NHS
Portsmouth Hospitals
NHS Trust

QUALITY IMPROVEMENT PLAN 2017

Contents

Introduction 3
Trust Profile 4
Single Item Quality Surveillance Group meeting 5

CQC Report Findings 2017 6

Trust Board Response 8

Developing a Culture of Continuous Improvement 8

Quality improvement aims 9

Quality Improvement Plan (QIP) 10

Quality Improvement Aims 11
Governance and Assurance 12

The Governance Structure 13

1. Valuing the Basics 14
1.1 Patient at the centre 15
1.2 Holistic care 15
1.3 Courageous discussions 16
1.4 Involving patients, families and carers 16

2. Supporting Vulnerability in Patients 17
2.1 Safeguarding 18
2.2 Mental Health 18
2.3 Dementia 19
2.4 Mental Capacity Act and Deprivation of Liberty Safeguards 20

3. Organisation that Learns 21
3.1 Zero tolerance of bullying 22
3.2 Behaviours and compassion 22
3.3 Right staff, right skills 23
3.4 Staff engagement 24

4. Moving Beyond Safe 25
4.1 Urgent care 26
4.2 No 'avoidable' deaths 26
4.3 Stop harm to patients 27
4.4 Right patient, right bed 28

5. Leading Well Through Good Governance 29
5.1 Leadership at all levels 30
5.2 Role clarity, responsibility and accountability 30
5.3 Standardising and consistency in processes 31
5.4 Being open and transparent 32

Introduction

The Quality Improvement Plan (QIP) for Portsmouth Hospitals NHS Trust attempts to address a number of concerns into the quality of care received by patients. The Care Quality Commission (CQC) rated the trust as "Inadequate" for medical care and safety in Emergency Care.

The Board is committed to understanding the root causes behind the failings in care provision and to systemically address those underlying causes. This will ensure that changes are made so that patients receive consistent, high-quality care and Portsmouth Hospitals NHS Trust becomes the employer of choice.

The Board will apply focus and rigour to ensure the delivery of the plan. The Board will also start work to create the conditions that allow staff to do their job well by removing blocks to success and managing risks to delivery. Partner agencies have kindly offered their support to the Trust and this is warmly welcomed. The CCG, local authorities, Healthwatch, NHS Improvement, NHS England and others will play a key role in scrutinising the assurance processes to ensure they are robust.

A core facet of the plan is the engagement of frontline staff in the improvement journey and alignment to the Quality Improvement Strategy. This will ensure the impact of the Improvements is understood and take advantage of the expertise and knowledge of staff as well as patients to ensure the plan is delivered. It will also start to signal a common purpose and priority for the organisation that is owned by frontline staff.

The Board is committed to ensuring that the Quality Improvement Plan is delivered at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation, the Board has set the ambition to be rated "Good" by 2019 and "Outstanding" by 2020.

Trust Profile

Queen Alexandra Hospital (QAH) started life more than a century ago as a military hospital. Today it is one of the largest, most modern hospitals in the region, with 1,200 beds housed in light, bright, infection resistant en-suite wards.

The current hospital was first opened by Princess Alexandra in 1980 before undergoing a major redevelopment to create a modern and 'fit for purpose' hospital, which was completed in 2009.

Included within our modern buildings are:

- 28 theatres - with four dedicated endoscopy theatres
- Two purpose-built interventional radiology suites, three MRI scanners, three CT scanners and a PET scanner
- State-of-the-art pathology laboratory
- Neonatal Unit, Level 3
- Hyper Acute Stroke Unit
- Superb critical care facilities

We provide comprehensive secondary care and specialist services to a local population of 675,000 people across South East Hampshire. We also offer some tertiary services to a wider catchment area in excess of two million people.

In the last year we saw:

- Over 73,000 planned admissions to hospital
- Over 141,000 Emergency Department attendances
- Over 566,000 outpatient appointments
- Over 54,000 emergency admissions
- Over 5,700 births in our maternity units
- We employ around 7,000 people making us the largest employer in Portsmouth

Recruiting and maintaining an effective workforce is a major priority and our strong partnerships with the Ministry of Defence, Carillion and NHS Professionals - who provide our temporary workforce helps us to achieve the goal of maintaining safe services for all of our patients.

Our Trust strategy has not been developed in isolation. We have an important role to play within the local health economy and we are a key player in the delivery plan of the Hampshire and Isle of Wight Health (HIOW) and Care System Sustainability and Transformation Plan (STP). This recognises the challenges we face, our vision for HIOW and the action we are taking to address our challenges and deliver our vision.

Single Item Quality Surveillance Group meeting

The Trust attended a Single Item Quality Surveillance Group on 22nd September 2017 led by NHS Improvement/NHS England involving partner organisations, commissioners and regulators. The purpose of the meeting was to look at wider surveillance and quality at a local, regional and national level and work with the Trust and System around identified quality concerns.

