Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC – DECEMBER 2015

Agenda Item Number: 212/15
Enclosure Number: (6)

Subject:	**Care Quality Commission Quality Improvement Plan October actions**
Prepared by:	Tracey Stenning, Head of Governance and Quality Fiona McNeight, Associate Director of Quality and Governance
Sponsored by:	Cathy Stone, Director of Nursing
Presented by:	Cathy Stone, Director of Nursing
Purpose of paper	Inform the Trust Board on progress against the Care Quality Commission Quality Improvement Plan
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	• This report contains an update against all actions contained within the CQC Quality Improvement Plan with a deadline of the 31st October 2015. • The report provides significant assurance that actions are being closely monitored. The large majority of actions have been closed, with some remaining on-going until there is sustained evidence of on-going compliance. **Compliance summary October:**

CQC Quality Improvement Plan – October 2015 position status (chapter 3)

Action type	Total no.	Complete	Complete		Within deadline / revised deadline	Breached deadline
			Actions complete; on-going monitoring (amber)	Action plan in place; on-going monitoring * (blue)		
Compliance	5	2	1	1	0	1
Must-do	6	3	1	1	0	1**
Should-do	4	3	1	0	0	0
Trust-wide	1	1	0	0	0	0

* These actions will be removed from the monthly reports and continue to be monitored through CSC Governance/performance reviews
** Cross references to compliance action which has breached the deadline.

- There are a total of 22 Compliance Actions within the report of which 5 were due to be completed in October.
  - 2 complete (2 requiring on-going monitoring).
  - 1 breached as noted below exception relating to medical and dental staff not meeting Trust targets to complete mandatory and statutory training remains (ref: CA20_M22).
- There are a total of 33 'Must do actions' within the report of which 6 were due to be completed in October. 5 of which cross reference to a compliance action referenced above.
  - 3 complete (2 requiring on-going monitoring).
  - 1 breached as noted below exception relating to medical and dental staff not meeting Trust targets to complete mandatory and statutory training remains.

- There are a total of 28 ‘Should do actions’ within the report of which 4 were due to be completed in October.
  - 3 complete (1 requiring on-going monitoring).
- There are a total of 5 ‘Trust-wide actions’ within the report of which 1 was due to be completed in October.
  - 1 complete

Key exceptions

- A formal meeting with the TDA, NHS England and system partners has been held. Urgent care actions will be revised to align Chapter 1 actions to Urgent Care plan.
- CA20_M22 regarding medical and dental staff not meeting Trust targets to complete mandatory and statutory training remains non compliant. This has been escalated and will form part of the CSC monthly Executive Performance Reviews and will continue to be monitored monthly.

CQC Quality Improvement Plan – Year-to-date position status (chapter 3)

Action type	Total no.	Complete	Complete		Within deadline / revised deadline	Breached deadline
			Actions complete; on-going monitoring (amber)	Action plan in place; on-going monitoring* (blue)		
Compliance	22	13	3	3	2	1
Must-do	33	24	3	3	2	1**
Should-do	28	22	3	2	1	0
Trust-wide	5	3	1	0	1	0

* These actions will be removed from the monthly reports and continue to be monitored through CSC Governance/performance reviews

** Cross references to compliance action which has breached the deadline.

- To date, of the 22 compliance actions:
  - 19 complete (6 requiring on-going monitoring).
  - 2 within deadline.
  - 1 breached relating to medical and dental staff not meeting Trust targets to complete mandatory and statutory training remains (ref: CA20_M22).
- To date, of the 33 ‘Must Do’ actions:
  - 30 complete (6 requiring on-going monitoring).
  - 2 within deadline.
  - 1 breached relating to medical and dental staff not meeting Trust targets to complete mandatory and statutory training remains (ref: CA20_M22).
- To date, of the 28 ‘Should Do’ actions:
  - 22 complete (5 requiring on-going monitoring).
  - 1 within deadline.
- To date, of the 5 Trust-wide actions:
  - 3 are complete (1 requiring on-going monitoring)
  - 2 within deadline.

Options and decisions required *Clearly identify options that are to be considered and any decisions required*	Any changes to format of report.

Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Monthly reporting to Governance and Quality Committee.
Consideration of legal issues (including Equality Impact Assessment)?	Legal requirement to meet the Health and Social Care Act regulations.
Consideration of Public and Patient Involvement and Communications Implications?	Nil.

