Portsmouth Hospitals NHS
NHS Trust

**TRUST BOARD PUBLIC – OCTOBER 2015**

**Agenda Item Number: 191/15**
**Enclosure Number: (7)**

| | |
|---|---|
| **Subject:** | **Care Quality Commission Quality Improvement Plan** |
| **Prepared by:** | Tracey Stenning, Head of Governance and Quality<br>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**<br>*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 is the second report to review the actions contained within the CQC Quality Improvement Plan.<br>• This report contains an update against all actions with a deadline of the 30th September 2015.<br>• 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.<br><br>**Compliance summary September:**<br>• There are a total of 22 Compliance Actions within the report of which 12 were due to be completed in September.<br>- 9 complete; with 4 requiring on-going monitoring.<br>- 3 actions with revised deadlines.<br>- Note below the exception relating to CA20_M22<br>• There are a total of 33 'Must do actions' within the report of which 3 were due to be completed in September. 11 of which cross reference to a compliance action referenced above.<br>- 3 complete; with 1 requiring on-going monitoring.<br>- Note below the exception relating to CA20_M22<br>• There are a total of 28 'Should do actions' within the report of which 3 were due to be completed in September.<br>- 13 complete; with 1 requiring on-going monitoring.<br>- 3 actions with revised deadlines.<br>• There are a total of 5 'Trust-wide actions' within the report of which 1 was due to be completed in September.<br>- Actions are in place with on-going monitoring required.<br><br>**Key exceptions**<br>• All metrics relating to delivery of the Urgent Care Phase 2 plan will be updated retrospectively following an exception report from Urgent Care Board to the Quality Improvement meeting.<br>• 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.<br>• To date, of the 22 compliance actions, 15 are now complete with 4 requiring on-going monitoring. 3 have a revised deadline and 3 are within deadline. CA20_M22 is non-compliant.<br>• To date, of the 33 'Must Do' actions, 25 are now complete with 4 requiring on-going monitoring. 3 have a revised deadline and 4 are within deadline. CA20_M22 is non-compliant.<br>• To date, of the 28 'Should Do' actions, 22 are now complete with 3 requiring on-going monitoring. 6 are within deadline.<br>• To date, of the 5 Trust-wide actions, 3 are complete with 1 requiring on-going monitoring. 2 are within deadline. |
| **Options and decisions required**<br>*Clearly identify options that are to be considered and any decisions required* | Any changes to format of report |
| **Next steps / future actions**:<br>*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 |

# 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** |
| 1. Review performance framework. | Director of Strategy | 30th September 2015 | Dark green |
| **September update:**<br>• Performance Review Framework has been reviewed and approved at EMT, Trust Board, and Operational Board. The new two hourly meetings commence in October. | | | |
| 2. Review Clinical Services Strategy and ensure supported by clear improvement plans. | Director of Strategy | 30th September 2015 | Amber |
| **September update:**<br>• 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. | | | |
| 3. Review Clinical Service Centre leadership capability and capacity. | Director of Human Resources and Organisational Development | 30th September 2015 | Dark green |
| **September update:**<br>• Review complete which highlights areas for improvement in terms of variation in management and leadership practice. This will now form part of the organisational development strategy being presented to Trust Board on the 1st October 2015. | | | |
| 4. Review the 10 Clinical Service Centre structure to consider the opportunity to streamline accountabilities and promote greater cohesion. | Chief Operating Officer | 30th September 2015 | Dark green |
| **September update:**<br>• The Clinical Service Centre structure has been discussed by the Executive Team; no further changes in structure to be taken at this stage. | | | |

| **Unscheduled care** | | | |
|---|---|---|---|
| **Action** | **Responsible lead** | **Deadline** | **Delivery rating** |
| 1. To agree with system partners the oversight monitoring arrangements proposed by the Trust Development Authority and NHS England. | Trust Development Authority and NHS England | 31st August 2015 | Dark green |
| **August update:**<br>• Accountability framework presented at Urgent Care Board. For follow up at monthly TDA Integrated Delivery Meeting.<br>**September update:**<br>• Accountability framework agreed – action complete. | | | |
| 2. Commissioning Strategy for Urgent Care, Frail Elderly and End of Life. | Commissioners | 30th September 2015 | 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** | | | |
|---|---|---|---|
| **Action** | **Responsible lead** | **Deadline** | **Delivery rating** |
| **September update:**<br>• End of Life Strategy received.<br>• 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:**<br>• 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 | |
| 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 | |
| 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 | |