Actions identified from the meeting:

Action	Organisation
Quality Oversight Group to identify specific actions which will enable the group to close down	NHS Improvement/ NHS England
The system to identify what is required to enable self-regulation	System convener
System approach to resolve urgent care improvements	All Organisations
Trust to liaise with HEE re their offer of support	Portsmouth Hospitals NHS Trust
System to produce a work programme for each organisation	All organisations
Liaise with Chief of Service Acute Medical Unit (AMU) regarding Acute Frailty Network for the Quality Improvement approach for the whole system	NHS England

The Trust currently has three Section 31 Enforcement Notices imposed on the registration with the CQC:

1. Acute Medical Unit (AMU) regarding adequate staffing relating to patient acuity, crowding of the GP referral area with fortnightly reporting on compliance.
2. ED and Mental Health relating to suitably qualified and competent staff in EDU, risk assessment and care planning of patients with mental health problems, oversight of patients with mental health concerns or safeguarding issues, correct application of MCA and DoLS with weekly reporting against the conditions.
3. Diagnostic and screening procedures in relation to resolving the backlog of radiology reporting and ensuring robust processes to report images taken with weekly reporting against the conditions.

The Trust has also been issued with a Section 29a Warning Notice, which requires significant improvements to be madein various aspects of clinical care and governance by 31st October 2017.

Within the February and May 2017 CQC reports there were a number of ‘must do’ actions and one ‘should do’ action. To address the shortcomings identified within the reports the Trust has worked on identifying key aims and causes and has undertaken a number of staff and patient engagement events.

CQC Report Findings 2017

The reports following the CQC inspections inspected Urgent and Emergency Services and Medical Care at QAH on the 16th, 17th, 28th February and 10th and 11th May were published on 24th August.

The following ratings have been applied:

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Urgent and Emergency Services	Inadequate	Good	Good	Requires Improvement	Requires Improvement	**Requires Improvement**
Medical Care	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	**Inadequate**

Figure 1 identifies the persistent concerns raised by the CQC and the root causes identified by the Trust.

Persistent problems	Relevant root causes
Board ownership	A, B, F
Lack of strategic view	A, B
Valuing the basics of care	C, G, I, K, M
Medicines management	C, G, I, M
Care of vulnerable patients (mental health, safeguarding, dementia)	C, G, I, J, K, L, M
Low staff morale	A, B, C, D, H
Poor patient flow	A, B, C, D, E, H, J
Poor governance	C, F, I, J
Poor risk management	I, J, M
Culture of bullying and inability to raise concerns	A, B, D, H

Root causes identified following CQC report

A. Board portfolios unclear

B. High turnover and proportion of interims in the leadership team

C. Roles, responsibilities and accountability was not clear and not reinforced

D. Leadership not visible and leaders not responsive to incidents

E. Revised Medical Model not implemented

F. Trust has not maintained a usable Board Assurance Framework

G. Inconsistent application of fundamentals of care

H. Lack of performance management

I. Not knowing what good is or looks like

J. Controls and processes unclear or failing

K. Lack of risk assessment and care planning

L. Staffing establishment

M. Staff knowledge, competence and expertise

Trust Board Response

The Trust Board have acknowledged that the CQC reports made difficult reading and have accepted the findings without reservation; acknowledging that the Trust had clearly fallen short in some key areas.

Since the inspections in February and May 2017, the Trust has made some significant and important changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care. We have improved how we care for our most vulnerable patients, including those who have mental health issues. We now have active, early risk assessments in our ED, a Mental Health Liaison Team working closely together and stronger cross-organisational working practices with colleagues from partners. The Trust Board have made it clear that secrecy, not speaking up and not working together for the good of all our patients has no place in our Trust.

The Trust Board consider that we have the skills, dedication and ambition to address all the issues raised by the CQC and ensure we give the best possible care we can to every patient. The successful implementation of this Quality Improvement Plan linked to the Quality Improvement Strategy will ensure that improvements are made and sustained for all Trust's services.

Developing a Culture of Continuous Improvement

Patients are at the heart of everything we do at Portsmouth Hospitals NHS Trust and we are committed to improving quality and achieving excellence in all that we do. Our aim is to be one of the most successful NHS Trusts in Caring for Patients, Caring for Each Other and Working towards a Happier, Healthier Portsmouth Community. We are committed to developing A Culture Of Learning And Doing Things Differently and supporting continuous Quality Improvement (QI), as advocated within NHS Improvements "Developing People, Improving Care" (2016) document.

For QI to be successfully embedded by all staff at all levels, a culture of improvement that spans the organisation is required. Strong leadership is key to the development of an improvement culture, and organisations that have successfully implemented QI strategies have demonstrated improvements in standards and outcomes across all aspects of care. QI is distinctly different to audit and has been shown to bring about more sustained improvement as it enables those with the experiences to explore and co-create the process, resulting in it being more likely that the whole organisation will 'own' the approach.

