The Royal Wolverhampton
NHS Trust

Care Quality Commission Action Plan
3 December 2018

Agenda Item No: 11.4

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS
NHS Trust

Trust Board

Meeting Date:	3rd December 2018
Title:	Care Quality Commission Action Plan
Purpose of the Report:	Advise
Summary:	Following the CQC inspection report dated June 2018 an action plan has been developed to include corporate and local actions. The Trust Management Committee will receive the plan and progress on a monthly basis until all actions are closed or being monitored by another sub Board Committee. This is the first update presented since development of the plan and agreement by both Directorates and Divisions regards monitoring and reporting action progress.
Action required:	To approve the plan and deliver actions outlined within the timeframe.
Clinical implications and view	As above
Patient, carer, public impact and views	Nil
Author + Contact Details:	Debra Hickman Deputy Chief Nurse Tel 01902 695968 Email debrahickman@nhs.net
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Links to Assurances	
Resource Implications:	Revenue: Capital: bereavement suite Workforce: a number of business cases are in process regards outreach expansion, palliative care expansion, sepsis nurses, bereavement nurses, ME roles and SJR reviewers regards backlogs Funding Source: various
Risks:	
Risk register reference:	TRR 3644 Amber (9)
Other formal bodies involved:	
References	https://www.cqc.org.uk/sites/default/files/new_reports/AAAH3914.pdf

Report Details

1.	The final report was received and published in June 2018, the attached action plan – appendix 1 was subsequently developed and presented to TMC for approval in July 2018 and subsequently September 2018. The action plan includes all transactional requirements identified from the anoounced inspection of March 2018, it also requests Directorates and Divisons to consider 'stretch' targets on how they will look to improve outcomes from previous ratings. This will be monitored via the Disional performance process, this will feature in future updates. This report provides the first update received from Directorates identified with specific actions, acknowledging not all core services were inspected. Divsions have also provided an overview on improvements made whereby system/process issues had a Trustwide impact.
2.	The following actions have been completed and closure approved via TMC are: 1.1.4 – Mixed equipment storage of clean & dirty items, this has now bwwn addressed. 2.3 – review of elective surgical readmsission rates 2.5 – Treatment waiting times disaggregation by site to address specific issues 1.6 – Explore staffing as per Birth rate plus methodology in Maternity
3.	Areas for focus: IP/HH Mandatory training Staffing levels Health & Safety Incidents and Audits Reuscitation trolley content compliance Fridge monitoring SOP for approval and roll out NatSips & LocSips requirements to be reviewed and audited SOP development regards O2 cylinder monitoring MCA/DoLs awareness, training compliance and audit
4.	Items for note: 4.1.3 – ISAS accreditation in Radiology, the service are not pursuing this at present

Appendices

1	Appendix 1 – CQC Trust Action plan

Appendix 1

CQC Action Plan

Beige writing Maria Arthur
Red writing Clair Hobbs
Blue writing Tracy Palmer
Purple writing Nicky Ballard
Green Sandra Roberts
Brown Kate Shaw
Orange Bev Morgan

