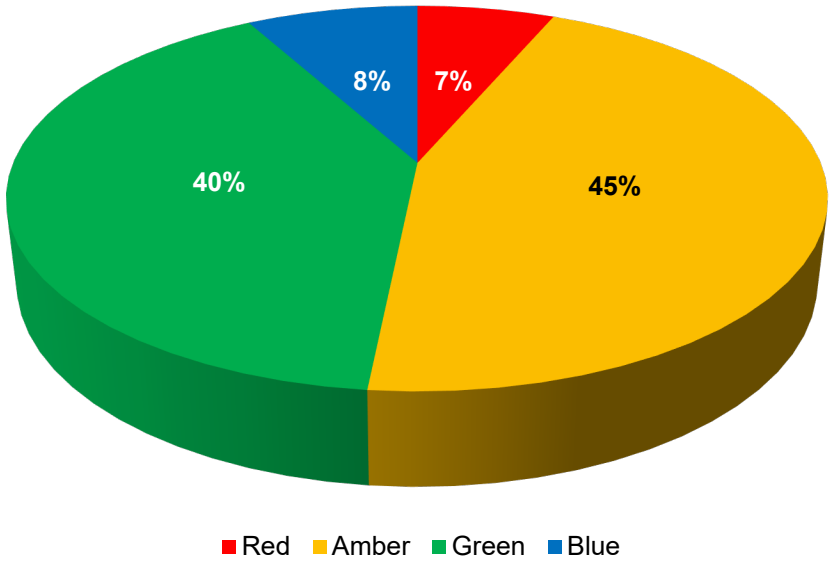
Cross-organisational and Functional/Divisional QIP Highlight Reports

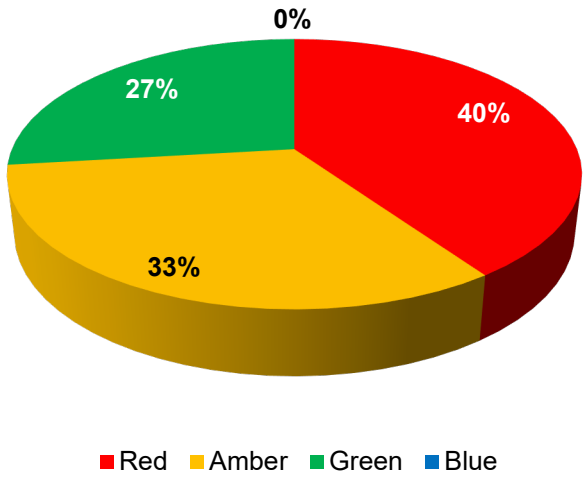
for November Quality Programme Board

OVERALL ASSURANCE
All work streams

ASSURANCE - all work streams November QPB



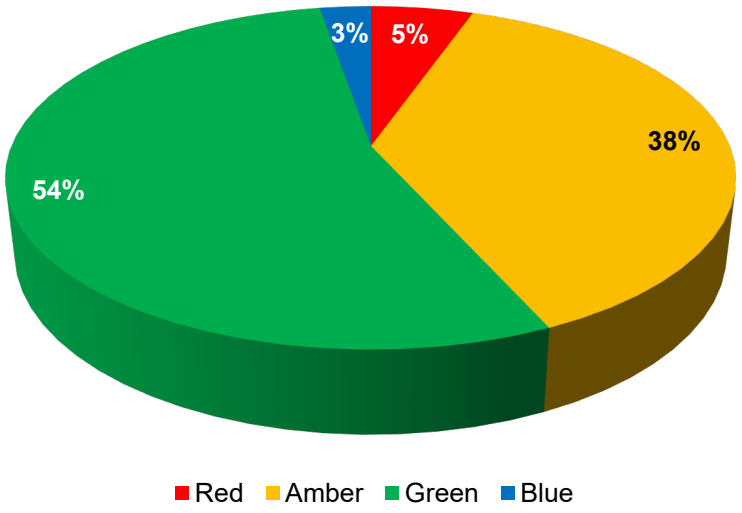
ASSURANCE - all work steams October QPB



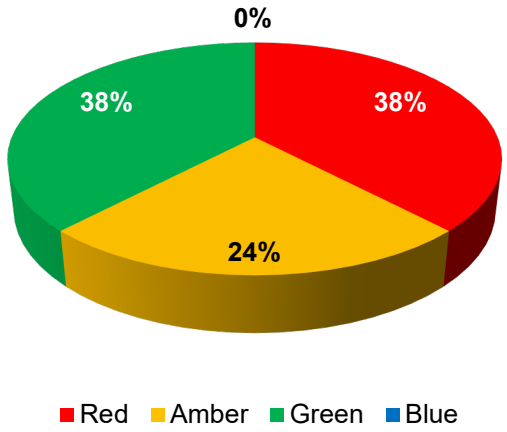
Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

