4.

Tanya Claridge
Assistant Director of Governance and Risk
January 2018

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Appendix 1: 2016 Compliance action plan overview (December 2017)

Compliance actions completed (which exceeded the original agreed deadline) and require internal assurance

Number	Required Outcome	Executive Lead	Completion date	Status	Reason for extension beyond completion date	Date of completion
2016_1	The Trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels.	Chief Nurse	31/03/2017	Complete	The majority of actions are complete. SafeCare implementation is ongoing; all wards have been trained and have begun to submit data. Four pilot wards are trialling tests of change for 1 to 1 nurse pool. This includes interventions to adopt priority to request a special. The Executive team are planning to discuss achievement of this action plan further with CQC.	December 2017
2016_3	Ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed.	Director of Governance & Operations	31/03/2017	Complete	The action planning toolkit has been developed, tested and approved by the Learning and Surveillance Hub. The deadline was exceeded due to ensuring appropriate engagement from members of staff that use action plans regularly.	December 2017

Action plans within agreed deadlines

Number	Required outcome	Executive Lead	Completion date	Status	Update
2016_2	Ensure that there is in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed including incident reporting and lessons learnt from these.	Director of Governance & Operations	31/03/2018	Ongoing	Work has begun and is planned for 2017 to undertake a formal review of corporate and divisional governance structure and reporting. A quality oversight system has been established through the Learning and Surveillance Hub. Governance has been tested during the Mapping our ProgRESS day with NHSI and outcome reports are being developed.

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Completed actions

Number	Required Outcome	Executive Lead	Completion date	Status	Outcome	Assurance and challenge rating
2016_5b	Ensure that all staff have had an annual appraisal.	Director of Governance & Operations	31/03/2017	**Complete**	The action plan is complete. An assurance review was planned for October 2017, but delayed due to PIR submission. Now planned for January 2018.	TBC
2016_6	Ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to Ensure that patients are protected from the risks of delayed treatment and care.	Director of Governance & Operations	31/03/2017	**Complete**	The action plan is complete. An assurance review was planned for October 2017, but delayed due to PIR submission. Now planned for January 2018.	TBC
2016_7	Ensure that patient information is held securely and patient confidentiality is maintained in relation to information about victims of domestic violence and the storage of property bags for deceased patients.	Medical Director	31/12/2016	**Complete**	The action plan is complete. An assurance and challenge review outcome was confidence.	**Confidence**
2016_8	Ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and the cleaning of equipment.	Chief Nurse	31/03/2017	**Complete**	The action plan is complete. An assurance and challenge review outcome was confidence.	**Confidence**
2016_9	Ensure that the use of patient group directions in A&E is in-line with trust policy.	Medical Director	31/12/2016	**Complete**	The action plan is complete. A challenge and assurance review outcome was confidence.	**Confidence**
2016_11	The Trust must review and risk assess the environment on ward 24 and put in place actions to mitigate the risk of the spread of infection.	Chief Nurse	30/10/2016	**Complete**	The action plan is complete. A challenge and assurance review outcome was confidence.	**Confidence**

2016_4	Ensure that there is, in operation, an effective system for reviewing and updating policies and procedures to ensure that patients are protected from receiving inappropriate or unsafe care or treatment.	Director of Governance & Operations	31/03/2017	**Complete**	. As of 01/12/17 1269 documents have been identified and compliance currently is 90.1%.	**Agreement to be sought in relation to assurance mechanism from the CQC (Jan 2018)**
2016_10	Ensure that relevant staff working in surgery comply with the five steps safer surgery process and that the WHO surgical checklist is consistently implemented.	Director of Governance & Operations	30/09/2017 Ext agreed by CQC	**Complete**	The action plan is complete. Theatre Safety has been tested during the Mapping our ProgRESS day. The reports are currently being populated.	
2016_5a	Ensure that all staff have completed mandatory training and role specific training.	Director of Governance & Operations	31/03/2017	**Complete**	Agreement to be sought in relation to assurance mechanism from the CQC (January 2018).	