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust				
									Directorate	Division	Trust	Trust Lead/Assurance group	
1.0 Safe													
1.1	**Improve Hand Hygiene practice consistently in Diagnostic imaging:**												
1.1.1	IP/HH mandatory training 100%.	DMT	31/05/2018	Directorate Gov Meet.	Training data				Management to review, cleanse and follow up red mandatory training. ED, Theatres, Diagnostic Imaging to address mandatory training non compliance	Division to set a 2 month improvement target for red mandatory training. Dv1 - Divisional position red 92.6%, nursing is however green at 95.5%. Dv 2 mandatory training 92.8 Dv 3 - DMT:Mandatory Training a focus of monthly performance meetings with Directorates held to account for delivery against target, divisional position is 95.55% Dv 3 - Directorates: Monthly monitoring of compliance in place.	Mandatory Training leads to target offers of training to poor compliance areas.	IPCG - Training SME	Blue Debra Hickman
1.1.2	Audit practice	DMT	31/05/2018	Directorate Gov Meet.	Audit reports	Implement oversight audits			Implement local audits	Dv1 - we track divisional compliance every month at divisional governance meeting. Whilst we are 5% behind our projection currently , we are in a better position than the previous 2 years at this same time. Dv 2 - Audit compliance is reviewed at the divisional monthly governance meetings and monitoring ongoing Dv 3 - Directorates: Audits reviewed monthly and progress monitoring in place. Support from Governance as required	Implement oversight audits - Div 3 behind trajectory. QIPP programees being introduced for medics - aid complaince	IP/IPCG	Red Sally Evans
1.1.3	Maintain cleaning logs	Surgery Dir MT	31/12/2018			Dv 1 - 100% compliance with completion and assurance.	E. Lengyel, Matron		Surgery core service to monitor compliance with cleaning logs	Dv 1 - Head of Nursing to add to Matron 1:1 for discussion. Dv 2 - Monitored at 1-1 Dv 1 - Matron now has monthly assurance from each band 7 lead. Less dust at both CCH and New Cross sites now most building work is complete. Monthly audits had shown an issue with dust on Theatre trolleys underneath - this has been addressed in all Theatres apart from CCH now by employing an additional floating TSA who has cleaning as part of their daily tasks. CCH post currently out to advert.	Revised cleaning strategies approved last month - relaunched	Environmental Group	
1.1.4	Mixed equipment storage clean in dirty – Diagnostic	Radiology Dir MT	30/11/2018			Environmental Audits			Review and address clean/dirty storage and include within local environmental audits. Dv 3 Radiology: The clean and dirty storage has been reviewed and is now separated out.Mixed equipment storage clean in dirty- Diagnostics				
1.1.5	Review safe staffing levels	Dir MT/DMT	30/04/2018			Consider assurance regards other professional groups			Medicine and Radiology to review safe staffing levels Dv 3 - Radiology: There is an algorithm for staffing in all of the areas in Radiology. Team leaders work coherently so no area goes understaffed. There are options to close scanners or bring additional staff in on overtime should the need arise. Demand and capacity work underway which includes workforce. Review safe staffing levels- Biannual review Ongoing monitoring	Dv 1 - Medicine - Biannual skill mix currently in progress.	Workforce review - Nursing, Medics to inform targeted action.	HR, Associate Chief Nurse	
1.1.6	Establish stock expiry checks – Diagnostic	Radiology Dir MT	30/11/2018						Directorates to ensure robust checking systems for stock expiry. Dv 3 - Radiology: Checking systems in place.Establish stock expiry checks Diagnostics- weekly review. Audit to confirm it is working.				
1.2	**Ensure COSHH compliance across services**												
1.2.1	Assess COSHH compliance in wards/depts.	HSO	31/01/2018	HSSG	Audits	Environmental Audits	Margaret Simcock		Implement COSHH risk assessment and control actions - Medical core service. - H&S department will be rolling out re-education for wards and departments and recommunication of procedures	Dv 3 - Directorates: COSHH compliance part of Service Lead/Manager role. Awaiting outcome of H&S Audit to identify further actions	H&S audit programme covering COSHH to prioritise areas identified by CQC.	HSO	
1.2.2	Directorates to action gaps.	DMT	31/12/2018	HSSG	Re- audits			Dec-18	Carry out local H&S, environmental inspections and follow up actions. (Margaret.S) Further awareness is to be issued in next issue of Risky Business. GP's via Primary Care Directorate requested to provide list of chemicals used. Due 14/12/18, Once received these will be added to Trust COSHH register Due 31/1/18, The above will enable risk assessment templates to be issued Due 31/12/18	Dv 1 - Last report received August 2018 meeting for quarter 1. Reduced number of incidents from Q4 (109 to 82). Top 3 categories continue to be violence and aggression, sharps, manual handling. No RIDDOR in Q1. H&S self assessments - local returns can be challenging, currently at 25% return. Directorates being challenged by Division. CAS alerts proactively being closed via Division. Environmental reports received monthly; non-returns have been addressed by Head of Nursing. Local environmental audits in theatres done weekly plus monthly audits and communicated at leadership meeting. Dv 3 - DMT: receive/ review quarterly H&S reports at Div Gov meetings Dv 3 - Directorates: Implement actions from environmental inspections and report to Division			