CROSS-ORGANISATIONAL WORK STREAMS

ASSURANCE - Trustwide work streams November QPB



ASSURANCE - Trustwide work streams October QPB



Overall RAG Rating			
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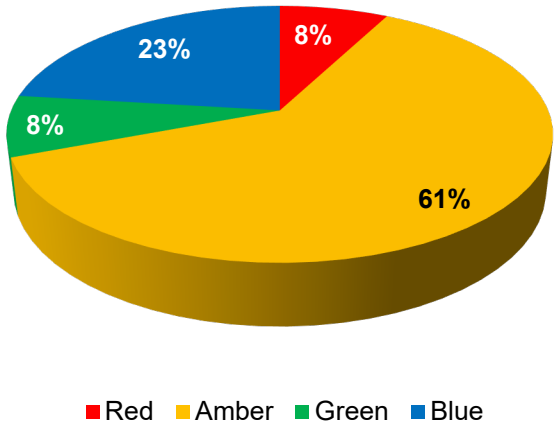
Urgent & Emergency Care work streams

ASSURANCE
Urgent & Emergency Care work streams
November QPB



Overall RAG Rating			
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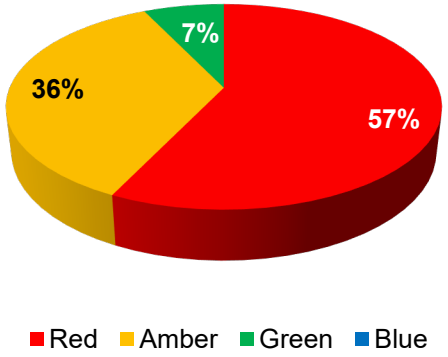
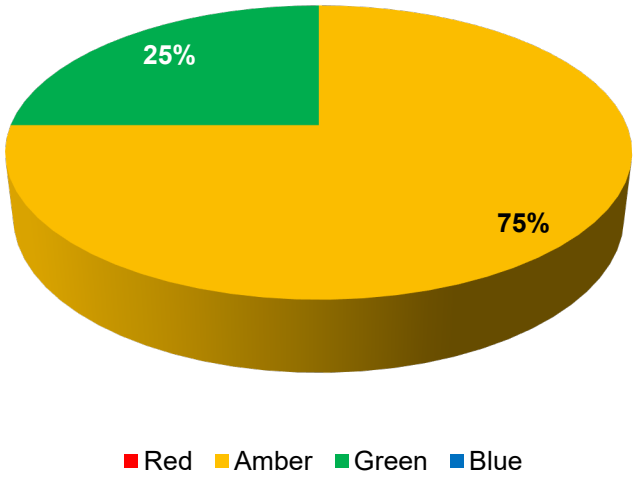
ASSURANCE
Urgent & Emergency Care work streams
October QPB



Surgery work streams

ASSURANCE
Surgery work streams
November QPB



Overall RAG Rating			
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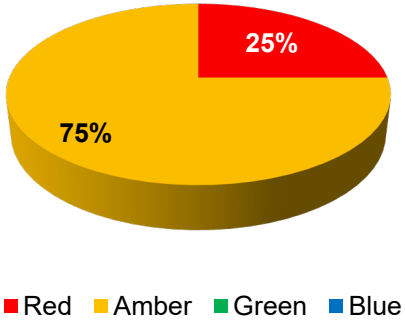
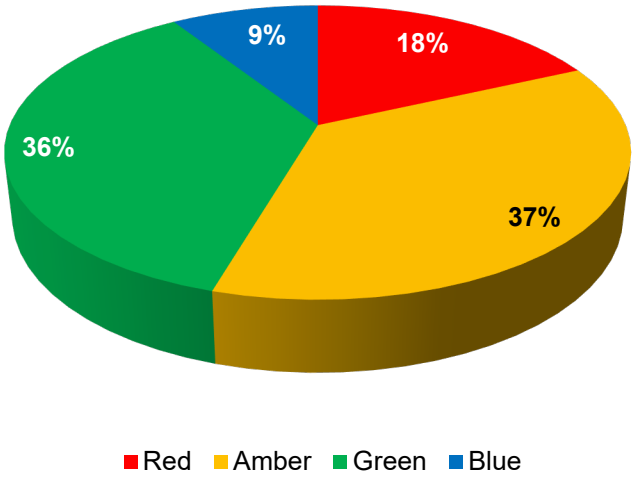
ASSURANCE
Surgery work streams
October QPB