| 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** |
| | | | | Ambulance Service | |
| 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 | |
| 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 | |
| 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 | |
| **August update:**<br>• A full report on the above actions will be provided at the TDA Integrated Delivery meeting in September 2015.<br>**September update:**<br>• The Urgent Care Board will provide an exception report to the Quality Improvement Plan oversight meeting to address the above actions. | | | | | |

| **End of Life Care** | | | |
|---|---|---|---|
| **Action** | **Responsible lead** | **Deadline** | **Delivery rating** |
| 2. Commissioning Strategy for End of Life Care. | Commissioners | 30th September 2015 | Dark green |
| **September update:**<br>• End of Life Strategy received. | | | |

| 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** |
| 3. 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 | |
| **September update: Revised deadline to complete review of committee framework**<br>• Review of committee framework underway. Changes in committee structure to have Executive agreement therefore, deadline extended. | | | |
| 4. Undertake full review of the current functionality of the Datix system; particularly the resource allocated to the management of this key process. | Associate Director of Quality and Governance | 30th September 2015 | Dark green |
| **September update:**<br>• Datix review completed. Report to be presented to Operational Board; date to be confirmed. | | | |
| 5. Review Terms of Reference for sub-Board Committees. | Director of Corporate Affairs and Business Development | ~~30th September 2015~~ 31st October 2015 | |
| **September update: Revised deadline to complete review.**<br>• Terms of Reference have been received and are currently under review. | | | |
| 6. Review the organisational development program. | Director of Human Resources and Organisational Development | 30th September 2015 | Dark green |
| **September update:**<br>• Complete and being presented to Trust Board on the 1st October 2015. A detailed work plan will follow. | | | |
| 7. Develop a clear, risk and escalation based Assurance Framework for Clinical Service Centres which describes triggers around when the Trust Board will increase monitoring and scrutiny. | Associate Director of Quality and Governance | ~~30th September 2015~~ Review November 2015 | |
| **September update: Revised deadline to be reviewed in November 2015; dependent on outcome of Datix review and agreed recommendations. If recommendations not agreed, escalation framework will be developed to support agreed process.**<br>• Datix review completed. Recommendations require agreement. Potential to utilise the risk register function within Datix. If agreement, escalation based framework will be written to support this function. | | | |