Purple writing Nicky Ballard

Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
1.3	Emergency trolley stock complies with Policy	DMT	30/11/2018	Resus Group	Audits		Nicola Wise			Dv 1 - Division to review planned resus audit results, QRV results, NAAS results and wider discussion in regards to quality rounds and findings. Dv 1 - Most recent resus audit was discussed at governance in August; showed non-compliance for daily checks in 4 areas (A15 Theatre recovery Paeds - 2 days, WEI, Mary Jones Ward - 1 day, B9 ICCU - 3 days, A26 Fracture clinic - 1 day). No equipment missing across Division 1. No gaps in checks for the inpatient areas. No gaps in weekly checks for any area. Results discussed at Matrons 1:1s and at divisional nursing leadership meeting plus emails sent to directorates for discussion and action at their governance meetings.	Review arrangements, programme and frequency of resuscitation audits, how results fed back and actioned. Reaudit of non compliance, paed trolleys - 83% revisit 100%	Resus Group
1.4.1	Staff communication and training around medication incidents (Discharge lounge/A5/A9/Medical Core Services)	DMT	30/11/2018	MMG	E mails / Training records / Alert notices	Medication Safety Officer to attend all Div Gov meetings	Alison Tennant			Dv 1 - Division requested Medication Safety Officer to attend Governance meeting to discuss concerns regarding increased reporting from General Surgery. Officer reported that these were no harm or low level harm incidents and the increase showed assurance of a good reporting culture. No significant concerns highlighted for division apart from Critical Care directorate where she is working with the teams to try and improve reporting from the area.	(Alison.T) New datix categories have been implemented. Monthly IGR reports sent to directorates contain details on number and categories of medication incidents. Further detail provided by governance officer and directorate pharmacist where there is one.	
1.4.2	Medication prescription, administration and storage (including chemotherapy drugs)	Dir Phar	31/12/2018	MMG	Audits				Review medicines storage security (including high risk medicines) in Outpatients core service Dv 3 - Pharmacy: Framework in place. Reporting being escalated to senior nurses, matrons and through pharmacy governance. (Alison.T) Framework in place. Reporting being escalated to senior nurses, matrons and through pharmacy governance.		Implement and report Medication audit programme (prescription, administration and storage)	Dir of Pharm
1.5	Ensure secure access for medicines and temperature monitoring. (Medicine and Surgery)	DMT	28/02/2019	MMG	Audits				Follow up to ensure fridge temperature checks in ED. Dv 3 - Pharmacy: Fridge monitoring SOP progressing. On agenda for November Policy Group (Alison.T) Fridge monitoring SOP progressing. On agenda for November Policy Group.	Dv 1 - No issues reported to Division in regards to Fridge temps -managed locally at present.	Review arrangements for the oversight of fridge temperature checks and reporting to areas.	Dir of Pharm
1.6	Explore staffing issues in midwifery through Birth rate+ review and identify links to SIs.HoM	HoM	30/11/2018	DirGovM	Business case				Monitored via maternity dashboard	Dv 1 - BR+ report working towards Midwife to birth ratio of 1:27 presently 1:29. Successful recruitment day on 8th October appointed into all current vacancies, and vacancies identified within BR+ report. as above all datix relating to staffing are reviewed by Matrons and HoM and SI's related to staffing are discussed at risk meeting.Birth rate + midwifery workforce review is complete. We are collecting data through weekly risk meeting in terms of any SUI's relating to staffing specifically surrounding any delays in care. This is work in progress.		
1.7	**Number and Learning from Never Events**											
1.7.1	AfPP Review	DivMT	31/01/2019	QSIG	Report	Dv 1 - No never events.	Dv 1 - DMT team members	Mar-19	Dv 1 - To ensure all team members attend AfPP training.	Divisional oversight of compliance results and monitoring of progress. Dv 1 - Peer review completed and local action plan in place; being monitored via Matron 1:1 with Head of Nursing currently. First all team training event took place on 10/10/18 with 56 attendees. Further training due 18/10/18 with 58 staff expected to be in attendance. Further dates to be agreed - probably for January 2019.		
1.7.2	NatSSIPs/LocSSIPs in practice	DivMT	31/12/2018	QSIG	Audits	Dv 1 - Full suite of LoCCSIPs per directorate with annual plan for audit and compliance.	Ian Badger - Dv 1 - Ian Badger for division 1	Mar-19	Dv 1 - Each directorate will have a suite of LocSSIPS available within their intranet page. Annual audits will be performed on these LocSSIPs and presented to Div. Governance and then QSIG.	Audit of NatSsips and LocSsips via QSIG. Divisional oversight of compliance results and monitoring of progress. Dv 1 - Peer review completed and local action plan in place; being monitored via Matron 1:1 with Head of Nursing currently. First all team training event took place on 10/10/18 with 56 Dv 1 - Audits reviewed by Directorate at each Divisional meeting prior to presentation at QSIG. Directorates challenged on any concerns from results and reattendance offered as necessary. Dv 2 - each Directorate has an established set. Discussed at Divisional performance meetings.Dv 3 - DMT: need to scope LocSSIPs in diagnostic and outpatient services to identify any gaps and resolve		