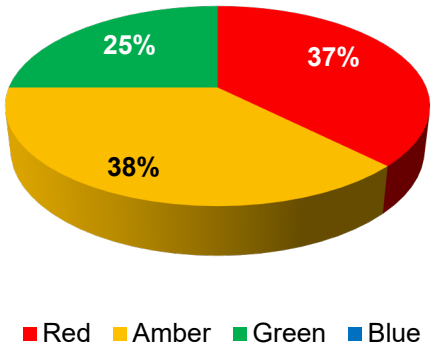


Diagnostic Imaging work streams

ASSURANCE
Diagnostic Imaging work streams
November QPB



ASSURANCE
Diagnostic Imaging work streams
October QPB



Overall RAG Rating			
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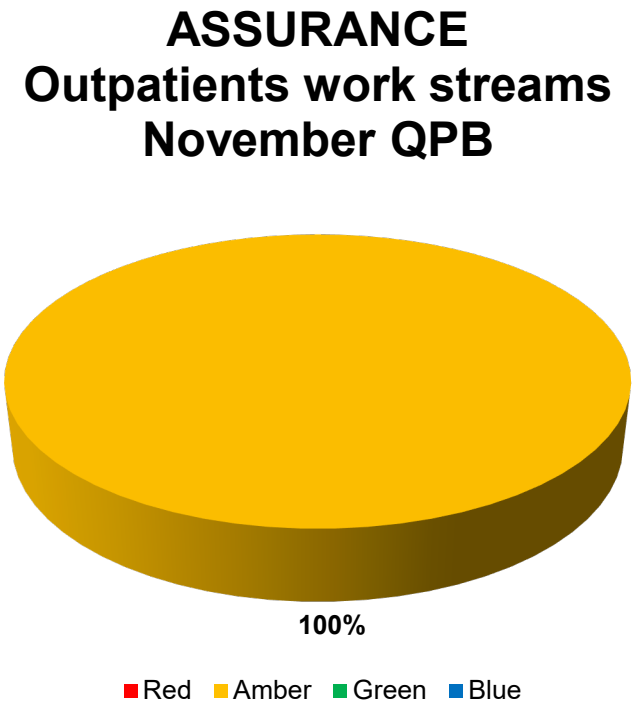
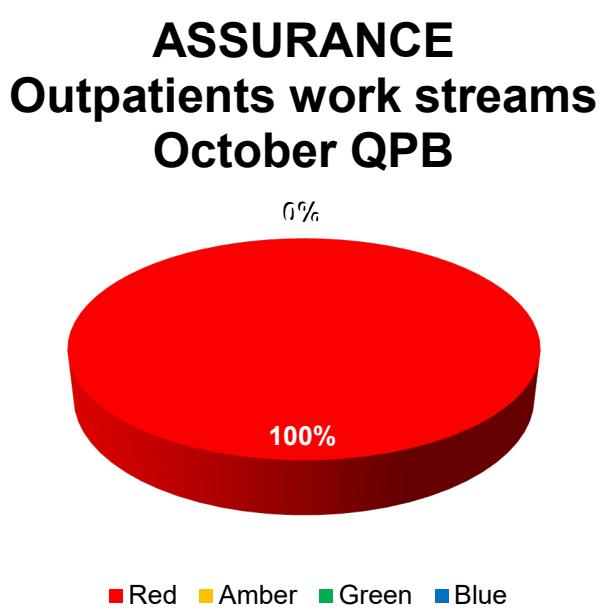
Outpatients work streams





Overall RAG Rating			
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RED RECOMMENDATIONS

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Amy Eagle	1st October 2018	30th June 2019	R	R	10%

MUST DO Recommendation:	TW 19.1: The trust must ensure that the healthcare records for patients' (requiring assessment for restrictive intervention) *subject to restraint* are complete and in line with the trust's policy and procedure.
We will have achieved GOOD when:	• Named lead for Reduction of Restrictive Intervention (RRI) in place • RRI strategy and protocol signed off and in place • Clear reporting and performance monitoring measures available • Staff training plan in place and trajectory agreed • Scenario based training sessions carried out in high risk areas to embed learning
Exec Summary:	Overall RAG status red as will not have met the target completion date. Mental health matron will be joining the Trust 5th November the actions will form part of their role.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 19.1.1 Review existing policy to ensure it meets best practice guidance	James Paget have shared their policy. This and current Trust policy will be reviewed as part of the next RRI meeting in November. Target completion date updated to 30/11/18 to reflect above. Action plan being developed to ensure communication of policy and highlighting need to record, document all key aspects and report on DATIX	A
TW 19.1.3 Amend policy and documentation as required	Completion date: 31/12/18. Mental health matron will be joining the Trust in 5th November with two weeks intense induction the actions will then form part of their role.	A
TW 19.1.4 Conduct a baseline audit of compliance	Completion date: 31/03/19 Mental health matron will be joining the Trust 5th November with two weeks intense induction the actions will then form part of their role. Plan to identify use of any restrictive practice on wards by use of DATIX recording / reporting (weekly) – baseline. Use DATIX to identify ward and patient	A

Highlight Report to: NOVEMBER QPB

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 19.1: The trust must ensure that the healthcare records for patients' (requiring assessment for restrictive intervention) subject to restraint are complete and in line with the trust's policy and procedure).