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Appendix 2: Responding to our 2016 CQC inspection: Assurance and Challenge: Use of Patient Group Directives

The Trust needs to ensure that the use of patient group directions in A&E is in-line with trust policy.			
Governance			
Executive Lead	**Overview Committee**	**Action plan leadership**	**Sub Committee/ Group/ work-stream**
Chief Nurse	Quality and Safety Committee	Deputy Director of Pharmacy (Governance)	Speciality Governance meeting
Assurance level			
Confidence	The trust action plan is complete. All PGDs have been reviewed, updated and are in date. All information regarding the review, assessment and develop of PGDs has been communicated to relevant staff.		

Objective or Aim to be delivered	**Actions and tasks to achieve the objective or aim**	**Named Individual responsible**	**Start Date**	**End Date**
To ensure all PGDs in use across the Trust are in date.	Review PGD database and assess which PGDs are out of date or approaching review.	Kim Towers	19.08.16	31.12.16
	Contact PGD authors and request review by agreed deadline/s.	Kim Towers	19.08.16	31.12.16
To upload the PGD's to the centralised library on SharePoint in line with the trusts procedure for locally developed document (see action plan 4).	Log and upload all PGD's once of the agreed standard.	Lucy Atkin	01.08.16	31.12.16
All PGDs have been reviewed and compliance with the Trust standard for clinical guidelines is currently100%. The Assurance Team have agreed with Pharmacy that control of the PGDs will remain with them as per the current process. The Assurance team track the percentage of in date PGDs fortnightly and flag any concerns with them as per the process for all other clinical guidelines.				

Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named Individual responsible	Start Date	End Date
To ensure each member of staff working to a PGD has signed to say they have read and understand the PGD, and that the authorising manager has confirmed competence to operate under the PGD.	Communicate with all departments using PGDs the requirements of service managers to ensure all actions have been undertaken.	Rachel Urban.	19.08.2016	31.10.2016
	Communicate with professional leads within each area the responsibilities of service leads.	Rachel Urban.	19.08.2016	31.10.2016
	Each area to ensure PGD competencies are signed off as per PGD policy.	Head of relevant service or department utilising PGDs	19.08.2016	31.10.2016
To communicate to Trust staff where to access approved PGDs	Add information to Medicines Safety Newsletter and communicate at relevant forums.	Rachel Urban	19.08.16	14.09.16
To ensure that all areas operating under PGDs undertake regular audit of practice vs the PGD and report this to the Medicines Safety Group	Communicate to all departments the requirements re audit for PGDs.	Rachel Urban		
	Develop a standard audit tool for areas to use.		19.08.16	14.09.16
The actions above were communicated via email to Matrons, Heads of Nursing, Pharmacy and Education and Training on 20/9/2016 to cascade to all service leads/managers. Email included Medicines Message Newsletter on PGDs, audit tool for auditing PGD use and questionnaire on how medications are supplied within each area. This was also discussed at the Nursing and Midwifery Forum on 11 August 2016.				

Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named Individual responsible	Start Date	End Date
To communicate information on how to develop, review and implement PGDs.	Communicate information to all departments	Rachel Urban	19.08.16	14.09.16
To review practice in A&E and develop action plan to address any issues identified.	Meet with relevant consultant and nursing lead within A&E to discuss and develop.	Neill McDonald and Rachel Urban	19.08.16	30.09.16
How to develop, review and implements PGDs was communicated via email to Matrons, Heads of Nursing, Pharmacy and Education and training on 20/9/2016 to cascade to all service leads/managers. Email included Medicines Message Newsletter on PGDs, audit tool for auditing PGD use and questionnaire on how medications are supplied within each area. This was also discussed at the Nursing and Midwifery Forum on 11 August 2016. The meeting with AED was held and all AED PGDs were reviewed and updated.				