Purple writing Nicky Ballard

Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
1.7.3	Review WHO checklist use in theatres and interventional procedures including ongoing educational support.	DivMT	30/08/2018	QSIG	Audits	Dv 1 - Qualitative audit results show full compliance to checklist and brief.	E. Lengyel, Matron & M. Ahudja, CD. DMT	Mar-19	Investigate and address WHO non-compliance issues across relevant Directorates (notably theatres NX, CCH.	Divisional oversight of compliance results and monitoring of progress. Dv 1 - Quarterly results discussed at Divisional Governance in October - main issue is in regards to the sign in not being done separately - it has been agreed that the WHO documentation should now be reviewed and amended to provide a further focus. A working group is being set up by Matron to lead on this. Further discussion on completion n of draft document to go to Div. Gov meeting. Dv 3 - DMT: WHO checklist returns gathered monthly and reported quarterly to SIG by Divisional Heads of Nursing	Undertake safety culture survey.	Nursing and Quality, HR
1.8	Identify causes of poor documentation including HF and redress (including fluid and nutritional records, re-positioning, patient care and treatment, care planning records) .	DMT	31/05/2018	DivGovM	Audits		Audit/monitor documentation compliance in ED, Medical core service Dv 2 - Monthly audit undertaken, reported the divisional governance.		Undertake care pathway review (including ED system and processes) to understand challenges/barriers. Outline expected standards via SOPs, training, induction and appraisal. Identify and undertake local prospective audits of records with prompt/live reporting of results.	Performance oversight monitoring of Documentation audit compliance. Monitor action plans from external reports, HF reviews and action plans in ED. Dv 1 - Documentation audit discussed at Governance in October - main issue is in regards to stamps. Communication has been sent to each directorate for how to order stamps and to share audit results locally. Poor compliance with documentation evident through Health assure dashboard which Head of Nursing discusses as necessary with relevant areas.	Develop system to enable live audit reporting. Establish resource requirement for HF training/expertise at RWT. Nursing audit review	HGLS/QSIG
1.9	Establish system and address triage delays in ED.	DMT	31/05/2018	DGovM	SOP							
1.10	Mental Capacity Act documentation and compliance.	HoSG	31/01/2019	SSG	Audits		Fiona Pickford		Medical and Maternity core service to address MCA/DoLs training compliance. Review and assure on staff training and competence in Surgery.	Training Needs Analysis (TNA) was completed to identify specific staff groups who needed to complete the training. 7. MCA and DoLs training is incorporated in the level 2 safeguarding adult and children's eLearning package which is available on kite site. Five additional training sessions have been provided in September 2017 by an outside speaker Susan Lassetter- MCA/DoLs Project Worker. MCA and DoLs training compliance is now at 97.7% (Sept 2018) MCA/DoLs was promoted on the Safeguarding Awareness week on 2nd October 2018. 12. Staff from the safeguarding team to be out on the key wards daily asking if there are any patients in tag bays in particular that would warrant DoLs. A meeting as taken place with Sister and the Dementia Nurse Consultant on C22 on ways the staff can complete the DoLS applications when working in the bays. There has been an increase in the number of urgent DoLs applications received from C22.15. MCA and DoLs audit to be completed by November 2018. The staff group includes all clinical front facing staff so would need to complete level 2 safeguarding adults and children's e-learning package available on kite.	Develop programme of routine audit of safeguarding documentation (prioritising high use areas)	Head of Safeguarding/ Safeguarding Steering group
1.11	Develop SOP for local checking of Oxygen cylinders to comply with national regulation.	DMTs	18/04/2018	Med. Gases Group	Audits		Sandra Roberts / Brendan Houston		Implement O2 check in local processes according to Policy (notably in Diagnostics).Dv 3 - Radiology: SOP in development - Introduced as a SOP and put in to OP86 policy and ratified in April '18	Dv 1 - Areas checked as part of quality rounds and no incidents have been reported in regards to Oxygen cylinders	Review policy requirement for O2 checks and roll out with compliance oversight by the Medical gases group.	Medical Gasses group
1.12	Review Dress Code policy and clarify wearing of scrubs, and establish process for observing non compliance	Dir WOD	30/11/2018	Policy Group	Policy				Directorate management to communicate, enforce and monitor compliance with Dress code policy (notably CCH theatres).	Trust policy reviewed and amended 4th Oct '18		
1.13	Establish system in theatres to ensure theatres are fit for purpose when in use (NX and CCH theatres).	DMT	31/05/2018	DivGovMeeting / Environmental Group	Audit		Tom Butler - Lewis Grant, DCOO	Mar-19		Div, Gov & Estates Dv 1 - Building work complete. Fire compartmentalisation starts wc 22/10/18. CCH work complete. Cleaning logs have been amended to address all equipment in each area. Band 7s continue to report monthly to Matron and escalate as necessary to estates. Theatre trollies are damp dusted daily. Also have appointed an environmental support worker whose job is to clean and maintain a tidy area/high standards I Theatre including equipment reports. No audits failed this quarter.- Theatre action plan to be developed		
1.14	**Agree Trust Quality/Safety Cultural Survey**	CNO	31/08/2018	Board	Survey						Trust to identify and undertake a Culture survey with financial year 2018/19. NSF - Nursing	Nursing and Quality, HR