# 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
## SEPTEMBER 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<br>2. Undertake bed re-profiling<br><br>Links to the delivery of Phase 2 of the system wide unscheduled care plan | Chief of Service Medicine<br><br>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<br>2. Patient experience survey of outliers quarterly (monthly during winter months)<br>3. Ratified Outlier Policy and staff communication<br>4. Complaints and incidents relating to outliers<br>5. Bed re-profiling complete | Monthly reporting of audit outcome and associated actions to Trust Board through the Integrated Performance Report<br><br>Quarterly reporting of evidence to the Governance and Quality Committee<br><br>Reduction in outliers in line with strategic plan | |
| **September update: Revised deadline due to timing of the Operational Board for ratification of Outlier Policy**<br>• Weekly notes audits have commenced in the Medicine Clinical Service Centre.<br>• Audit commenced in Medicine for Older People, Rehabilitation and Stroke Clinical Service Centre. Evidence available to demonstrate senior review of outliers.<br>• Patient experience survey of outliers will be reported through the quarterly Patient Experience Report.<br>• Outlier Policy is due to be presented to the Operational Board on the 7th October for ratification.<br>• Complaints and incidents relating to outliers are presented to the Urgent Care Board on a monthly basis.<br>• 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 patient flow<br>2. Undertake monthly Quality Care Reviews* | Director of Operations- Unscheduled care<br><br>Supported by Deputy Director of Nursing | Chief Operating Officer | ~~30th Sept. 2015~~ On-going monthly monitoring | 1. Progress against delivery of Phase 2 of the system wide unscheduled care plan<br>2. Outcome of monthly Quality Care Reviews* | Reporting progress against Phase 2 system wide plan implementation to the Urgent Care Board<br><br>Monthly exception reporting of outcome and learning from Quality Care Reviews* in the | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | incorporating checks on risk assessment completeness | Trust Board Integrated Performance Report | |
| **September update:**<br>• 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<br>**August update (M11):**<br>• The implementation of Phase 2 of the system-wide unscheduled care plan is in progress.<br>• Complaints/PALS relating to outliers and moves being monitored monthly through the unscheduled care metrics, no concerns to note. | | | | | | | | | |
| 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<br>2. Incorporate patient move status in protocol for clinical handover<br>3. Undertake monthly audit of clinical handover | Duty Hospital Manager Team Leader<br><br>Deputy Director of Nursing | Director of Nursing | ~~30th Sept. 2015~~ 31st Oct. 2015 | 1. <3 non-clinical moves after 9pm<br>2. Protocol for clinical handover<br>3. Monthly audit results and associated actions | Monthly reporting of performance in Integrated Performance Report to Trust Board<br><br>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 | |
| **September update: Deadline revised to align to CA3_M24 when protocol for clinical handover will be finalised as part of the Professional Standards**<br>• Clinical Service Centres have been requested to capture daily non-clinical moves between 0700 and 2100. Duty Hospital Managers will collate moves after 2100.<br>• To be reported through the monthly Integrated Performance Report to Trust Board. | | | | | | | | | |
| CA5 M17 | Surgery | Staff were not aware of standard protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness for day case surgery. | 1. Ensure all staff are clear about existing protocols for pre-assessment<br>2. Focussed work to ensure all staff feel confident to verbalise practices to external visitors<br>3. Implement work program for modernisation work stream for pre-assessment<br>4. Undertake monthly | Head of Nursing Critical Care, HSDU, Anaesthetics and Theatres<br><br>Director of Operations-Scheduled Care | Director of Nursing | 30th Sept. 2015 | 1. Staff communications highlighting existing protocols<br>2. Evidence of staff engagement<br>3. Delivery against work plan for pre-assessment<br>4. Outcome of monthly Quality Care Reviews* | Reporting progress against Improvement Plan through the monthly Surgery and Cancer Clinical Service Centre Executive Performance Review<br><br>Cancelled operations performance data reported monthly within the TDA Accountability Framework Metrics within the Integrated Performance Report to | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | Quality Care Reviews* | | | | | Trust Board<br><br>Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report<br><br>Quarterly reporting of outcomes and learning of the Quality Care Reviews* to the Governance and Quality Committee | |
| **September update:**<br>• Actions complete.<br>• Modernisation programme completed and operationalized.<br>• New substantive Senior Sister for Pre-Operative assessment appointed with a focus on strengthening the operational management and quality assurance processes of the department. | | | | | | | | | |
| CA7 M19 | Medicine Surgery Children & young people **Trust-wide** | GP discharge summaries were not being sent out in a timely manner and did not include all relevant information in line with Department of Health (2009) guidelines. | 1. Implement Electronic Discharge Summary project plan (Pilot commenced in June 15) | Electronic Discharge Summary Project Lead | Medical Director | ~~30th Sept. 2015~~ 30th Nov. 2015 | 1. Electronic Discharge Summary project plan implemented to deadlines. | Monthly reporting through the Governance and Quality Committee<br><br>Monthly exception reporting to the Clinical Quality Review Meeting with Commissioners<br><br>Quarterly reporting of compliance with the Contract schedule 'Transfer of and discharge from care protocols' to the Governance and Quality Committee | |
| **September update: Revised deadline for full roll-out; once roll out is complete areas not meeting the required levels in completing the ICE discharge summaries will be re-visited**<br>• The original roll out plan was scheduled for completion in January 2016. However, this has been expedited for ICE electronic discharge summaries to be completed by the 7th November 2015.<br>• Paediatrics are the last area on the rollout; they will continue using EPRO to electronically transfer their electronic discharge summaries. Therefore there will be a period of time where | | | | | | | | | |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| four areas will be reverting to paper discharge summaries following the planned VitalPAC electronic discharge summaries switch off. These are CHOC, Head and Neck, MSK and Woman and Children. All other departments will be using ICE electronic discharge summaries by the 30th September 2015.<br>• During the project roll out electronic discharge summaries are being monitored to review usage and compliance. It is envisaged that this monitoring / reporting will eventually move over to the Trust Information Services. | | | | | | | | | |