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 19.1.5 Agree an improvement trajectory	Completion date: 30/04/19	A
TW 19.1.6 Conduct scenario based training sessions in high risk areas to embed learning	Completion date: 30/06/19. Focus on high risk areas first to improve compliance as identified by H&S Lead. Training will be in addition to current provision. There will be a requirement to bring refreshers in annually / 18 months max for high risk areas. Documentation will form part of the training and roles and responsibilities if restraint used.	A
New action: TW 19.1.7 Review and monitor compliance against policy	Plan to identify use of any restrictive practice on wards by use of DATIX recording / reporting (weekly). Notes to be reviewed in line with policy to review compliance and understanding (percentage of documentation completed as required). If non compliance support and further awareness training for wards to be provided where required. Feedback to be provided to Mental Health Board. Longer term plan - area matrons to take monitor compliance.	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Issue – Capacity across workforce to undertake actions within target completion date		
Issue – The working group have identified the likelihood that wider groups of staff will require more specialist training associated with maintaining safety and working with difficult patients. NNUH trainers do not have the capacity or training facilities to increase the level of training as required.	22 staff per day can be trained, cost of £150 per training day (50 sessions – 1 per week) = Approx. £7500	Request QPB to consider if finances available to progress and support for staff to be released to attend training

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	John Paul Garside	1st Sept 2018	30th November 2018	R	R	0%

SHOULD DO Recommendation:	TW 29.1: The Trust should ensure that complaints are responded to in line with the complaints policy deadline of 25 working days
We will have achieved GOOD when:	• Complaints response time within 25 days reported through monthly complaints report, received by CaPE
Exec Summary:	Assurance is red. Work is being carried out to investigate how we report the percentage of investigations completed within 25 days (by division) on a monthly basis to support learning from complaints within and across the divisions, awaiting evidence before action is completed before the end of November

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
New action TW 29.1.6 Agree and report a KPI for responding to complaints within 25 days	Target completion date: 30/11/18. Actions required by Trust Secretary - review baseline, set target and set trajectory for achieving the target.	R

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Highlight Report to: NOVEMBER QPB

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	TBC	1st December 2018	31st March 2020	R	R	50%
SHOULD DO Recommendation:	DI 5.1: Ensure effective processes are in place for the timely completion of diagnostic reports					
We will have achieved GOOD when:	Diagnostic reports are available to clinicians within a time period that is appropriate for clinical risk.					
Exec Summary:	Assurance RAG is Red, as the department are unable to assess their performance against standards and set an improvement trajectory in the absence of nationally published standards					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
DI 5.1.1 Robust review of existing reporting processes with clear recommendations for improvement.	A comprehensive system is in place to monitor and track demand for reporting. Radiology are working with an external company (LTS) and NHSi to review capacity and demand modelling.	A
DI 5.1.2 Agree a professional standard and standard operating procedure for provision of diagnostic reports with clear reporting timescales.	A SOP is in place for inpatient reporting, for which performance is reported in the IPR. Awaiting publication of national CQC recommended diagnostic reporting times. No update on when this is likely to be published	R
DI 5.1.3 Baseline compliance audit.	Awaiting targets as per DI 5.1.3 above.	R

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	DI 5.1: Ensure effective processes are in place for the timely completion of diagnostic reports

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
DI 5.1.4 Agree improvement trajectory	Awaiting targets as per DI 5.1.3 above. However, positive feedback on the Trust's reporting backlog was received verbally during the recent GIRFT visit that took place in August 2018. The written report is awaited. Benchmark performance data is also being collected and available.	A
DI 5.1.5 Monitor compliance against improvement trajectory	Awaiting targets as per DI 5.1.3 above.	R

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Lack of national guidance for reporting targets is preventing development of an improvement trajectory for reporting.	Escalate to QPB.	Request clarity from NHSi as to exact requirements and source of data in CQC report

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Maggie Pacheco	1st October 2018	31st March 2019	R	R	0%

SHOULD DO Recommendation:	U 13.1: The Trust should ensure that a safety thermometer is implemented for Children's and Adult emergency services
We will have achieved GOOD when:	A method is in place of showing the prevalence of patient harms and providing immediate information and analysis for frontline teams to monitor their performance in harm free care. It is suggested this is via the safety thermometer and national paediatric safety thermometer. N.B. the CQC are aware that this information is reported in the nursing dashboard and still requested the safety thermometer implementation.
Exec Summary:	Assurance is RED. The Trust requires clarity on which tools should be completed within Emergency Services.