Purple writing Nicky Ballard

Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
1.14.1	Completion of survey annually by departments	DMT/Heads Dept	31/12/2018	Workforce	Survey reports		Alan Duffell		All Directorates/sub-teams to undertake annual stress risk assessments. All departments to communicate chatback results, review and complete action plans following feedback.	Ensure oversight of Chatback results and action planning. Dv 1 - culture survey for Maternity completed. Dv 3 - DMT: stress risk assessments monitored as part of H&S assessment requirements. Key findings from stress RA, Chatback, Staff Survey etc. reviewed at monthly performance meetings.	Monitor and follow up response and action planning in hotspot areas, offering further support as needed.	HR
1.15	Develop the model of Discharge Lounge including vision and DMO	DMT	31/08/2018	DivMT	Model					Review staff training/awareness of Discharge lounge staff re clinical care/deterioration/escalation - Dv 2 - SOP completed, approved by Division. Allocated funding to commence some building re-configuration. This will incorporate quality initiatives for improved patient experience		
1.16.1	**Review Safeguarding training policy for scope**	HoS	31/10/2018	SSG	Policy				(Fiona.P) Revised Safeguarding Children and Adult Training Programme commenced which covers October 2018 to 2021.		Review	
1.16.2	Ensure a Safeguarding system for full staff compliance to Policy	DMT/Heads	31/08/2018	DivGov	Training records	Dv 1 - Training to be consistently green across division.	Dv 1 - DMDs, Head of Nursing, Head of Midwifery	Dec-18	Management to review, cleanse and follow up red mandatory training. Address safeguarding training non compliance in Maternity , Diagnostic Imaging particularly Medical staff L3) -	Division to set a 2 month improvement target for red mandatory training. Dv 1 - Safeguarding Adults: green at 97.9%. Safeguarding children level 1: green at 98.7%. Dv 2 - Current process has not seen improvement particularly regarding medical staff compliance. New targeted communication process to be piloted as of October 2018. Dv 3 - DMT: Mandatory Training a focus of monthly performance meetings Dv 3 - Directorates: Action plans in place. Discussed weekly at Team meetings and staff briefings. Formally to reported to Division to monthly	Review target populations for safeguarding training levels (within policy) to ensure appropriate and achievable. Safeguarding team to target low compliance areas and staff groups for targeted training.	Head of Safeguarding
1.16.3	Implement MCA/DoLs assessment audits	DMT	30/04/2018	DivGov/SSG	Audits					Dv 1 - Not complete Dv 2 - all nursing audit under review. Dv 3 - Implement MCA/DOLs assessment audits- Nursing audits are being reviewed across the division. 3m review	Safeguarding team to devise routine audit for MCA/DoLs and reporting results .	Head of Safeguarding
2.0 Effective												
2.1	Audit Sepsis 6 compliance and identify issues to action including human factors	Sepsis leadsx2	31/01/2019	DPG	Audits		Yat Wah Li		This is an ongoing action with audit in the form of data submission for CQUIN in addition to sepsis reports provided as part of the DPG meeting on a monthly basis. we have focused on ED, haematology/oncology and recently paediatric wards with regards to sepsis management. We will also be interviewing for sepsis nurses on 27th November and have VitalPAC (with NEWS2/sepsis module implementation) being delayed until 31 Jan 2019.	CQUIN Audits 1/4 yearly ED and Inpts	Develop routine annual audit plan for Sepsis, monitored by DPG. CQUIN compliance IQPR VitalPac upgrade and CD rollout sepsis nurses	DPG
2.2	Develop structure/process for Mortality reviews	Medical Director	30/08/2019	MRG/TB	Report		Ananth Viswanath		Directorate management to monitor the completion and analysis of death reviews for the service ensuring adequate trained reviewers and time to complete. Death review analysis/outcomes to be actioned at local Governance/Mortality meetings. Dv 3 - Paediatrics: Mortality reviewed as part of Directorate performance and local governance processes (Ananth.V) - learning from deaths policy (OP 87) will be revised to incorporate Medical Examiners model that dovetails with mortality reviews by Dec '18 - Medical Examiners appointed and will be accommodated in a purpose-built bereavement centre by Nov '18 - Medical Examiners will undertake initial scrutiny of all deaths in hospital and identify cases for more detailed SJR reviews by Dec '18 - We are aiming to have a team of dedicated and trained mortality reviewers to ensure the reviews are timely and independent by Jan '19. - An IT platform to support the learning from deaths agenda and reduce administrative burden is being commissioned by Aug '19	Divisions to oversee Directorate Mortality review (performance and outcomes) as routine within their Quality/Governance agenda. v 1 - Discussed as a standard agenda item quarterly at Divisional Governance. Head of Nursing encouraging more staff to attend SJR training. Mortality returns are overseen by Division and areas invited to explain poor compliance to div gov meeting as necessary (most recent being Crit Care). Dv 3 - DMT: Mortality a standing item on Div Gov agenda.	Increase pool of staff trained in SJR. Project group to address key issues including backlog of reviews, standard mortality reporting, policy compliance etc. Trust Mortality group to monitor assurance on mortality review outcomes. ME Role commences 3/12/18. Q! Mortality plan	Mortality Project Group
												Green Gwen Nuttall
2.3	Implement a review of elective surgical readmission rates	DMD Div1	30/11/2018	DivGov	Audits					Dv 1 - Suggest to close. Admissions categorised into related and unrelated conditions. Results so far show we are below national average		
2.4	National benchmark of mothers receiving steroids post prem delivery – outlier result in Maternity	Dir MT	30/11/2018						Maternity to investigate and address result to National benchmark.	Dv 1 Policy in place for steroid use for preterm mothers is in line with national best practice / guidance.		
2.5	Treatment waiting times disaggregation by site to address specific issues – Surgery	DMT Surgery	30/11/2018							Amend waiting time reporting by site. Dv 1 - Suggest to close. Same on both sites. Work already part of on-going programme through OTEG.		
3.0 Caring												