| CA9 M4 | Medicine Surgery End of Life Care **Trust-wide** | There were inadequate supplies of intravenous pumps, drip stands, pressure-relieving mattresses and other equipment. | 1. Ensure timely and appropriate supply of equipment<br>2. Daily monitoring of pressure relieving mattresses and patient requirements<br>3. Reinforcement of escalation for non availability of equipment<br>4. Review of equipment library processes<br>5. Undertake monthly Quality Care Reviews* | Head of Professions Clinical Support Services | Director of Nursing | 30th Sept. 2015 | 1. Positive balance of equipment availability<br>2. Daily equipment availability escalation emails.<br>3. Communications regarding escalation of non availability of equipment.<br>4. Outcome of review of equipment library and associated actions<br>5. Outcome of Quality Care Reviews* | Daily escalation e-mails detailing equipment availability<br><br>Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report<br><br>6 monthly reporting to the Governance and Quality Committee from the Medical Devices Management Committee<br><br>Harm free care within National Patient Safety Thermometer limits and incident data reported through the monthly Integrated Performance Report to Trust Board | Dark green |
| **September update:**<br>• A daily list of the availability of pressure relieving mattresses and cushions (along with the longest wait) to all Modern Matrons, Heads of Nursing, Duty Hospital Managers and Operations Centre staff. This e-mail also contains a link to the availability of various other equipment, such as syringe pumps.<br>• Completed review of equipment library processes | | | | | | | | | |
| 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<br>2. Ensure warning lights come on outside each theatre to identify specific theatre<br>3. Anomolies in the illuminated indicator | Head of Nursing Critical Care, HSDU, Anaesthetics and Theatres | Medical Director | ~~30th Sep. 2015~~<br><br>Monthly updates | 1. Evidence of daily checks of alarms.<br>2. Evidence of daily checks of warning lights<br>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 |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | panels making it difficult to identify which theatre has pulled the alarm to be addressed through Carillion | | | | | | |
| **September update: Monthly updates to ensure progress with nurse call panel**<br>• Training has been delivered to teams with clarification of lighting system at the Clinical Governance Meeting.<br>• A Purchase Order has been raised with the Contractors for the new nurse call panels; all other works required have been completed.<br>**August update: Revised deadline pending completion of small works.**<br>• 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.<br>• Carillion confirmed in March 2014 they have resolved the issues with the 'follow-me' warning lights outside theatres.<br>• A quotation has been requested for the new nurse call panel; all other works required have been completed. | | | | | | | | | |
| CA11 M15 | Medicine **Trust-wide** | The falls action plans were not followed in a consistent way across the medical services. | 1. Hold Falls summit to proactively prevent falls<br>2. Undertake monthly audit of compliance with risk assessment and action plans<br>3. Introduce mandated training sessions for all nursing staff | Head of Infection Prevention and Clinical Safety | Director of Nursing | 31st Sept. 2015 | 1. Falls summit outcome<br>2. Monthly audit data and associated action plans<br>3. Training records | Reporting progress against Clinical Service Centre Improvement Plans through the monthly Executive Performance Reviews<br><br>Monthly reporting of falls performance data in the Integrated Performance Report to Trust Board<br><br>Quarterly reporting of the evidence to the Governance and Quality Committee | Dark Green |
| **September update:**<br>• Falls summit held 10th August.<br>• Monthly audit of completion of risk assessments undertaken and reported through the Integrated Performance Report.<br>• Falls training is underway. Evidence of numbers of staff attending falls training sent to all Ward Managers, Modern Matrons and Heads of Nursing received. | | | | | | | | | |
| CA12 M16 | Surgery | Compliance with the World Health Organisation (WHO) Surgical Safety Checklist | 1. Establish a Safer Surgery Steering Group to promote compliance<br>2. Review governance | Chief of Service Critical Care, HSDU, Anaesthetics and Theatres | Medical Director | 31st Aug. 2015 | 1. Terms of Reference and minutes of meetings of Safer Surgery | Reporting progress against Critical Care, HSDU, Anaesthetics and Theatres Clinical Service Centre | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | was not documented appropriately. | arrangements for remote theatres e.g. ophthalmology<br>3. Undertake WHO Quality and observational Trust-wide audits | | | | Steering Group.<br>2. Evidence of governance reviews of remote theatres and associated actions<br>3. WHO audit results and associated actions<br>4. WHO quality and observational audit outcomes and associated actions | Improvement Plan through the monthly Executive Performance Reviews<br><br>Critical Care, HSDU, Anaesthetics and Theatres Clinical Service Centre quarterly report to the Governance and Quality Committee | |
| **September update:**<br>• Evidence of audit and actions for remote areas (Ophthalmology, MRI, Cardiology, Endoscopy) received; with the exception of Cardiology all are showing 100% compliance. The Cardiology department have a WHO Safety Checklist and Team Brief template which is currently being used for all cardiac procedures. These were reviewed and updated in March 2015, but are currently being revisited by the WHO Checklist Lead to ensure that they fit with the models being used in other cardiology departments.<br>• Maternity Theatres are using a modified version of the Theatre WHO checklist which has been agreed via internal governance mechanisms. This has been audited recently and results are to be forwarded to the Safer Surgery Steering Group. The Woman and Children's Clinical Service Centre have developed a new checklist for the Gynaecology ambulatory clinic, which is due to be submitted to the Woman and Children's Governance Committee. This will be audited once it has been fully embedded in practice.<br>**August update:**<br>• Safer Surgery Steering Group Terms of Reference and minutes received.<br>• Speciality audits underway. The Care Quality Commission specifically picked up non-compliance in Ophthalmology. Monthly audits have been undertaken which have demonstrated full compliance. | | | | | | | | | |
| CA14 M29 | Surgery **Trust-wide** | Patient records and drug charts were not complete and did not contain all required information relating to a patient's care and treatment. | 1. Undertake initial weekly audit of drug charts and patient records within Surgery<br>2. Undertake monthly Quality Care Reviews* | Head of Nursing Surgery<br><br>Deputy Director of Nursing | Director of Nursing | 30th Sept. 2015 | 1. Audit results and associated actions<br>2. Outcome of Quality Care Reviews* | Reporting progress against Surgery and Cancer Clinical Service Centre Improvement Plan through the monthly Executive Performance Reviews<br><br>Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated | 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 |
|---|---|---|---|---|---|---|---|---|