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	1: Deliver safe, high quality patient centered care 3: Become the hospital of choice for general, specialist and selected tertiary services 5: Develop sufficient financial strengths to adapt to change and invest in the future.
BAF/Corporate Risk Register Reference (if applicable)	1-1516
Risk Description	Inability to maintain on-going compliance with all CQC standards.
CQC Reference	

Committees/Meetings at which paper has been approved:	**Date**
Governance and Quality Committee	3rd November 2015

Chapter 1: Board Governance and Assurance

Key:							
	Blue	Actions complete; on-going monitoring required	**Amber**	Action plan in place; on-going monitoring of actions	**Dark green**	Completed with evidence submitted	**Red**	Breached expected deadline

Well-led			
Action	**Responsible Lead**	**Deadline**	**Delivery rating**
2. Review Clinical Services Strategy and ensure supported by clear improvement plans.	Director of Strategy	~~30th September 2015~~ 30th November 2015	Amber
October update: Revised deadline to evaluate new models of care prior to final development of the strategy • Extensive listening exercise conducted throughout August and September, involving a wide range of internal and external stakeholders. A summary of this exercise was presented to Trust Board in September. Due to the rapidly changing external environment within our health system, the Board requested that the potential new models of care receive careful evaluation ahead of the final development of the Trust wide strategy. An options appraisal has been requested by the Board for the November meeting. **September update:** • The Clinical Services Strategy has been reviewed as part of the overall Trust Strategy, and presented to Trust Board in September. Some minor amendments are required and there is agreement that the full strategy be presented to the Trust Board in October 2015.			
5. Undertake a detailed assessment against Monitor's Well-Led Framework.	Director of Human Resources and Organisational Development	31st October 2015	Dark green
October update: • The assessment has been undertaken by the Trust Board and Clinical Services Centres. In addition Ernst & Young have been undertaking some work around culture integrity. The Chief Executive, Director of Human Resources and Organisational Development and the Head of Organisational Development are in the process of having face-to-face discussions with each Clinical Service Management Team to set out the expectations as leaders. • The Trust Board have discussed and agreed priorities for organisational health which includes a programme of Board development using the headings of the well-led domain. The Trust Organisational Development strategy and the well-led domains are a key feature in priority areas moving forward. • Delivery against the assessment will be on-going.			
6. Review the Trust Board operational performance.	Director of Corporate Affairs and Business Development	~~31st October 2015~~ 30th November 2015	Amber
October update: Revised deadline to complete work • This is linked to the review of the Board sub-committee terms of reference, membership and the review of the existing meeting framework			
7. Develop a Trust Board development program incorporating Ernst and Young review findings.	Director of Corporate Affairs and Business Development	31st October 2015	Dark green
October update:			

Well-led			
Action	**Responsible Lead**	**Deadline**	**Delivery rating**
• This has been agreed with the Trust Board and is part of the Organisational Priorities work			
8. Revise existing Trust Strategy.	Director of Strategy	~~31st October 2015~~ 30th November 2015	Amber
October update: • Extensive listening exercise conducted throughout August and September, involving a wide range of internal and external stakeholders. A summary of this exercise was presented to Trust Board in September. Due to the rapidly changing external environment within our health system, the Board requested that the potential new models of care receive careful evaluation ahead of the final development of the Trust wide strategy. An options appraisal has been requested by the Board for the November meeting.			

Unscheduled care			
Action	**Responsible lead**	**Deadline**	**Delivery rating**
2. Commissioning Strategy for Urgent Care, Frail Elderly and End of Life.	Commissioners	30th September 2015	Red
October m update: • End of Life Strategy received. • System strategy for Urgent Care or Frail Elderly not received.			
3. Delivery of system-wide Urgent Care Plan (underpinned by the Accountability Framework).	All Accountable Officers	On-going with monthly review at the Urgent Care Board	Amber
September update: • On-going with monthly oversight at the Urgent Care Board.			