Early Board level support and backing are cited as being critical success factors; at PHT the Board have committed to delivering the Quality Improvement Aims, which will be underpinned by the development of a new Quality Improvement Strategy (2018-2021).

Quality improvement aims

- Valuing the basics
- Moving beyond safe
- Supporting vulnerability in patients
- An organisation that learns
- Leading well through good governance

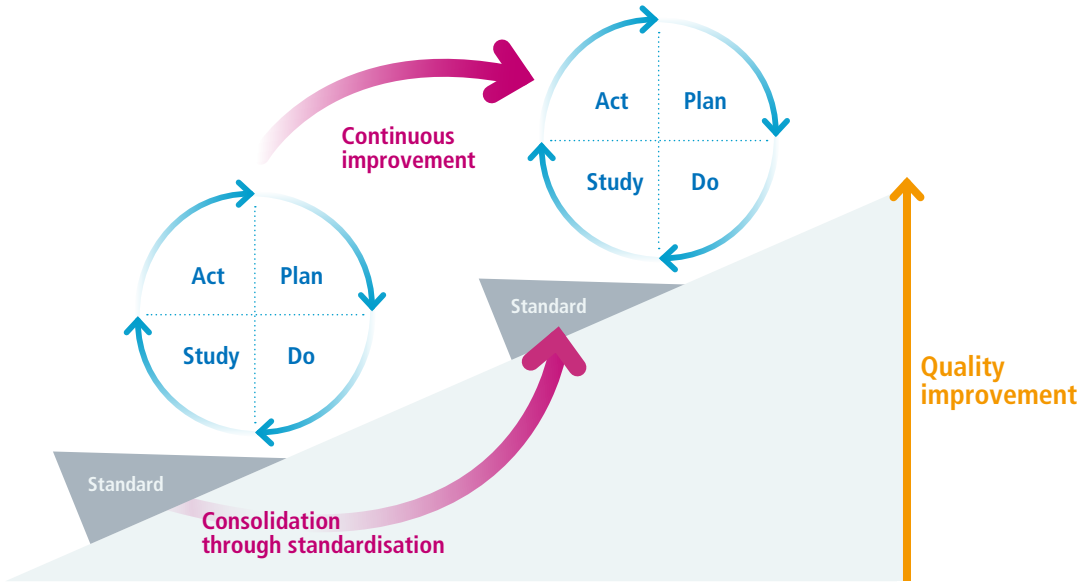
The Quality Improvement Strategy (2018-2021) is currently being developed with stakeholder engagement and once delivered will ensure that effective QI skills are embedded and locally owned. In order to support the implementation a number of actions have already been agreed:

The Quality Improvement Strategy stakeholder events have identified the QI aims and seven themes underpinning the aims.

The development of a virtual 'Portsmouth Improvement Academy' led by a triumvirate of a doctor, a nurse/midwife/ Allied Health Professional (AHP) representative and a service manager. This Triumvirate will support the delivery of the agreed QI Strategy using QI training to build capability and capacity amongst the workforce. The vision of the 'Portsmouth Improvement Academy' is to oversee a 'hub' of QI Facilitators whose role will be to train, mentor and support staff working through QI projects.

The Trust will adopt the Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) as our chosen QI methodology. It is simple for all staff to use and is a widely understood methodology that has been successfully used in many healthcare settings. Furthermore it builds on the existing knowledge and skills of many of our staff, and harnessing that enthusiasm and knowledge from frontline staff will enable us to make progress faster. The MFI utilises the Plan, Do, Study, Act (PDSA) cycle to facilitate change from the front line, thus encouraging altered behaviours, working together, creative thinking, and fundamentally, using measurement to guide improvement (Figure 2).

Figure 2: Demonstrating Change by the use of the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle



Quality Improvement Plan (QIP)

The QIP brings together all the actions that the Trust believes to be the most important. The Trust also believe that gaining traction on these will deliver the improvements necessary to achieve the short-term goal of an overall Trust CQC rating of at least "Requires Improvement" by March 2018 and the longer-term ambition of an overall Trust CQC rating of "Good" by 2019, and an "Outstanding" by 2020.

Whilst the issues were identified within the Urgent and Emergency Services and Medical Care, we acknowledge that these findings are potentially translatable across the whole organisation. The identified aims align to the Trust Quality Account Priorities for 2017/2018.

The plan to achieve "Requires Improvement" is very detailed and will form the basis of our work plan for the next year. Simultaneously, we will introduce, implement and start to embed the Quality Improvement Strategy.

We will approach our Improvement Plan through:

- Robust leadership to drive recovery
- Focused Board oversight and scrutiny
- Executive Accountability for delivery of improvement plans
- Building strong leadership at all levels within the Trust
- Extensive staff engagement to drive innovation
- A rigorous QI approach throughout the organisation
- Supported Programme and Project management
- A single reporting structure for Board, Commissioners and Regulators
- Support and work with our partners
- Support and involvement from patients, service users and the public
- Relationships with the Acute and Mental Health Alliances
- External support from experts to address capability

We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn from research.