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
U 13.1.1 Set up process where monthly data is captured for submission to the national safety thermometer database	The Trust requires clarity from our improvement partners on which version of the safety thermometer is appropriate for adult and children's Emergency Departments.	A
U 13.1.2 Results are discussed at Specialty and Divisional Governance meetings (Urgent and Emergency care and Children's services)	Future action	

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
		13.1.1 Please clarify the tool required

BLUE RECOMMENDATIONS

Domain: **Responsive**

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Jo Segasby	1st October 2018	31st October 2019	R	B	100%
SHOULD DO Recommendation:	TW 27.1: The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.					
We will have achieved GOOD when:	RTT Remedial Action Plan is in place, signed off by Commissioners and NHS England setting out the Trust's planned RTT improvement trajectory.					
Exec Summary:	Assurance RAG is 'Blue' as signed off RTT RAP is in place.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 27.1.2 Robust plans in place for the management of backlog of patients in all specialties with agreed improvement trajectories.	Target completion date: September 2018 RTT RAP agreed with Commissioners and NHS England.	B
TW 27.1.3 Regular Clinical Harm review group meeting to assess for potential avoidable harm.	Meetings in place, terms of reference (TOR) recently reviewed. Action completed, evidence : TOR and meeting minutes.	B
TW 27.1.6 Develop lead provider model for ENT, Urology, Cardiology.	Proposed target completion date: March 2019 Governance arrangement and structure in development.	A

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 27.1: The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 27.1.7 Progress capital programme for additional theatre capacity	Proposed target completion date: 28th February 2019 Procurement exercise underway to utilise Turnstone Court.	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	Tracey Fleming	1st September 2018	31st December 2018	R	B	90%
MUST DO Recommendation:	DI 2.1: Ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.					
We will have achieved GOOD when:	Refer to recommendation TW 31.1					
Exec Summary:	Assurance is BLUE. The department is on track to procure a barcode tracking system and a comprehensive audit programme is already in place.					

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
DI 2.1.1 Implement a robust procedure for tracking of key PPE	Radiology are in the process of introducing a barcode system onto all the lead coats to improve the audit process. Labels are being tested and system being procured. .	G
DI 2.1.2 Implement a robust process of compliance audits	Audits are taking place. All lead aprons audited every two years, or every 6 months if there is any concern.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Frankie Swords	1st October 2018	1st November 2018	R	B	100%

MUST DO Recommendation:	U 1.1 & 8.1: The Trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children & adults. The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.
We will have achieved GOOD when:	• The ED department will have: • Suitable Handwashing sinks throughout the department • A sluice within Children's ED • A HDU for Children and Young people outside of Resus. • Children and young people ED area is large enough to accommodate all children and young people. • Waiting facilities for Children and Young people large enough to accommodate all children and young people separate from adult waiting space. • Secured access to Children's ED for both entry and exit. • Piped oxygen and suction available in all ED patient areas. • Suitable areas for mental health patients that can be isolated from environmental and ligature risks if required following patient environmental risk assessments
Exec Summary:	Assurance is Blue as all works are complete. The quiet rooms can be used if staffing is moved from other areas. Sent to Evidence Group on the 1st of November 2018.
Page 1 of 2	

QIP Workstream Highlight Report

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	U 1.1 & 8.1: The Trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children and adults. The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 1.1.1 Ensure that recommended environmental changes to ED are implemented	The quiet rooms are ligature free quiet cubicles with the ability to accommodate appropriate patients with mental health presentations. The quiet rooms are finished other than one door which needs a change from a key lock to a proximity card lock – this is on order from SERCO. A clean has been completed, ready for use if required, however staffing does not allow these to be open at all times.	G
U 1.1.2 : Ensure ligature cutters and other recommended emergency equipment is available within high risk areas; U 1.1.3 : ii) Audit availability	The ligature cutters have been added to all ED resus trolleys and a temporary change has been made to the adult and Paed resus trolley audit check list. A new audit checklist is being produced week commencing 1.10.2018 with involvement of trust resus officer. Daily checks of the seal must happen with weekly checks of all contents. Copies of audit sheets will be included in the evidence repository.	G
U 1.1.4 Review adult and children's environment by MH specialists	A Mental Health walk round and risk assessment of the quiet rooms took place on the 31st of August.	G for adults R for paeds

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
The quiet rooms will require dedicated staffing and may not be able to open depending on acuity and staffing levels.		

Domain
Safe

Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Helen May/ Jo Walmsley	1st September 2018	1st November 2018	R	B	100%

MUST DO Recommendation:	U 3.1: Action plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.
We will have achieved GOOD when:	The Emergency Department has: • Additional space in adult and paediatric areas compared to November 2017 as outlined in plans submitted to the CQC. • A HDU area for children outside of the resuscitation area
Exec Summary:	Assurance is Blue as all works are complete. Sent to Evidence Group on the 1st of November 2018.