Unscheduled care – support needed from system partners					
Key issues	**Support needed**	**KPI**	**By when***	**Lead**	**Delivery rating**
System plan to deliver 4hr A&E Standard.	Portsmouth South East Hampshire Fareham and Gosport System Urgent Care Improvement Plan to sustainably deliver NHS Constitution Standard, including partner response times.	4 hour A&E standard 95%	9th July 2015 (plan)	Clinical Commissioning Groups	Red
The older the patient, the more likely to attend A&E and be admitted to QAH, with ony 50-60% of patients >75 waiting <4hrs, (Compared to National Target of 82% and then staying in hospital longer than necessary with all the associated clinical needs.	Frail elderly commissioning strategy and plan.	4% reduction attendances	31st August 2015	Clinical Commissioning Groups	Red
Ambulance conveyance rates are 5% higher than the national average.	Plan to deliver reduced conveyance rates and 'batching'.	5% reduction	31st August 2015	Clinical Commissioning Groups / South Central Ambulance Service	Red
Over 120 medically fit patients who are not in the right place for their care needs, including patients at the end of their life.	Reduction in medically fit patients to better meet their needs, including first home to assess model of care.	<64	31st July 2015	Clinical Commissioning Groups / Partners	Red
Significant number of mental health and detoxification patients using Emergency Department Services.	Increase in psychiatric and detoxification services in the community to release observation ward beds.	6 beds released	30th September 2015	Clinical Commissioning Groups	Red
Imbalance between admission and discharge, particularly at the weekend.	Plan for Hampshire to match Portsmouth's daily responsiveness.	20 complex discharges	31st July 2015	Hampshire County Council / Southern Health NHS Foundation Trust	Red

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Unscheduled care – support needed from system partners					
Key issues	**Support needed**	**KPI**	**By when***	**Lead**	**Delivery rating**
August update: • A full report on the above actions will be provided at the TDA Integrated Delivery meeting in September 2015. **September update:** • The Urgent Care Board will provide an exception report to the Quality Improvement Plan oversight meeting to address the above actions. **October update:** • Meeting held on 28th October: awaiting report to update position.					

Governance and Assurance			
Action	**Responsible lead**	**Deadline**	**Delivery rating**
1. The Director of Corporate Affairs and Business Development should assume ownership of the Board Assurance Framework on behalf of the Trust Board; the Trust Board should be more influential in deciding strategic risk scores, movements and impacts.	Director of Corporate Affairs and Business Development	~~31st August 2015~~ ~~31st October 2015~~ 30th November 2015	Amber
October update: Revised deadline to complete work • This has been agreed. Whilst the BAF was considered an exemplar 5 years ago, a review is underway to identify current best practice. **August update: Revised deadline to align to re-setting of Strategic Objectives at Board workshop** • All strategic objectives will be reviewed at the October Board workshop and the Director of Corporate Affairs will assume ownership of the Board Assurance Framework with revised objectives.			
2. Review the current meeting framework and ensure that there is sufficient Executive capacity particularly in relation to quality and workforce.	Director of Corporate Affairs and Business Development	~~30th September 2015~~ ~~31st October 2015~~ 30th November 2015	Amber
October update: Revised deadline to complete work • This is inextricably linked to review of Committee terms of reference and membership. **September update: Revised deadline to complete review of committee framework** • Review of committee framework underway. Changes in committee structure to have Executive agreement therefore, deadline extended.			
4. Review Terms of Reference for sub-Board Committees.	Director of Corporate Affairs and Business Development	~~30th September 2015~~ ~~31st October 2015~~	Amber

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Governance and Assurance			
Action	**Responsible lead**	**Deadline**	**Delivery rating**
		30th November 2015	
October update: • Review underway **September update: Revised deadline to complete review.** • Terms of Reference have been received and are currently under review.			
7. Ensure that there are clear links between action plans and risk registers to provide a more rounded assessment on plan slippage.	Associate Director of Quality and Governance	31st October 2015	Dark green
October update: • Risk registers reviewed. Process instigated to increase accountability. Risks 15 and over and greater than 2 years on a register now being presented at the CSC performance reviews for discussion (commencing October reviews). CSCs continue to present their risk registers to the Risk Assurance Committee on a rolling programme basis. • A process implemented for quarterly audits of Responsible Committee minutes to provide assurance of oversight and management of risks and associated action plans • There is no corporate view of all organisational risks as CSC risk registers are separate documents. Identified need to implement the Datix Risk Register module which would improve risk oversight and action plan monitoring. This is being addressed through the Datix review and associated action plan and is an additional action to be taken forward.			
8. Ensure proper completion of risk registers to ensure they are used effectively to hold to account.	Associate Director of Quality and Governance	31st October 2015	Dark green
October update: • Risk registers reviewed. Process instigated to increase accountability. Risks 15 and over and greater than 2 years on a register now being presented at the CSC performance reviews for discussion (commencing October reviews). CSCs continue to present their risk registers to the Risk Assurance Committee on a rolling programme basis.			
9. Undertake a full detailed review of risk management from Trust Board to ward including processes for the production of the Board Assurance Framework, risk calibration and risk appetite.	Director of Corporate Affairs and Business Development	~~31st October 2015~~ 30th November 2015	Amber
October update: • Work underway. Linked to the work undertaken by Associate Director of Quality and Governance.			