Quality Improvement Aims

Once the five aims were identified, we held an engagement exercise to inform frontline staff and ensure they were all understandable. Each of the aims has an Executive Sponsor who will work with the Clinical Lead to ensure delivery of the improvements.

Valuing the Basics

Executive Sponsor: Chief Operating Officer

- Patient at the centre
- Holistic care
- Courageous discussions
- Involving patients, families and carers.

Organisation that Learns

Executive Sponsor: Medical Director

- Zero tolerance of bullying
- Behaviours and compassion
- Right staff, right skills
- Staff engagement.

Supporting Vulnerability in patients

Executive Sponsor: Director of Workforce and Organisational Development

- Safeguarding
- Mental Health
- Dementia
- Mental Capacity Act and Deprivation of Liberty.

Moving Beyond Safe

Executive Sponsor: Director of Finance

- Urgent care
- No 'avoidable' deaths
- Stop harm to patients
- Right patient, right bed.

Leading Well through Good Governance

Executive Sponsor: Chief Nurse

- Leadership at all levels
- Role clarity, responsibility and accountability
- Standardising and consistency in processes
- Being open and transparent.

Governance and Assurance

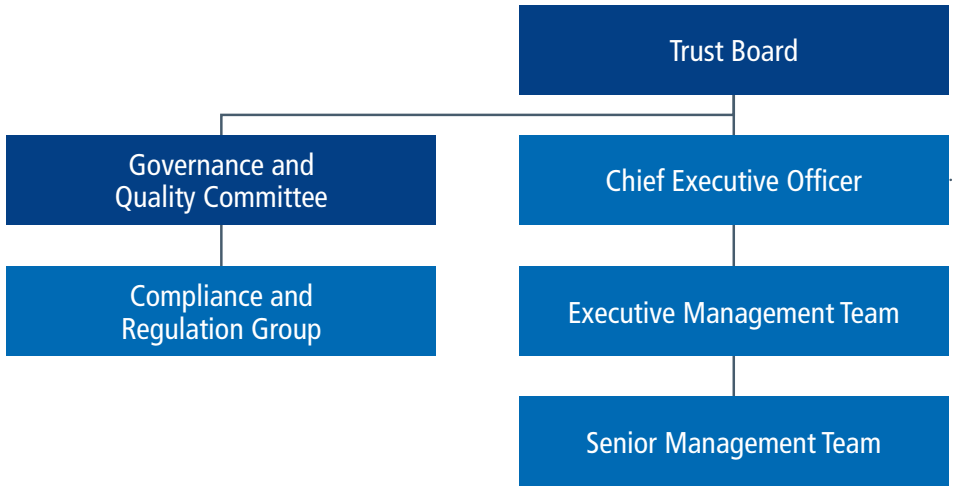
A rigorous reporting programme both internally and to key stakeholders is now in place.

The Trust has established a Compliance and Regulation Group (CRG) that meets weekly to provide oversight and seek assurance against operational delivery of improvement plans. Currently this is chaired by the Chief Nurse until the Director of Strategy, Governance and Performance is in post. The CRG reports to the Governance and Quality Committee, which is a sub-committee of the Board.

Sitting alongside the internal governance arrangements is the Quality Improvement Plan Oversight Group (QIPOG), which is responsible for ensuring that as a health system there is ownership of issues and action taken to deliver system-wide improvements. Whilst the QIPOG has no formal reporting line into the Trust it provides external assurance to the Chief Executive and Executive Management Team.

The Governance Structure

Reporting Structure



NHS Improvement/NHS England Quality Improvement Plan Oversight Group

- A Non-Executive Director chairs the Governance and Quality committee and will hold the executive sponsor to account for each area of the Quality Improvement Plan
- Regular updates will be provided by the executive sponsors to the senior management team and any issues will be escalated to the executive management team
- Five keys enablers have been set up to support the Quality Improvement Plan aims
- These enablers will be designed to establish the structures, capabilities, buy-in, and vision necessary to achieve change on a large scale.

Key Enablers

1. Valuing the Basics

The CQC raised significant concerns about the safety and care of vulnerable patient, such as frail older people or patients living with dementia. There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores. Patients, some of which deemed as high risk of malnutrition were not assisted with their meals. Staff did not always consistently follow infection control procedures. Staff the CQC spoke to did not have knowledge of the Trust pain assessment tool for patients who could not verbalise their pain.

We recognised that we had significant work to do to improve some fundamentals within basic nursing care. Immediately following the CQC inspection, all nurses were required to re-read their NMC - The Code and to report that they were practising within The Code.