Purple writing Nicky Ballard

Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
3.1	Identify ways to reduce lengthy delays for patient transport.	Div 2 DCOO	31/05/2018	DivMT	Audit				Review/establish contract compliance monitoring.		Esculated to CCG contract monitoring in place. Improving position. Test of change will be winter	
4.0 Responsive												
4.1	Achieve national targets for RTT - external review	DCOOs	30/06/2019	Contract & Performance / DivMT	Report		Kevin Stringer / Gwen Nuttall / Mike Sharon		Dv 3 - DMT: RTT monitoring in place . We did however have an intensive support review (external) for our cancer 62 pathways. This report was completed in Aug 18, the evidence via report is available and has been shared with Finance & Performance, Quality Governance and TMC. The accountable leads are myself and Simon Grummet (Trust cancer lead).	Review surgical admission pathways to improve RTT Dv 1 - Trust wide issue which is ongoing and picked up in other forums. Highlighted in cover report	RTT performance monitored.Improvement plan in place	
4.1.1	Implement recommendations	DCOOs	tbc	F&PC	IQPR							
4.1.2	EPAU having no weekend service – Gynae	Dir MT	30/04/2018						Gynaecology to review weekend service provision for EPAU	Dv 1 - EPAU – no service at the weekends this relates to challenges within the sonography service. HOM and Matron are future proofing service for Nurse and Midwife led sonography service – 2 RM's and 2 RN's are undergoing training and this will be a rolling training programme for the future .Presently the sonography service is challenged – vacancy and sickness has created some capacity issues, this is a risk that is escalated to divisional RR, and COO is aware. This means that presently we are unable to provide a 7 day service, this is under continual review and is being monitored closely. Recruitment is in progress – there is a recognised lack of experienced sonographers locally and nationally. Succession planning and development of staff in scanning competencies to support service is in progress.		
4.1.3	No ISAS sign up/accreditation – Diagnostic	Dir MT	30/11/2018						Radiology to review/consider accreditation requirement. Dv 3 - Radiology: This is not being considered at present TMC to note and approve			
4.1.4	LD/Dementia provision – Diagnostic	Radiology Dir MT	31/03/2019						Directorate to review LD patient needs within the service and address Dv 3 - Radiology: There is no written process for this as yet. Work with Dementia Leads to support best practice hoping to have implemented by March 2019 LD/Dementia Provision Diagnostic- Working with Dementia leads for completion (Fiona.P) LD All Ages Strategy completed. New LD posts (children and adult) x 2 Band 6 in recruitment stage. Expect to be in post by end of March 2019		Strategies rollout flags on portal	
4.1.5	No urgent referrals process – Diagnostic	Radiology Dir MT	30/11/2018						Document and communicate a process for urgent referrals. Dv 3 - Radiology: There is no written process for this - urgent request on the electronic requesting system in place			
4.1.6	Facility for patient isolation – Diagnostic	Radiology Dir MT	30/11/2018						Directorate to review the service facility and address Dv 3 - Radiology: SOP 27 is the written procedure for patients who require isolation			
4.1.7	Interpreter facility for patients - Diagnostic	Radiology Dir MT	30/11/2018						Directorate to review the service facility and address Dv 3 - Radiology: Interpreters are booked in line with the Trust Interpreting Policy			
5.0 Well Led												
5.1	Develop new Mandatory training model	Dir.Workforce	01/04/2019	Education and Training / TMC	Kite site		Louise Nickell		This review is currently underway, and a Director confirm and challenge step will now be part of the sign off around MT topics/frequency and target groups. Each topic has been allocated a 'reader' of the learning content, who has worked with the SME to provide first level challenge and scrutiny around course content, learning outcomes and user acceptability- this has now been completed for all topics. Next stage is to redesign the learning content into new e learning packages, and test for user acceptability and accuracy. Then the director level scrutiny panel will occur between now and March		Review mandatory training policy and training subjects with particular focus on target groups, compliance targets/thresholds, frequency and mode of training.	Head of E&T and SME
5.2	Confirm Sepsis training requirements for Maternity staff	Head of Midwifery	30/01/2019	Directorate Gov. Group	Minutes				X	Each topic has been allocated a 'reader' of the learning content, who has worked with the SME to provide first level challenge and scrutiny around course content, learning outcomes and user acceptability- this has now been completed for all topics.	As in line with Trust	
										Then the director level scrutiny panel will occur between now and march		