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
U 3.1.1 Review current progress against agreed expansion plans and agree a completion trajectory	Complete	B
U 3.1.2 Ensure that a Children's enhanced care area is included within the Children's ED environment.	Complete	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Frankie Swords	1st August 2018	1st August 2018	R	B	100%

MUST DO Recommendation:	U 10.1: Ensure there is a medical lead appointed for the service
We will have achieved GOOD when:	A medical lead is in post and working as part of the departmental triumvirate. The staff within ED can identify their medical lead in QAA.
Exec Summary:	This is Blue as Tarek Kherbeck and Jane Evans have been appointed as clinical leads. This went to the evidence group on 1/11/18.

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
U 10.1.1 Appoint a Medical Lead for Urgent and Emergency Care	Complete	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

AMBER OR GREEN RECOMMENDATIONS

Chief Operating Officer Work Streams

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Clive Beech	**1st October 2018**	**31st December 2018**	**R**	**A**	**50%**

MUST DO Recommendation:	TW 15.1: Oxygen cylinders are stored safely, oxygen is readily available in all patient areas, and that this equipment is properly maintained
We will have achieved GOOD when:	• Oxygen cylinders are stored in accordance with Health and Safety Executive (HSE) guidance, specifically to keep cylinders chained or clamped to prevent them from falling over. • Piped oxygen equipment is checked at the required frequency with records kept of checks made. • All oxygen equipment is maintained according to the required schedule
Exec Summary:	A decision is required regarding casings for storage of small CD oxygen cylinders. On most wards and departments these are stored unsupported in the recess on the front reception desk. On wards that have lots of these cylinders they are stored in a special rack. Costings have been provided

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 15.1.1 Site survey of medical gases availability, storage and maintenance	A dedicated medical gas porter completes a twice daily check. Nurses and ODPs also conduct daily checks in clinical areas. A check of oxygen cylinders to the trolley bays to be added to the ED daily checklist with an instruction to change if the cylinder is less than a quarter full. A quote has been obtained for 2 CD oxygen holders to be installed in the ED observation room. A storage rack has been supplied to ensure no medical gas cylinders are stored unsupported in the medical gas store. The medical gas porter is to ensure the gas store has 2 metal CD oxygen holders for patients transferred from ED on a hospital bed. A recommendation has been made that new beds have integral CD oxygen holders put into the new bed business case.	A

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 15.1: Oxygen cylinders are stored safely, oxygen is readily available in all patient areas, and that this equipment is properly maintained.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 15.1.2 Review Medical gases equipment maintenance schedule and complete any backlog maintenance against an agreed trajectory.	A Medical Gas Maintenance Schedule is in place. All wards and clinical areas receive an annual maintenance visit with one month's advance notice to ensure equipment is available. All equipment is serviced and a sticker is placed on all equipment to indicate when items have been serviced and when they are due, as per the Medical Devices Policy	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Decision required regarding casings for storage of small CD oxygen cylinders	Costings have been provided. Risk assessment to be carried out to determine if cost is merited.	

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Hilary Winch	1st November 2018	1st November 2018	G	G	100%
SHOULD DO Recommendation:	TW 28.1: Effective processes are in place for correct handling and disposal of clinical waste					
We will have achieved GOOD when:	Clinical waste is handled and disposed of appropriately and risks to staff safety are minimised					
Exec Summary:	Assurance RAG is BLUE, as effective systems and processes are in place for the handling and disposal of clinical waste, together with incident reporting and escalation procedures.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 28.1.1 Robust review of current processes in place for the management of clinical waste against national guidance with recommendations for improvement.	• A joint approach is taken to clinical waste management between Health & Safety, Facilities and Serco. • An up to date Waste Management Policy is in place and published on Trust docs. Policy is due for review in November 2018. Audits are conducted to ensure bagged waste is placed in the correct bins (clinical or hazardous). Posters have been created and placed above bins to advise correct utilisation of waste facilities. • There had been an issue with supply of sharps bins in January 2018. A new provider has been sourced and supply of accessories for new bins has been an issue but a plan is in place to resolve this. • Any incidents are reported on Datix and reports are monitored and automatically sent to Health & Safety for review.	B

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 28.1: Effective processes are in place for correct handling and disposal of clinical waste