The Trust held a 'Supporting vulnerable patient information event' on Friday 8th September 2017, with a focus on the fundamentals of care. This information day launched the start of a series of mandatory training sessions.

Specific actions

- 1.1 Patient at the centre
- 1.2 Holistic care
- 1.3 Courageous discussions
- 1.4 Involving patients, families and carers

1.1 Patient at the centre

Action	Outcome	Completion
Single sex accommodation requirements for patients are maintained and a system to report breaches is in place	All breaches are reported and investigated appropriately	Complete
Re-launch the protected meal time initiative	Ensure meal times are protected enabling improved nutrition	31/12/2017
Pilot patient centred questions as part of bedside handover to formally recognise patient involvement with every shift handover	Patients and their families or carers are involved in the care planning process	31/12/2017
Embed the principles of the "if you had 1000 days left to live" (TODAY programme) to value patient time as the most important currency in healthcare	Principles embedded in every day practice	31/03/2018
Following the End PJ Paralysis campaign embed the principles into practice	Principles embedded in every day practice	31/03/2018

1.2 Holistic care

Action	Outcome	Completion
Patients receive individualised nursing care	Every patient has an individualised nursing care plan	31/12/2017
Improve dignity for patients through improvements in continence care	Dignity maintained for patients	31/03/2018
Review nursing documentation to facilitate the provision of holistic care	Streamlined documentation which supports and evidences care provision	31/03/2018

1.3 Courageous discussions

Action	Outcome	Completion
Embedding the principles of 'No decision about me without me' so patients are involved in making decisions about their care and treatment	Care will be delivered in partnership with patients to meet their needs and appropriate advocacy as required	30/06/2018
Implement the principles of Achieving Priorities of Care (APOC)	Allowing patients and families to have a dignified death in line with their wishes	30/06/2018

1.4 Involving patients, families and carers

Action	Outcome	Completion
Implement patient engagement strategy *Get Involved* (2017-2020) to strengthen patient engagement across all services at PHT	Patient engagement strategy to be ratified by the board so that patients and carers will be involved in all service re-design/improvement initiatives	31/12/2017
Promote the Friends and Family Test (FFT) throughout the organisation, with particular focus on the Emergency Department, to increase the response rate to at least the England average of 24% and to ensure compliance with the contractual requirements	Increased FFT response rate and positive recommendations for Emergency Department to be at, or above, the England average	31/03/2018
Strengthen and embed the Being Open Policy	Staff actively involve and discuss care issues with patients and families in an open and meaningful way as part of their everyday care	31/03/2018

2. Supporting Vulnerability in Patients

The CQC report highlighted a number of concerns regarding the care of vulnerable patients. This included patients with acute and specialist mental health needs, patients living with dementia and those patients who required additional safeguards to be in place to maintain their safety and dignity.

We recognised that our clinical staff were finding the application of theory and legislative requirements into practice challenging; in particular, in relation to the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and The Mental Health Act. The safety of vulnerable patients in the Emergency Decision Unit (EDU) within the Emergency Department was of particular concern. We also identified that we lacked subject matter expertise within safeguarding and mental health. A significant programme of work and education has commenced to address these issues, which had been identified and included within the Quality Account Priorities for 2017/18.

As part of the Portsmouth Quality Bundle, the Trust has introduced a vulnerable patient module to drive consistent standards of care for this patient group.

There is a need to focus on the safety of children and young people; particularly those with specialist mental health needs and those cared for within an adult environment where necessary. The Trust is working with Portsmouth Safeguarding Adult and Children Boards to review current processes and safeguarding practices to improve safety and experience.

The CQC highlighted concerns regarding the adherence to the Administration of Medication Policy, with particular reference to covert medication. As this is key to supporting vulnerability inpatients who lack capacity, an education and awareness programme has commenced. This will require on-going focus.

Specific actions

- 2.1 Safeguarding
- 2.2 Mental Health
- 2.3 Dementia
- 2.4 Mental Capacity Act and Deprivation of Liberty Safeguards

2.1 Safeguarding

Action	Outcome	Completion
External review of Child Safeguarding in Emergency Department to identify any gaps in safeguarding procedures	Fully compliant with safeguarding children procedures.	31/12/2017
External review of safeguarding processes and training material (CCG, Safeguarding Boards and local authorities) for both adult and child safeguarding	External assurance of internal processes and education programmes	30/11/2017
Strengthen the Adult Safeguarding Team and leadership	To have the capacity and subject matter expertise to support the organisation in delivery of statutory requirements	31/01/2018

2.2 Mental Health

Action	Outcome	Completion
External review of Trust compliance against the requirements of the Mental Health Act	Identified areas for improvement and associated action plan	Complete
Ensure adequate staff with the correct skills to care for patients with acute and specialist mental health needs	Patients cared for by appropriately trained and skilled staff	Complete
Improve governance, oversight and key stakeholder relationships	Identify Executive lead for Mental Health and Establish Mental Health and Mental Capacity Board chaired by a Non-Executive Director	Complete