Purple writing Nicky Ballard

Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
5.3	System of assuring compliance to PAT test policy	Head Med. Equipment	30/11/2018	Med. Devices Group	Audit data		Rob Millard		Ensure all equipment checks are within date - ED, Medical core service.		Review arrangements for PAT testing and assurance reporting.	Head of Estates
5.4	Effective management of risk registers to include timely Closure of actions and risks, relevance of evidence.	and Corporate Heads	30/11/2018	QSIG/QGAC/Audit Committee	Div Data pack/TRR BAF/Internal Audit report		Shashidhar Cherukuri		All risks must but reviewed and updated monthly. A monthly risk register review meeting is held to oversee and follow up the TRR updates.	Divisions to devise arrangements to oversee the management and progression of Directorate risk registers. Dv 1 - Divisional risk register reviewed monthly at div gov meeting. Directorate risks reviewed as part of Quality meetings. IP risks also reviewed at Divisional nurse leadership meeting. Dv 3 - DMT: As per policy risks <12 reviewed min. quarterly; risks 12+ reviewed monthly. Reviews take place at both Directorate and Divisional level.	Review central governance and resource and structure to oversee risk register management.	Head of Governance and Legal Services
5.5	Review RCA process for patient and staff involvement and feed learning into training programmes and system learning and link with SJR process.	Head of Governance	31/03/2018	MRG / QSIG	Policy			Dec-18	Staff implementing the Trust DoC process are required to invite input of patients/relatives to inform the RCA investigation. The Duty of Candour (DoC) process is applied to all serious incident investigations. Following review in 2018 the DoC process includes the requirement for clinical leads delivering DoC to invite the patient/family to state any areas of concern they wish to highlight/form part of the investigation. This offer is also stated in DoC documentation to the patient. Areas identified are passed to the investigator to form part of investigation or address via other appropriate processes eg PALs, Complaints etc. The existing link between SJR and SUI process will ensure that where a death is reviewed and triggers a SUI or investigation the process (including DoC) will apply as above. The new ME role and bereavement team will also have a role in the support/involvement of patients/families		Current RCA training to have independent review by HF expert and inform further development. Review central governance structure and resource for RCA oversight and theme analysis to inform learning and improvement. Develop improvement assessment/evaluation framework. SJR process revised - learning log	Head of Governance and Legal Services
5.6	Establish Teletracking assurance around patient information governance.	Head of Comms/DPO	31/05/2018	IGSG	MOU		Raz Edwards				Need further work	
5.6.1	Patient/public poster re use and management of information	Head of Comms	31/01/2019	IGSG	Posters		Sally Evans				Need further work	
5.6.2	Publish on line fair processing notice.	DPO		IGSG	Website						Need further work	
5.6.3	Undertake Privacy Impact Assessment.	Head of Governance & Head of Comms	30/08/2018		PIA				X			
5.7	Review internet/intranet management processes	Heads of Comms/Med Ill	30/04/2018	tbc			Sally Evans / Nigel Beardsmore				Intranet under review, new intranet launch planned April '19. Internet is having an ongoing review.GDPR - training, policy review in progress	
5.8	Minimise risk of IG breaches through open log ins	DMTs	23/04/2018	IGSG	Audit	Dv 1 - No ICO reportable incidents.	Dv 1 - DMT	Mar-19	Implement local IG audits and compliance follow up.	Dv 1 - IG breaches to be monitored via div gov and RCA investigations and action plans. Dv 1 - Divisional IG breaches - in the first 2 quarters there have been 135 incidents reported trust wide with 37 related to division 1. Compared to the same time last year there has been a decrease of 31 incidents. This is the second consecutive year where division have seen a significant reduction in total number of incidents reported. Trends relate to data quality issues or data being disclosed in error with only 1 occurrence of unauthorised access. Cardiac has tripled their amount of incidents from 3 to 9, division have requested an aggregated RCA in respect of this. Dv 3 - DMT: directorates engage with IG audits undertaken via IG team	Review and publish local procedure guidance for IT login security. Implement Trust IG audits once IG resource agreed.	IGSG