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

| Ref. | Core service | Compliance action | Improvement action(s) | Lead | Exec. lead | Deadline | Evidence required | Assurance | Delivery rating |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Performance Report<br><br>Quarterly reporting of outcomes and learning of the Quality Care Reviews* to the Governance and Quality Committee | |
| **September update:**<br>• Weekly audits in place. | | | | | | | | | |
| CA15 M31 | Surgery End of Life Care **Trust-wide** | Patient records were not always stored so that patient confidentiality was maintained. | 1. Review current practice across surgery through Quality Care Reviews*<br>2. Reinforce to staff Trust-wide information governance requirements and good practice | Deputy Director of Nursing<br><br>Information Governance Manager | Director of Corporate Affairs | 30th Sept. 2015 | 1. Outcome of Quality Care Reviews*<br>2. Communication of staff responsibilities in relation to information governance | Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report<br><br>Quarterly reporting of outcomes and learning of the Quality Care Reviews* to the Governance and Quality Committee | Dark green |
| **September update:**<br>• Trust-wide e-mail re-enforcing staff responsibilities in relation to patient confidentiality and Information Governance sent as action related to M27. | | | | | | | | | |
| 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~~<br>On-going monthly monitoring | 1. Monthly training compliance data<br>2. Clinical Service Centre performance review metrics | Reporting essential skills training performance data through Clinical Service Centre monthly Executive Performance Reviews<br><br>Trust and Clinical Service Centre level performance data reported monthly in the Integrated Performance Report to Trust Board | Red |
| **September update:**<br>• No significant improvement has been noted. This has been escalated and will form part of the CSC monthly Executive Performance Reviews.<br>**August update: Deadline amended to show on-going monthly monitoring required.**<br>• 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 | | | | | | | | | |

| 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
## SEPTEMBER 2015 ACTIONS UPDATE