Chapter 3: Care Quality Commission Quality Operational Improvement Plan

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Chapter 3 – Care Quality Commission Quality Operational Improvement Plan
OCTOBER 2015 ACTIONS UPDATE

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
KEY: CA: Compliance action; M: 'Must do' actions; S: 'Should do' actions; TWM: Trust-wide 'must do' actions * The Quality Care Reviews will undertake a baseline assessment of all performance metrics. This baseline will inform the improvement trajectory required against each key metric									
CA1 M11	Medicine **Trust-wide**	The medical outliers were not regularly reviewed by medical consultants.	1. Outlier Policy to be ratified and communicated to staff 2. Undertake bed re-profiling Links to the delivery of Phase 2 of the system wide unscheduled care plan	Chief of Service Medicine Chief of Service Medicine for Older People, Rehabilitation and Stroke	Chief Operating Officer	~~30th Sept. 2015~~ 31st Oct. 2015	1. Monthly notes audit to ensure outliers have daily senior review 2. Patient experience survey of outliers quarterly (monthly during winter months) 3. Ratified Outlier Policy and staff communication 4. Complaints and incidents relating to outliers 5. Bed re-profiling complete	Monthly reporting of audit outcome and associated actions to Trust Board through the Integrated Performance Report Quarterly reporting of evidence to the Governance and Quality Committee Reduction in outliers in line with strategic plan	Dark green
October update: • Following comments to the draft Outlier policy, the policy was presented to the Operational Board and ratified on the 21st October 2015 for ratification. Staff communication will follow once the appropriate process for the publication of policies has been followed. **September update: Revised deadline due to timing of the Operational Board for ratification of Outlier Policy** • Weekly notes audits have commenced in the Medicine Clinical Service Centre. • Audit commenced in Medicine for Older People, Rehabilitation and Stroke Clinical Service Centre. Evidence available to demonstrate senior review of outliers. • Patient experience survey of outliers will be reported through the quarterly Patient Experience Report. • Outlier Policy is due to be presented to the Operational Board on the 7th October for ratification. • Complaints and incidents relating to outliers are presented to the Urgent Care Board on a monthly basis. • G1 ward increased the number of beds in mid-September and the Stroke wards have been re-profiled. Further bed re-profiling may be required.									
CA2 M11	Surgery **Trust-wide**	Patients were not allocated to specialist wards according to their clinical needs.	1. On-going implementation of Phase 2 of the system wide unscheduled care plan to improve	Director of Operations-Unscheduled care	Chief Operating Officer	~~30th Sept. 2015~~ On-going monthly monitoring	1. Progress against delivery of Phase 2 of the system wide unscheduled	Reporting progress against Phase 2 system wide plan implementation to the Urgent Care Board	Amber