Ensure risk assessment of patients with acute and specialist mental health needs in the Emergency Department are undertaken	By March 2018 the percentage of patients being risk assessed will exceed 90% consistently	31/03/2018
Ensure appropriate care plan and intervention in place for patients with acute and specialist mental health needs in the Emergency Department	Individualised care plans and intervention based on accurate risk assessment to improve safety	31/03/2018
Trust-wide environmental review to assess the risks of managing patients with acute and specialist mental health needs	Completion of audit	31/03/2018
Enhance staff education and awareness regarding mental health	Staff can display improved understanding and awareness of their responsibilities under the Mental Health Act	31/03/2018

2.3 Dementia

Action	Outcome	Completion
Recruit a lead Dementia Nurse Specialist	Develop and delivery of a strategy in line with NHS Improvement Dementia Assessment and Improvement Framework (October 2017)	31/12/2017
Audit the consistent use of the 'This is Me' document	Completion of audit	31/12/2017
Implement reminiscence trolleys in every ward	Trolleys available in all wards	31/12/2017
Increase activities available for patients living with dementia	A variety of activities available to support stimulation and distraction therapies	31/03/2018

Review the dementia screening process to ensure it fits with clinical practice	Achieve the national standards for dementia screening to meet or exceed 90%	31/03/2018
Improve the support for carers of patients living with dementia	Appropriate signposting and improved awareness of the Carers Cafe	31/03/2018

2.4 Mental Capacity Act and Deprivation of Liberty Safeguards

Action	Outcome	Completion
Strengthen the governance arrangements around DoLS to ensure timely assessment	Discharge our legal responsibilities under the MCA/ DoLS to keep patients safe in our care	31/12/2017
Weekly clinical review of patients under MCA and DoLS, including documentation	Completion of audit and direct feedback to clinical staff to improve learning	31/03/2018
Implement a revised education and training programme for all clinical staff regarding MCA and DoLS	Staff have the confidence to translate the theory into clinical practice demonstrated through the improved care and safety for vulnerable patients	31/03/2018
Intensive focused training for all staff on application of the MCA in practice	Improved understanding and documentation regarding Mental Capacity Assessments and Best Interest Decision Making	31/03/2018

3. Organisation that Learns

The CQC reported that the staff perceived a culture of bullying and felt reluctant to speak up. This was expressed by different staff groups who raised concerns to the CQC before, during and after the inspection. The CQC reported that the processes for raising concerns internally were not open and free from blame. This discouraged staff from feeling free to raise concerns.

As an immediate response, the Trust refreshed the Freedom to Speak Up campaign and Respect Me initiative. As well as a Guardian, we now have an independent team of 16 Freedom to Speak Up advocates to support individuals with information, guidance and by listening. All have attended the national training and are actively promoting the importance of staff feeling safe and supported to speak up about anything that concerns them.

In addition, a programme to develop culture and leadership will be commencing in early 2018 using the NHS Improvement toolkit which is based on significant research and evidence and has been 'tested' with five pilot Trusts. The programmes aim is to develop and implement a collective leadership strategy to embed a culture that enables the delivery of continuously improving, high quality, safe and compassionate care for patients. Further work is required to respond to our challenges with recruiting and retaining our workforce, which includes a revised workforce strategy, a recruitment and retention steering group to support staff career development and education as well as a refresh of our marketing and attraction processes. New roles development is critical to underpinning our future workforce needs as is the continuation of building strong relationships with our partnering organisations and universities.

There will be a continuation of staff engagement methodologies such as Listening into Action. These are being strengthened to support the integration of a new senior leadership team with frontline staff, and build on giving staff a voice and the permission to make change happen in their own area of work and beyond.

Specific actions

- 3.1 Zero tolerance of bullying
- 3.2 Behaviours and compassion
- 3.3 Right staff, right skills
- 3.4 Staff engagement

3.1 Zero tolerance of bullying

Action	Outcome	Completion
Freedom to Speak Up promotion week	Staff feel confident and know how to raise concerns	Complete
Identification and training of 16 Freedom to Speak Up advocates	Staff feel confident to raise concerns without recrimination	Complete
Appointment of Freedom to Speak Up Guardian	Staff feel confident to raise concerns without recrimination	Complete
External review of leadership behaviours to identify areas to identify areas where leadership values and behaviours need challenging and improving	Improved national staff survey results and reduction in employee relations' cases. Reduction in bullying and harassment concerns raised by staff	31/03/2018

3.2 Behaviours and compassion

Action	Outcome	Completion
Implement Multidisciplinary Schwartz round	Provide a safe and supportive environment for staff to share and learn from their experiences, improve staff morale and team working	Complete
Provide education on embedding trust values and behaviours into Job Planning rounds with consultants	Increase compliance with Job planning on CRMS	31/03/2018
Map all recruitment processes and align to trust standard	Ensure value based recruitment process is applied to all staff groups	31/03/2018