Purple writing Nicky Ballard

Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
5.9	Review of patient notes' storage and security in each ward/department	DMTs	31/04/2018	Med Records' Group	Audit		Sam Smith (1) Head of Health Records	Dec-18	(Sam.S) In process of confirming with all Matrons that they have got lockable cabinets on the wards.	Dv 1 - Head of Nursing to review all areas via Matrons for storage of patient notes and ensure correct equipment ordered as necessary. Dv 1 - Checked earlier in the year and trolleys ordered. To recheck in October to ensure all now in place. Dv 3 - Directorates: Management of patient notes in line with Trust policy	IG audit programme to prioritise Medical, Surgery, Diagnostics core Service.	DPO
5.10	Each department to complete Stress survey annually	DMT/Heads	31/01/2019	WODC	Reports		Alan Duffell		Team Stress RA and action plans to be developed and reviewed in Directorates with minutes of ongoing monitoring.	Division to oversee the redress of risks falling from Stress RA and action plans. Dv 1 - Stress risk assessments usually managed at directorate level; Head of Nursing has now requested to see local stress risk assessments for the top 3 areas in division with the highest turnover rates/lowest retention levels. Dv 3 - DMT: review key findings from stress RAs via performance meetings	Trust H&S annual audit programme to oversee compliance with stress RA/action planning and risk redress. Reporting to H&S Steering group and to COG.	HSSG
						Aspirations						
5.11						Each department to develop a "Good to Great" CQI plan	DMT/Heads	17/08/2018	QSIG	Plans Dv 1 - Directorates currently addressing. Dv 3 - Directorates/DMT: Monthly CQC self assessments undertaken and discussed at monthly performance meetings. This includes actions to progress from good to great	Dv 1 - Division to discuss at each quality meeting and review quarterly.	
5.12	Develop a management handbook - aide memoire	DCEO	31/08/2018	TMC	Handbook		Senior Nurses / Education					
5.13						Develop a Trust overarching CQI strategy and plan	Mike Sharon	31/08/2018	TMC	Strategy /plan		
5.14			31/12/2018			Develop an enhanced model of RCA	HoG	30/08/2018	Each Directorate to ensure adequate staff training RCA investigations.	Divisional oversight and RCA signoff to include further guidance and scrutiny on the use of 5 why's to establish root causes and closer consideration of human factors affecting the occurrence.	Internal RCA training package to be reviewed to consider human factors input. Training and guidance to be extended to investigators and to others involved in the RCA review and approval process. Central Governance structure changes to include roles to support RCA investigations/investigators and to provide closer oversight of final RCA reports. Human Factors/RCA training programme commenced October, with 2 further days scheduled for Nov and Dec. Investigations Officer role has been submitted on Trac for advert	Head of Governance and Legal Services
5.15	Q1 methodology - corporate approach, resource, tools, support Query - presume this means QI methodology (Quality Improvement)		30/04/2019				Mike Sharon		Consultation and Implementation	Consultation and Implementation	Trust to develop and implement a Quality Improvement strategy. Consider other requirements i.e. Project group for roll out, QI expertise and training, potential resource etc. Q1 plan	Nursing and Quality
5.16	Review of audit programme - QIPP to engage medical staff						Audit				Trust Audit plan includes QIPP projects. Medics offered and encouraged to select from plan or additional items relevant	Trust Audit Convenor
5.17	Monthly round up - key note speakers						Sally Evans - Head of Comms					
5.18	Celebration of success		30/11/2018				Sally Evans - Head of Comms			Dv 3 - DMT: Division 3 newsletter "Showboat" to share items of interest, good news, successes, monthly "Above and Beyond" award	The Trust now has in place, Well Done Wednesday - social media. Trust Brief - all user bulletin, Trust Talk 1/4 newsletter, Nursing Newsletter, monthly, Div 3 "showboat	
5.19	Local Policy out of date (Chaperone and others unspecified) No local policy for handling patients of no fixed abode, migrant community) – Diagnostic	Dir MT	TBC	Policy Group / Div MT					Directorate management to review local policies. Dv 3 - Radiology: Policies now in date and under regular review.			