Plan on a Page: Patient Group Directives (summary)	
Compliance	
Risk management	**Assurance**
Regular audit of compliance	**Fortnightly review of policy compliance. Staff conversations regard awareness and knowledge of PGDs.**
Continuous improvement (processes and tools)	
Regular audit of PGD compliance	
Behaviours (Mandates and resources)	
Ensure review and assessment of local audit findings and track any associated actions (Medicines Safety Group)	

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Appendix 3: responding to our CQC inspection 2016: Ward 24 Infection Control

The trust must review and risks assess the environment on ward 24 and put in place actions to mitigate risk of the spread of infection.			
Governance			
Executive Lead	**Overview Committee**	**Action plan leadership**	**Sub Committee/ Group/ work-stream**
Chief Nurse	Quality and Safety Committee	Director of Infection Prevention and Control	Infection Prevention and Control Committee
Assurance level			
Confidence	The trust action plan is complete. The risk assessment was completed and shared with the Division. The internal walls have been repaired and repainted and new hand wash basins installed. Further work will be undertaken in 2017 to create a separate commode storage area.		

Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named Individual responsible	Start Date	End Date
The Trust will understand the risk associated with the environment on Ward 24 regarding prevention of HCAI.	Undertake an IPC risk assessment of the ward environment on ward 24 including position and access to hand wash basins, ward bathroom and shower.	Rosemarie Dobson	01/08/2016	31/10/2016
The Trust will respond to the outcome of the risk assessment and put appropriate mitigation in place.	Generate a risk and control log with an associated action plan.	Rosemarie Dobson	01/08/2016	31/10/2016
	Escalate any high level risks as per the Trust's risk escalation framework.			
The Trust will be confident that the IPC procedures related to standard precautions is complied with on the ward.	IPC nurses to assess IPC standard precautions on the ward including observation and audit of hand hygiene, PPE use, commode cleaning and compliance with 'I am clean' indicator tape .	Rosemarie Dobson/Simon Joseph	01/08/2016	30/09/2016

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Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named Individual responsible	Start Date	End Date
A review of Ward 24 was undertaken on 22nd September 16 and a risk assessment completed. A risk and control log was generated and shared with the Division as per the risk escalation framework. The risk assessment recommended repair to the internal walls and installation of wash hand basins which is complete. The assessment also recommended a separate commode storage area be created; this work has been approved and factored into the Trust's estates improvement plan. IPC nurses assessed IPC standards on Ward 24 in September 2016. The ward regularly completes IPC audits as per the Trust standard.				

Plan on a Page: Ward 24 (summary)	
Compliance	
Risk management	**Assurance**
Monthly data collection Ward accreditation scheme	Audit results on Meridian discussed at Infection Prevention and Control Committee.
Continuous improvement (processes and tools)	
Monthly audit of compliance	
Behaviours (Mandates and resources)	
Ensure review and assessment of local audit findings and track any associated actions (IPCC)	

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Appendix 4: Progress against internal audit recommendations

Report Ref	Report Name	Rating	Issue	Recommendation	Priority / Status	Responsibility	Original action date	Update	Status
BH/45/17	Monitoring CQC Compliance	Significant	Fundamental Standards Matrix	The Fundamental Standards Matrix should be an embedded document, which is updated frequently and presented to an appropriate oversight committee on a regular basis.	Medium	Director of Governance and Operations	30-Nov-17	The matrix has been updated post the revision of the CQC Fundamental Standards and will be brought to the CQC Steering Group on a quarterly basis	The matrix has been revised and will be presented at the CQC Steering Group In January 2018. The Trust has purchased a CQC compliance module for Datix which will simplify and improve reporting.
BH/45/17	Monitoring CQC Compliance	Significant	External Visits Policy	The Policy for Management of External Agency Visits should be reviewed and updated as appropriate.	Low	Director of Governance and Operations	30-Nov-17	This has been reviewed and rewritten. It requires a period of consultation,	Complete