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
			patient flow 2. Undertake monthly Quality Care Reviews*	Supported by Deputy Director of Nursing			care plan 2. Outcome of monthly Quality Care Reviews* incorporating checks on risk assessment completeness	Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report	
October update: • Meeting held 28th October; awaiting exception report. **September update:** • Agreed at the Quality improvement oversight meeting that the Urgent Care Board would monitor the compliance with the Phase 2 plan and an exception report would be provided to the oversight meeting **August update (M11):** • The implementation of Phase 2 of the system-wide unscheduled care plan is in progress. • Complaints/PALS relating to outliers and moves being monitored monthly through the unscheduled care metrics, no concerns to note.									
CA3 M24	Surgery **Trust-wide**	Nursing handovers did not provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.	1. Standardise clinical handover with development of a handover protocol 2. Implementation of safety huddles (introduced in conjunction with Perfect Care week) 3. Undertake monthly Quality Care Reviews*	Deputy Director of Nursing	Director of Nursing	~~31st Aug. 2015~~ 31st October 2015	1. Protocol for clinical handover 2. Outcome of Perfect Care week and Quality Care Reviews	Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report Quarterly reporting of outcomes and learning of the Quality Care Reviews* to the Governance and Quality Committee	Dark green
October update: • The professional standards have now been launched and contain specific information relating to handovers. • Safety huddles form part of the Perfect Care Week and will be on a rolling programme. **August update: Revised deadline to bring in line with the revision and implementation of the 'Professional Standards'.** • 'Professional Standards' are being developed for each ward. These will be presented to the Heads of Nursing meeting for clarification and agreement; following which they will be translated into the other Trust Professional Standards. Additional detail regarding handovers will be included. A pilot will take place during September and will be reviewed at the end of September; final version expected in October. • In terms of Safety Huddles, Perfect Care Week was piloted in April on 2 wards, a further session on 5 wards July /August and will continue with 4 wards 3 times a year. In the professional standards there is an expectation of safety huddles. Expect these to improve as wards are engaged in Perfect Care Week. • This item was not included in the Quality Care Review for August as the 'Professional Standards had not yet been developed.									

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Chapter 3 – Care Quality Commission Quality Operational Improvement Plan
OCTOBER 2015 ACTIONS UPDATE

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
CA4 M10	Medicine Surgery **Trust-wide**	Patients were not appropriately monitored and patients were moved several times and at night and for non-clinical reasons.	1. Ensure all non-clinical moves take place prior to 9pm 2. Incorporate patient move status in protocol for clinical handover 3. Undertake monthly audit of clinical handover	Duty Hospital Manager Team Leader Deputy Director of Nursing	Director of Nursing	~~30th Sept. 2015~~ 31st Oct. 2015	1. <3 non-clinical moves after 9pm 2. Protocol for clinical handover 3. Monthly audit results and associated actions	Monthly reporting of performance in Integrated Performance Report to Trust Board Outcome of monthly clinical handover audit to be presented to the Patient Safety Steering Group, with monthly exception reporting to the Governance and Quality Committee	Blue
October update: • Reporting of patient moves continues through the monthly Integrated Performance report to Trust Board. • Professional standards have been circulated to wards and handovers have been observed through Perfect Care Week. These will be monitored through Frontline Peer Reviews and Quality Care Reviews and further Perfect Care Week sessions. The documentation audit now contains a section that compares the information in the handover sheet (used at handover) with the magnetic boards, the patient journey boards and the nursing documentation to triangulate that all information is aligned. This is reported monthly to sisters, matrons, heads of nursing; monitored through the Documentation Group and will be reported quarterly to the Governance and Quality Committee from quarter 3. **September update: Deadline revised to align to CA3_M24 when protocol for clinical handover will be finalised as part of the Professional Standards** • Clinical Service Centres have been requested to capture daily non-clinical moves between 0700 and 2100. Duty Hospital Managers will collate moves after 2100. • To be reported through the monthly Integrated Performance Report to Trust Board.								
CA10 M5	Surgery	The cardiac arrest call bell system in E level theatres was unable to identify the location of the emergency.	1. Daily checks to demonstrate alarms are working 2. Ensure warning lights come on outside each theatre to identify specific theatre 3. Anomolies in the illuminated indicator panels making it difficult to identify which theatre has pulled the alarm to be addressed through Carillion	Head of Nursing Critical Care, HSDU, Anaesthetics and Theatres	Medical Director	~~30th Sep. 2015~~ Monthly updates	1. Evidence of daily checks of alarms. 2. Evidence of daily checks of warning lights 3. Evidence of communications with Carillion and outcome	Reporting progress against Critical Care, HSDU, Anaesthetics and Theatres Clinical Service Centre Improvement Plan through the monthly Executive Performance Reviews	Amber
October update: • Work to complete the installation of additional alarm panels in theatres is due to commence on the 27th and 28th October and commissioned on the 29th October 2015. **September update: Monthly updates to ensure progress with nurse call panel**									