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 28.1.2 Complete baseline compliance audit	Multiple routine audits take place. Serco conducts pre-acceptance audits annually to audit waste segregation and identify issues. The audit is reported to Octagon and Health & Safety and any issues highlighted locally to ward staff. Facilities undertakes monthly Performance Management System (PMS) audits according to a schedule. The audits cover waste segregation, packaging and labelling, handling, final disposal and consignment. Any issues are addressed through contract management processes. Health & Safety audits the Waste Management Policy every 2 years to ensure compliance with the policy. The Sharps Bins provider audits at least annually to ensure compliance with supply, assembly, use and disposal. Additionally, any non-conformance is highlighted by the external waste collection company with escalation protocols in place.	B
TW 28.1.3 Set improvement trajectory	Clinical waste issues are reported on Datix, as well as discussed locally in housekeepers meetings. Issues are highlighted to the Inoculation Incident Group, which in turn reports to the Health & Safety Committee.	B
TW 28.1.4 Monthly audit of compliance	As per TW 28.1.2	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Hilary Winch	1st Sept 2018	1st December 2018	R	G	50%

SHOULD DO Recommendation:	TW 31.1: The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff
We will have achieved GOOD when:	Processes are in place to ensure staff receive sufficient protection effectively from radiation and hazardous materials: 1) Policies and processes are in place that cover the logging, checking and maintenance of specialist PPE 2) Functioning specialist PPE is available to staff at the point of need 3) Staff are trained on the appropriate use of specialist PPE
Exec Summary:	Robust processes for identifying and checking specialist PPE are in place

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 31.1.1 Review Trust policy to determine what PPE is required for each area within the Trust	There is no national or legal definition of 'specialist' PPE. Locally, the Trust considers this to be PPE that is reused and not disposable. This primarily refers to lead aprons and lead glasses used for radiation protection, and equipment used in Emergency Preparedness, Resilience and Response (EPRR) situations. Details of these items are set out in the relevant plans, as different equipment is required for different situations. For example, this includes Chemical, biological, radiological and nuclear defence (CBRNe), HAZMAT, VHF, seasonal flu and pandemic flu. A general PPE Policy is in place on Trust Docs and is currently in mid-review.	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 31.1: The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 31.1.2 Implement a robust process of compliance audits	Audits of radiation protection equipment is covered under action DI 2.1.2. Audits of EPRR equipment are conducted through the compliance process with NHS England EPRR Core Standards. The Trust is compliant and the assurance documents were approved and signed off on 28/08/2018, with regional approval due on 10/09/2018. Local internal audits are also conducted periodically by the Trust EPRR and BC Lead.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Cursty Pepper	External review August 2018. Discharge Lounge open by 1 November 2018	1st December 2019	A	G	25%

MUST DO Recommendation:	TW 6.1: The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas. TW 6.2: The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety
We will have achieved GOOD when:	• We have increased capacity and flow, resulting in improved performance in key flow metrics (e.g. 4 hour target, stranded patients and median time of discharge)
Exec Summary:	Assurance RAG has improved from 'Amber' to 'Green', as significant work is underway to review bed and site management processes and the escalation policy.

Open Actions (Page 1 of 3)	Progress Update and Next Steps	Action RAG
TW 6.1.1 Engage the Intensive Support Team to review and facilitate improvement work in capacity management / escalation.	MOU signed and scope agreed. ECIST on site from 5th November	G
TW 6.1.2 The Trust will have a clear Escalation Policy that includes Standard Operating Procedures. The Policy will guide the approach to be used within the hospital when there is extreme pressure on beds	Draft Escalation Policy discussed at HMB on 16th October - draft out for circulation with virtual testing w/c 29th Oct and system table top exercise on 8th November. Final version to HMB 20th November.	G

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 6.1: The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas. TW 6.2: The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety.

Open Actions (Page 2 of 3)	Progress Update and Next Steps	Action RAG
TW 6.1.3 Fully embed the Red/Green approach of ensuring patients receive the right care at the right time and do not wait in a hospital bed longer than is required for either internal or external reasons.	ECIST session on 5th November. Dashboard in development to support monitoring	G
TW 6.1.4 Increase the involvement of system partners support and action when planning for known times of capacity pressure in the system.	Weekly meetings in place - good engagement. EEAST Liaison joining the Winter Team in October	G
TW 6.1.5 Ensure the RAT system is active and working 24/7 in ED with breach analysis when not used to understand themes, blocks and barriers.	RATs facility will be opened from 14th December; full monitoring in place, no issues identified	G
TW 6.1.6 Establish a formal process of multiprofessional, cross system review of activity surges and implement improvement recommendations to enable the systems to respond safely to periods of increased demand.	Capacity Planning Group review this weekly and it is formally monitored and recommendations made via the SORT group. The weekly Winter Group has also been established and Information Services are supporting a review of all data currently provided to create an operational and assurance dashboard with more informed data analysis	G
TW 6.1.7 Establish a Discharge Lounge to free inpatient capacity earlier in the day.	The Discharge Suite build is underway and the unit is due to open on 14th December 2018.	G

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Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 6.1: The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas. TW 6.2: The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety.