| Ref. | Core service | Compliance action | Improvement action(s) | Lead | Exec. lead | Deadline | Evidence required | Assurance | Delivery rating |
|---|---|---|---|---|---|---|---|---|---|
| Performance Reviews from September and will continue to be monitored closely monthly. | | | | | | | | | |
| CA21 M23 | Medicine Surgery **Trust-wide** | Nursing staff did not receive formal clinical supervision in line with professional standards. | 1. Undertake a review of clinical supervision and reflective practice processes<br>2. Link with Frimley Park to learn best practice | Acting Head of Nursing and Midwifery education | Director of Nursing | 30th Sept. 2015 | 1. Outcome of review and associated actions<br>2. Implemented learning | Staff pledge 2 (personal development and management support) of the National Staff Survey above National average for 2015 – maintain and improve this position | Blue |
| **September update:**<br>• Clinical supervision scoping exercise completed which highlighted additional guidance required for staff which will be distributed by the Learning and Development Department. Review identified large clinical supervision resource within the library and staff supported through reflective practice, mentoring and coaching networks. Links have been made with Frimley Park to determine if we can adopt any additional practice and learning from them. Meeting being arranged between teams. | | | | | | | | | |
| CA22 M25 | End of Life Care **Trust-wide** | Nursing staff did not have appropriate training in the safe use of syringe drivers. | 1. Launch End of Life Strategy<br>2. Targeted training for all surgical nursing staff in the use of syringe drivers<br>3. Implement End of Life Care action plan<br>4. Undertake monthly Quality Care Reviews* | Head of Nursing Surgery<br><br>Head of Nursing Medicine for Older People, Rehabilitation and Stroke | Director of Nursing | 30th Sept. 2015 | 1. Training records for all surgical nursing staff<br>2. Progress against End of Life Care action plan<br>3. Outcome of monthly Quality Care Reviews* | Clinical Service Centre monthly Executive Performance Reviews<br><br>Minutes from the End of Life Steering Group<br><br>Monthly exception reporting from the Clinical Effectiveness Steering Group to the Governance and Quality Committee<br><br>Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report | Blue |
| **September update:**<br>• Syringe driver training in place. Competence currently: SAU – 87%, E2 – 92%, E3 – 91%, D7 – 96% and Surgical High Care Unit –79%. Order approved for new drip stands.<br>• The end of life care action plan has been implemented; elements remain on-going. | | | | | | | | | |
| 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<br><br>Urgent Care Board Quality Metrics | 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 |
|---|---|---|---|---|---|---|---|---|