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
• Training has been delivered to teams with clarification of lighting system at the Clinical Governance Meeting. • A Purchase Order has been raised with the Contractors for the new nurse call panels; all other works required have been completed. **August update: Revised deadline pending completion of small works.** • Assurance has been provided that the emergency alarms are checked every day in theatres (alarm tests E1-20) and recovery (alarms/O2/Suction). The warning lights outside theatres/recovery are included as part of this check. There are no reported issues. • Carillion confirmed in March 2014 they have resolved the issues with the 'follow-me' warning lights outside theatres. • A quotation has been requested for the new nurse call panel; all other works required have been completed.									
CA13 M28	Surgery	Records relating to the assessment and monitoring of deteriorating patients in recovery were not kept.	1. Develop a post-operative monitoring protocol compliant with Trust-wide VitalPAC Early Warning Score for patients in recovery 2. Audit compliance with protocol once implemented 3. Review Theatre VitalPAC Early Warning Score (TViEWS) Policy 4. Introduce a record keeping standards update at Clinical Service Centre Clinical Governance Meeting 5. Ensure the Intraoperative care record contains a TViEWS observation record and undertake quarterly audit of compliance with completion	Head of Nursing Critical Care, HSDU, Anaesthetics and Theatres	Medical Director	31st Oct. 2015	1. Post-operative monitoring protocol developed 2. Protocol audit results and associated actions 3. Evidence of policy review 4. Clinical Service Centre Clinical Governance Meeting minutes evidence record keeping standards update 5. Audit results with associated action plans	Reporting progress against Critical Care, HSDU, Anaesthetics and Theatres Clinical Service Centre Improvement Plan through the monthly Executive Performance Reviews Deteriorating Patient Steering Group report to the Patient Safety Steering Group with exceptions reported to the Governance and Quality Committee Critical Care, HSDU, Anaesthetics and Theatres Clinical Service Centre quarterly report to the Governance and Quality Committee	Amber
October update: • The Post Operative monitoring (t-VIEWS) protocol has been drafted, however, clarification is being sought from the Resuscitation team and Anaesthetics recovery lead on how frequently the t-VIEWS is required to be recorded. • An audit tool to determine compliance with the protocol has been devised and is ready for launch once the protocol has been agreed. • Regarding the policy review, this is an on-going agenda item and will include final ratification of policy and audit outcomes (Recovery Quality Improvement Group minutes and Critical Care, HSDU, Anaesthetics and Theatres governance October agenda (minutes not available yet) and September minutes provided as evidence). • A snapshot audit of current compliance with the Deteriorating Patient Policy and scoring of t-VIEWS which took place between the 1st-16th October shows 94-100% compliance with all									

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
elements except t-VIEWS being scored every time observations are taken. There is no concern regarding patient safety as patients are being continually monitored and appropriate action taken.									
CA20 M22	Medicine Surgery Critical Care Children & young people **Trust-wide**	Medical and dental staff did not meet trust targets to complete mandatory and statutory training.	1. Ensure all medical and dental staff complete essential skills training in line with Trust policy for compliance	Chief of Service for each Clinical Service Centre	Medical Director	~~31st Aug. 2015~~ On-going monthly monitoring	1. Monthly training compliance data 2. Clinical Service Centre performance review metrics	Reporting essential skills training performance data through Clinical Service Centre monthly Executive Performance Reviews Trust and Clinical Service Centre level performance data reported monthly in the Integrated Performance Report to Trust Board	Red
October update: • The Director of Workforce and Organisation Development has sent compliance levels of staff to all Clinical Service Centres Chief of Service and General Managers to ensure that all staff are encouraged to undertake training. Where an issue with the supply of training has been identified, all efforts will be made to correct this. • It has been noted that there are a number of staff identified within the Corporate Service Centre that are not employed by the Trust and therefore, should not be included on the Electronic Staff Record; action is underway to correct this. • Monitoring continues at the Monthly Executive Performance Reviews. **September update:** • No significant improvement has been noted. This has been escalated and will form part of the CSC monthly Executive Performance Reviews. **August update: Deadline amended to show on-going monthly monitoring required.** • No significant improvement (although the change of Drs may have impacted upon this) has been noted. This has been escalated and will form part of the CSC monthly Executive Performance Reviews from September and will continue to be monitored closely monthly.									
M9	**Trust-wide**	There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.	1. On-going implementation of Phase 2 of the system wide unscheduled care plan to improve patient flow	Director of Operations - Unscheduled Care	Chief Operating Officer	On-going	1. Implemented Phase 2 of the system wide unscheduled care plan to deadline	Reporting progress against Phase 2 system wide plan implementation to the Urgent Care Board Urgent Care Board Quality Metrics	Amber
October update: • Meeting held 28th October 2015; awaiting report. **September update:** • Agreed at the Quality improvement oversight meeting that the Urgent Care Board would monitor the compliance with the Phase 2 plan and an exception report would be provided to the oversight meeting									
M33	**Trust-wide**	Action is taken to improve the leadership where	1. Participation in Trust-wide cultural programme (Ernst and	Deputy Director of Nursing	Director of Nursing	~~31st Aug. 2015~~ 31st October	1. Leadership Accountability Framework	Validation of impact of professional standards concordat through	Dark green