Implement NHSI Culture and Leadership Programme	Develop a culture that enables and sustains continuous improvement of safe, high quality and compassionate care	31/08/2018
Revision of Nursing, Midwifery and Allied Health Profession Strategy	Improve compassionate care and engagement with frontline staff	31/12/2018

3.3 Right staff, right skills

Action	Outcome	Completion
Further overseas recruitment	Reduction in vacancy rate and temporary workforce spend	On-going
Implement plans for revised and new roles to support difficult to recruit posts	Reduction in vacancy rate and temporary workforce spend	31/01/2018
Audit compliance with local induction process	All staff will receive a supportive and helpful local induction	31/01/2018
Revision of workforce strategy	Clear and current written strategy in place to address workforce priorities	28/02/2018
Recruitment and Retention event	Improved understanding by staff of opportunities to develop their careers and the benefits available to new employees	31/08/2018
Board / Director development programme to be developed and implemented	New Board are clear on priorities, their shared and individual objectives and are effectively executing their responsibility as a board	31/08/2018

3.4 Staff engagement

Action	Outcome	Completion
Introduce monthly forums for the junior doctors to meet the Medical Director and Chief Registrar	To improve staff engagement with the Junior Medical staff who work in a transient role	Complete
Introduce monthly forums for the Consultants to meet the Medical Director and Chief Executive Officer	To improve staff engagement with the Senior Medical staff	Complete
Widen the attendance at the professional forum for Nurses and Midwives	To improve engagement with the Nursing and Midwifery force to strengthen Board to Ward	30/11/2017
Staff Big Conversations personally hosted by the CEO	Staff report feeling more engaged and able to make changes happen in their own area of work	31/12/2017
Introduce an annual staff engagement calendar of events	Staff report increased levels of engagement	31/12/2017

4. Moving Beyond Safe

The CQC reported many patient safety issues, which included concerns regarding the management of incidents, safety in the urgent care pathway, patient moves and outlying from speciality bed base and general concerns regarding the risk to patients in respect of safeguarding vulnerability.

As a minimum, the Trust must provide safe care to patients and so patient safety is of the highest priority to address. Patent safety is about working to prevent errors in healthcare that can cause harm to patients.

When patient's start to physically deteriorate, it is important that the change in vital signs is picked up and, that this change in the patient's condition is responded to with appropriate escalation in care so that the patient receives correct and timely monitoring, referral and treatment. Wessex Patient Safety Collaborative has partnered with the Trust to support patient safety scale up projects across Wessex. The Trust is implementing the Time to Act innovation.

In addition, there has been further focus on learning from deaths, including the introduction of Mortality Review Panels to review deaths. Patients are reviewed by a clinical panel, within 48 hours of death, and the 'Avoidability of Death'recorded, as well as Trust learning points. The cause of death and comorbidities are elucidated and recorded. Referrals are made to the coroner, as a Safety Learning Event, as a SIRI, or for the relevant department to review at their Mortality and Morbidity meetings.

The Trust is implementing a number of safety initiatives in relation to the urgent care pathway to improve safety and patient experience.

Specific actions

- 4.1 Urgent care
- 4.2 No 'avoidable' deaths
- 4.3 Stop harm to patients
- 4.4 Right patient, right bed

4.1 Urgent care

Action	Outcome	Completion
Implementation of revised Medical Model of care	100% of patients will be reviewed by a consultant within 14 hours of admission to hospital	Complete
Development of a robust urgent care transformation plan and a delivery structure	To improve the quality of care in the unscheduled care pathway	30/11/2017
Implementation of the patient flow bundle 'SAFER'	Improve patient journey and experience by reducing unnecessary waiting	31/03/2018
Implementation of the Red 2 Green day initiative	Reducing delays in hospital care and associated risks to patients	31/03/2018

4.2 No 'avoidable' deaths

Action	Outcome	Completion
Implementation of the Learning from Deaths policy	Policy published, implemented and embedded in practice	31/12/2017
Training in Structured Judgement Review	Consistent approach to reviewing patient deaths to improve learning	31/12/2017
Further roll-out of the Mortality Reviews across all specialities	All deaths are reviewed and any identified learning shared across the organisation	31/03/2018
Implementation of the Time to Act initiative	Patient's condition received appropriate escalation to ensure patients receive the correct and timely monitoring, referral and treatment	31/07/2018