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

| Ref. | Core service | Compliance action | Improvement action(s) | Lead | Exec. lead | Deadline | Evidence required | Assurance | Delivery rating |
|---|---|---|---|---|---|---|---|---|---|
| **September update:**<br>• 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 | | | | | | | | | |
| M26 | Clinical Support | All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded. | 1. Reinforce sliding scale insulin and appropriate recording to all pharmacists.<br>2. Include in local induction for new pharmacists the Trust sliding scale insulin<br>3. Undertake quarterly spot checks for pharmacy staff awareness | Director of Pharmacy | Medical Director | 30th Sept. 2015 | 1. Evidence of communication to all pharmacists<br>2. Local induction materials<br>3. Results of quarterly spot checks of pharmacy staff awareness<br>4. Medication Safety Committee minutes<br>5. Sharing of best practice across the organisation | Progress against Clinical Support Clinical Service Centre quality improvement plan through monthly Executive Performance Reviews | Dark green |
| **September update:**<br>• Evidence of communication to Pharmacists received.<br>• There is a plan for new pharmacists to attend junior doctor induction where this will be covered. It will also be added as a specific item to Pharmacy induction paperwork.<br>• The first audit will take place in November, following data collection on Medicines Reconciliation data day to identify the location of patients. | | | | | | | | | |
| M32 | **Trust-wide** | The trust fully participates in all national audits for which it is eligible on end of life care. | 1. Establish a process to ensure national end of life care audits are identified and a Trust lead appointed<br>2. Participation in eligible National Audits relating to end of life care (commences June 15 – Sept 15) | Head of Nursing Medicine for Older People, Rehabilitation and Stroke | Director of Nursing | 30th Sept. 2015 | 1. Minutes from the Clinical Effectiveness Steering Group to inform the monthly Clinical Service Centre Performance Reviews to ensure that follow through arises and appropriate timely methods of escalation are implemented<br>2. Timely and | Monthly exception report and minutes of the Clinical Effectiveness Steering Group to the Governance and Quality Committee | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | complete submission to National audits relating to End of Life Care within required timeframes | | |
| **September update:**<br>• The Trust is fully participating in the End of Life Care of the Dying in Hospital 2015 audit. Monitored through the Clinical Effectiveness and Mortality Steering Group. | | | | | | | | | |
| S8 | Surgery | Staff in surgery understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. | 1. Provide additional Mental Capacity Act / Deprivation of Liberty Safeguards training sessions for surgical staff<br>2. Undertake monthly Quality Care Reviews* to assess staff knowledge | Head of Nursing Surgery | Director of Nursing | 30th Sept. 2015 | 1. Training records for surgical staff<br>2. Outcome of Quality Care Reviews* and associated actions | Surgery and Cancer Clinical Service Centre monthly Executive Performance Review | Dark green |
| **September update:**<br>• All Band 7 staff have completed training. The forthcoming grand round will include an agenda item / training for MCA for doctors. | | | | | | | | | |
| S18 | Women and Children **Trust-wide** | There are appropriate facilities for teenagers admitted to the wards, and accommodation is provided in bays with patients of a similar age. | 1. Ensure the Task and Finish group in place addresses the operational issues and risk of influx of Young People as currently the Patient Administration System suggests only 1 or 2 beds required. | Head of Nursing Women and Children<br><br>Clinical Director of the Paediatric Unit | Director of Nursing | 30th Sept. 2015 | 1. Operational issues and actions taken to address | Women and Children Clinical Service Centre progress against improvement plan at monthly Executive Performance Review | Blue |
| **September update:**<br>• LiA event arranged for 9th February 2016.<br>• Setting up focus group to enable young people to provide feedback to the Trust.<br>• Women and Children Clinical Service Centre are offering the other Clinical Service Centres flexibility for over 16 year olds when capacity within the paediatric unit allows. | | | | | | | | | |
| S20 | Women and Children | Arrangements for psychological and emotional support | 1. Trust to raise identified gaps with Clinical Commissioning Group | Head of Nursing Women and Children | Director of Nursing | 30th Sept. 2015 | 1. Communication with Commissioners | Women and Children Clinical Service Centre progress against | Blue |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | for children and young people with non-acute mental health needs is reviewed. | leads especially in the outpatient department setting. | | | | regarding identified gaps | improvement plan at monthly Executive Performance Review | |
| **September update:**<br>• The issue has been raised with the Clinical Commissioning Group and discussions are on-going relating to outpatient setting. | | | | | | | | | |
| S24 | **Trust-wide** | Patient information is available in an easy-to-read format. | 1. Ensure patient information complies with the Patient Information Policy<br>2. Remind all staff about the need to ensure patient information meets requirements of the policy and availability of easy read leaflets are available on request through Health Information centre<br>3. Undertake monthly Quality Care Reviews* | Head of Patient Experience | Director of Nursing | 30th Sept. 2015 | 1. Samples of patient information<br>2. Evidence of communication to staff<br>3. Outcome of Quality Care Reviews* and associated actions | Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report | Dark green |
| **September update:**<br>• A staff information leaflet has been developed and ratified to support the local policy. This quick reference guide has been published in the local staff magazine LINK. | | | | | | | | | |
| S25 | Corporate Patient Experience **Trust-wide** | Patients are given information about how to make a complaint and what responses they should expect to receive. | 1. Ensure information on how to complain is available in each ward/department.<br>2. Improve accessibility and information on the Trust website<br>3. Undertake monthly Quality Care Reviews* | Head of Patient Experience | Director of Nursing | 30th Sept. 2015 | 1. Updated website<br>2. Outcome of Quality Care Reviews* and association actions | Monthly exception reporting of outcome and learning from Quality Care Reviews* in the Trust Board Integrated Performance Report | Dark green |
| **September update:**<br>• The information leaflet has been reviewed to reflect feedback from patients and their families.<br>• Access to information about how to complain is now on the front page of the hospital internet site.<br>• Complainants are provided with an opportunity to provide feedback on resolution of their complaints about the process for complaining via a survey and additional telephone feedback is also sought.<br>• Hard copy information leaflets are available at the PALS desk. | | | | | | | | | |

| 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
## SEPTEMBER 2015 ACTIONS UPDATE

| Ref. | Core service | Compliance action | Improvement action(s) | Lead | Exec. lead | Deadline | Evidence required | Assurance | Delivery rating |
|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | Monthly reporting to Operational Board | Amber |

**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.

| 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 |
|---|---|---|---|---|---|---|---|---|