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
		there are services and ward areas of concern.	Young) 2. Develop a targeted Leadership Accountability Framework in partnership with staff 3. Develop professional standards for all clinical groups of staff 4. Re-profile staff as required 5. Introduce re-validation for all staff banded 7 and above			2015	developed 2. Leadership Accountability framework implemented. 3. Profession standards in place for all clinical staff 4. Implementation of capability policy and protocol, as required 5. Re-validation programme established, launched and plan of implementation	monthly performance review process and associated organisational learning Outcome of Ernst and Young review and associated actions	
October update: • The Professional Standards for wards has been circulated to all wards and will be monitored through Frontline Peer Reviews and Quality Care Reviews. **August update: Revised deadline to bring in line with the revision and implementation of the 'Professional Standards'.** • Professional Standards, linked to the Leadership Accountability Framework was implemented in July. 'Professional Standards' are being developed for each ward. These will be presented to the Heads of Nursing meeting for clarification and agreement; following which they will be translated into the other Trust Professional Standards. Additional detail regarding handovers will be included. A pilot will take place during September and will be reviewed at the end of September; final version expected in October. • For registered nurses and midwives Revalidation comes into effect from April 2016. In preparation a section has been added to the usual Appraisal form so that each year there is a documented conversation to check that a nurse or midwife is on track with revalidation requirements. This will also be included in the Bite Size Appraisal training.									
S2	Clinical Support	Medicines reconciliation is based on one or more sources of information to determine which medicines an individual patient has been prescribed outside the hospital and still requires while	1. Ensure medicines are reconciled in line with the Medicines Reconciliation Policy	Director of Pharmacy	Medical Director	31st Oct. 2015	1. Medicine reconciliation audit results	Quarterly reporting of the evidence to the Governance and Quality Committee Medicines reconciliation is in line with Trust Policy Regional benchmarking data demonstrating good performance	Dark green

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
		in hospital.							
October update: • Audits of medicine reconciliations continue on a monthly basis, with the results being reported through the quarterly quality report. • The monthly percentage of medicines reconciliations initiated within 24hrs has increased to an average of 80.1% for quarter 2 which is above the threshold of 80%.									
S3	**Trust-wide**	The 'This is me' booklet for patients living with dementia is used appropriately by staff.	1. Re-launch the Dementia Strategy 2. 'This is me' booklet to be provided to all patients with dementia 3. Undertake monthly Quality Care Reviews* 4. Trust-wide refresh of induction information for all staff 5. Continue carer experience surveys	Head of Nursing Medicine for Older People, Rehabilitation and Stroke	Director of Nursing	~~31st Aug. 2015~~ ~~31st Oct. 2015~~ 31st March 2016	1. Re-launch of the Dementia Strategy 2. Outcome of Quality Care Reviews* 3. Outcome of carer feedback surveys and associated actions 4. Dementia Steering Group minutes	Dementia carer experience feedback reported through the Integrated Performance Report to Trust Board Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report	Amber
October update: Revised deadline due to the Dementia Strategy revision required. • The Dementia Strategy is currently under review. This will then require consultation and formal ratification, it is anticipated that this will be complete February 2016, March at the latest. • Further promotion of the 'This is me' booklet is underway through the Dementia Case Workers. The use of the booklet has been re-emphaised at the Operational Board (21st October) and Clinical Service Centre involvement re-iterated. • Induction will emphasise the use of the 'This is me' booklet. The essential skills handbook will be revised for the next version (2016) to include the booklet.								
S11	**Trust-wide**	Patient clinical details are recorded in a clear and consistent manner so that there is no risk of information being missed.	1. Re-launch the Clinical Records Management Policy 2. Modify documentation audit tool 3. Undertake monthly documentation spot audits including medical and nursing students	Deputy Director of Nursing	Director of Nursing	31st Oct. 2015	1. Re-launch of Clinical Records Management Policy 2. Amended documentation audit tool 3. Outcome of monthly spot audits and associated actions	Quarterly reporting of the evidence to the Governance and Quality Committee	Dark green
October update: • Clinical Records Management Policy revised and distributed as per Trust process, 12th October 2015. • The documentation audit re-commenced in September 2015. This is reported monthly to Sisters, Matrons and Heads of Nursing; monitored through the documentation Group and will be reported quarterly to the Governance and Quality Committee from quarter 3.									