4.3 Stop harm to patients

Action	Outcome	Completion
Pilot the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle for reducing pressure damage	Aid staff in prioritising care, highlighting which patients are high risk of pressure damage	31/03/2018
Establish a senior safety team under the leadership of the Medical Director and Chief Nurse	Team in place to set the strategic direction for safety and drive the changes needed	31/03/2018
Standardisation of clinical handover documentation	Consistent completion of handover documentation to ensure patient safety	30/04/2018
Introduce a Six Month Safety Sprint concept	Improved outcome measures associated with » Deteriorating patients » Sepsis » Learning from events and feedback » Learning from deaths	31/08/2018
Initiate consultant ward round standards	Improved communication of patient pathway	31/05/2018
Undertake assessment of safety culture using the Cultural Barometer	Baseline assessment complete and improvements required identified with a reassessment date	31/08/2018

Trust-wide roll out of the NHS Improvement Falls Collaborative initiative	A prompt review of all patients who have fallen to ensure appropriate strategies are in place to prevent further patient falls A reduction in the number of injurious falls	31/12/2018

4.4 Right patient, right bed

Action	Outcome	Completion
Utilise the functionality within BedView to allocate the right patient to the right bed.	Right patient in the right bed every time, reducing the need for patient moves and outliers	31/12/2017
Revise all Standard Operating Procedures in relation to patient flow within the Operations centre	Clear procedures to reduce patient moves, outliers and length of stay	31/12/2017

5. Leading Well Through Good Governance

The CQC identified that the quality of incident investigations was very poor and that there was limited evidence or assurance that lessons learned from incidents were implemented. There were concerns highlighted relating to grading of incidents and the application of Duty of Candour. The CQC identified the need to review governance processes and reporting functions to ensure they are fit for purpose and to ensure risks were identified and managed, to include a review of the Board Assurance Framework.

The Trust has commenced an external review of its governance arrangements. This includes a full review of the Board Assurance Framework and Risk Management Strategy.

Specific actions

- 5.1 Leadership at all levels
- 5.2 Role clarity, responsibility and accountability
- 5.3 Standardising and consistency in processes
- 5.4 Being open and transparent

5.1 Leadership at all levels

Action	Outcome	Completion
Introduce Board to Ward Quality rounds	Standardised approach to Board to Ward rounds that demonstrate engagement with frontline staff	28/02/2018
Improve the compliance rate and quality of appraisals	Meeting or exceeding 85% target and that staff report a meaningful appraisal	31/03/2018
Support the Trust key leadership programmes	Staff in leadership roles will feel confident to lead and manage their services	31/03/2018
Recruit to board vacancies substantively	Substantive board will be in post	31/03/2018
Agree and introduce a Board Development Programme	Improved board relationships and establishment of a high performing board	31/08/2018

5.2 Role clarity, responsibility and accountability

Action	Outcome	Completion
All nursing staff to sign that they have read and understood the NMC – The Code	Nurses to be aware of their accountability as a Registered Nurse	Complete
Review and standardise nursing job descriptions	Nurses are clear about their role and responsibilities	30/11/2017
Improve the compliance rate and quality of appraisals	Meeting or exceeding 85% target and that staff report a meaningful appraisal	31/03/2018

5.3 Standardising and consistency in processes

Action	Outcome	Completion
Undertake an external governance review	Introduce revised Board Assurance Framework, Corporate Risk Register, Risk Management Policy and Strategy, Corporate Governance Arrangements and Divisional Governance arrangements to ensure a standardised integrated approach	31/01/2018
Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework	Improved understanding of metrics and delivery against performance management framework	31/01/2018
Increase the number of staff trained in Root Cause Analysis methodology and risk management	Demonstrate organisational understanding of risk management and improve the quality and learning from incident investigations	31/03/2018
Improve incident management processes to foster learning and improve effectiveness	Consistent grading/investigation of incidents and ensuring there is shared, organisational learning	31/03/2018
Protect patients confidentiality through safe storage of records	Confidentiality maintained	31/03/2018
Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'	Staff on the frontline nursing staff have a clear understanding of the care they are delivering to patients against defined standards	31/05/2018

5.4 Being open and transparent

Action	Outcome	Completion
Building relationships with stakeholders and partners in line with the Chief Executive's 100-Day Plan	Improved working relationships across the health economy that benefit patients	30/11/2017
When significant incidents are being investigated, patients or family will be asked for their input to setting the terms of the investigation, and updated as investigations progress"	Improved involvement of patients and family when significant incidents occur	30/11/2017
Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework	Improved understanding of metrics and delivery against performance management framework	31/01/2018
Strengthen and embed the Being Open Policy including the application of Duty of Candour legislation	Staff actively involve and discuss care issues with Patients and families in an open and meaningful way as part of their everyday care. There are no breaches of Duty of Candour legislation	31/03/2018
Protect patients confidentiality through safe storage of records	Confidentiality maintained	31/03/2018
Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'	Staff on the frontline nursing staff have a clear understanding of the care they are delivering to patients against defined standards	31/05/2018

porthosp.nhs.uk
Quality Improvement Plan 2017
©Portsmouth Hospitals NHS Trust 2017
@QAHospitalNews

PPCEJ1017