Key:	Blue	Actions complete; on-going monitoring required	Amber	Action plan in place; on-going monitoring of actions	Dark green	Completed with evidence submitted	Red	Breached expected deadline

Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
S12	**Trust-wide**	Documentation regarding fluid intake and output, and comfort rounds, is appropriately completed to demonstrate that care is delivered.	1. Re-launch ward professional standards 2. Undertake monthly Quality Care Reviews*	Deputy Director of Nursing	Director of Nursing	~~31st Aug. 2015~~ 31st Oct. 2015	1. Launch of ward professional standards 2. Outcome of monthly Quality Care Reviews*	Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report	Dark green
October update: • The Professional Standards for wards has been circulated to all wards and will be monitored through Frontline Peer Reviews and Quality Care Reviews.									
S20	Women and Children	Arrangements for psychological and emotional support for children and young people with non-acute mental health needs is reviewed.	1. Trust to raise identified gaps with Clinical Commissioning Group leads especially in the outpatient department setting.	Head of Nursing Women and Children	Director of Nursing	30th Sept. 2015	1. Communication with Commissioners regarding identified gaps	Women and Children Clinical Service Centre progress against improvement plan at monthly Executive Performance Review	Blue
October update: • The Contracting team have confirmed that psychological care is not included in tariff and that historically this has been provided by Primary Care. A paper outlying the service needs, costs and possible solutions is currently being drafted. **September update:** • The issue has been raised with the Clinical Commissioning Group and discussions are on-going relating to outpatient setting.									
S22	**Trust-wide**	Services have detailed strategic plans for service developments, for example, for the single point of access and appropriate provision of high dependency services.	Action linked to action 2 of 'well-led' within the Trust Strategic Quality Improvement Plan Deadline: ~~30th September 2015~~ Revised deadline 30th November 2015						Amber
October update: • Extensive listening exercise conducted throughout August and September, involving a wide range of internal and external stakeholders. A summary of this exercise was presented to Trust Board in September. Due to the rapidly changing external environment within our health system, the Board requested that the potential new models of care receive careful									

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Ref.	Core service	Compliance action	Improvement action(s)	Lead	Exec. lead	Deadline	Evidence required	Assurance	Delivery rating
evaluation ahead of the final development of the Trust wide strategy. An options appraisal has been requested by the Board for the November meeting. **September update:** • The Clinical Services Strategy has been reviewed as part of the overall Trust Strategy, and presented to Trust Board in September. Some minor amendments are required and there is agreement that the full strategy be presented to the Trust Board in October 2015.									
TWM 1	**Trust-wide**	The trust clinical strategy is supported by clear improvement plans and these are monitored and evaluated appropriately.	Action linked to action 2 of 'well-led' within the Trust Strategic Quality Improvement Plan Deadline: ~~30th September 2015~~ Revised deadline 30th November 2015					Monthly reporting to Operational Board	Amber
October update: • Extensive listening exercise conducted throughout August and September, involving a wide range of internal and external stakeholders. A summary of this exercise was presented to Trust Board in September. Due to the rapidly changing external environment within our health system, the Board requested that the potential new models of care receive careful evaluation ahead of the final development of the Trust wide strategy. An options appraisal has been requested by the Board for the November meeting. **September update:** • The Clinical Services Strategy has been reviewed as part of the overall Trust Strategy, and presented to Trust Board in September. Some minor amendments are required and there is agreement that the full strategy be presented to the Trust Board in October 2015.									
TWM 3	Corporate	The trust board has a development programme and there should be appropriate and timely assessment of its performance.	Action linked to action 7 of 'well-led' within the Trust Strategic Quality Improvement Plan Deadline: 31st October 2015					Trust Board minutes	Dark Green
October update: • This has been agreed with the Trust Board and is part of the Organisational Priorities work.									