Open Actions (Page 3 of 3)	Progress Update and Next Steps	Action RAG
TW 6.1.8 Embed professional MDT challenge to expedite patient pathways.	ECIST session on 5th November to launch #longstaywednesday which is MDT supportive challenge and review of discharge processes and delays	G
TW 6.1.9 Ensure medical engagement with Internal Professional Standards for whole site approach to delivering emergency access standards.	Discussed at Service Director meetings, HMB and Directorate meetings. Internal Professional Standards are included in the revised escalation policy due for sign off on 20th November	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Need Winter Room COD/DND roles in place Other risk is recruitment to additional space	CVs being sought and individuals approached -further interviews on 28/10/18 Targeted approaches being used to headhunt the right people	Risk for noting re incomplete team

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Debbie Laws	1st December 2018	31st December 2018	G	G	75%

MUST DO Recommendation:	TW 14.1: Compliance improves for major incident training
We will have achieved GOOD when:	• 90% or more of all staff members that need major incident training have received required training. • Staff members are able to articulate the nature of a major incident, their individual actions and escalation processes
Exec Summary:	Assurance RAG is Green, as there are comprehensive systems and processes in place for Major Incident training and Business Continuity planning. The Trust is compliant with all national standards and requirements. Work is underway and on track to improve capture of compliance levels.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 14.1.1 Review current compliance levels with major incident training / EPRR business continuity standards	Training matrix in place to identify which staff groups require which levels of training. NHS England indicates the core training requirements at strategic and tactical level. All Exec team members have completed or booked to complete by end December 18 as dictated by the National Occupations Standards. Up to date training records are held by the Trust EPRR and BC Lead for both strategic and tactical levels. Ongoing work required to identify compliance figures for all staff. NNUH is fully compliant with EPRR business continuity standards as per self-assessment.	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 14.1: Compliance improves for major incident training.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 14.1.2 Review current training provision for major incident to ensure it is fit for purpose	The EPRR and BC Lead has reviewed the general and tactical Major Incident internal training programme provided within the Trust to ensure it is compliant with National Occupational Standards. This is enacted on a regular basis (at least several times a year). The ED Major Incident Training programme has been reviewed (August 2018) and is now compliant. Loggist training has also been reviewed in the last 6 months and is compliant with recommended EPRR training standards.	G
TW 14.1.3 Set an improvement trajectory (risk stratified)	The EPRR and BC Lead is working with HR to capture training compliance rates for all staff. Once this is achieved, an improvement trajectory will be set for 95% compliance.	G
TW 14.1.4 Conduct a system wide major incident training exercise in accordance with NHSE /local authority schedule	The EPRR and BC Lead is the leader of the Local Health Resilience Partnership and, as such, sets up the regular and required system wide major incident training exercises . These are conducted at least once every 12 months and the Trust is fully compliant with the Norfolk Resilience Forum (NRF) requirements. Trust staff participate in external exercises as appropriate as an active member of the NRF. The last live exercise was December 2017 – evidence obtained. The next live exercise is required in 2020 as per Civil Contingencies Act 2004.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Major incident training was not recorded on ESR prior to Sept 2017.	Induction records added to ESR since 05/09/2017; however anything prior to this date is not available.	

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Ellie Fosker	1st May 2019	1st May 2019	G	G	25%
MUST DO Recommendation:	TW 25.1: Equipment is maintained and is fit for purpose					
We will have achieved GOOD when:	All equipment is fit for purpose, correctly maintained and replaced when necessary.					
Exec Summary:	Assurance RAG is Green, as robust systems are in place for recording, checking and maintaining equipment					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 25.1.1 Site survey of equipment availability, storage and maintenance.	Clinical Engineering (CE) uses a Medical Devices (MD) database called 'Equip', this database contains all of the information related to every MD asset within the trust, including maintenance schedules and maintenance history. Equipment availability data is analysed through monthly Datix reports relating to the lack of equipment availability	G
TW 25.1.2 Implement a robust process of checking equipment in outpatient areas to include SoPs.	MD's within outpatient areas are captured through the planned preventative maintenance (PPM) schedules generated from 'Equip'. Any areas with MD's that required daily/weekly/monthly users checks are recorded locally and held with the users. Outpatient Standards are being created, which will include checking of all equipment.	G
TW 25.1.3 Implement an audit of compliance.	CE will commence a rolling MD audit schedule in September 2018 to ensure accurate records of equipment on 'Equip'.	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 25.1: Equipment is maintained and is fit for purpose

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 25.1.4 Robust review of EME systems and processes for equipment PAT testing, asset register, planned preventative maintenance and capital replacement.	Robust review of CE systems, processes, PPM and asset register to be undertaken by an external MD professional (the co-finder / Chair of the National Performance Advisory Group). There may be issues with funding for the review to take place. The Capital Replacement programme is to be established through the Medical Devices Committee (MDC). There may be issues with having the required attendance at the MDC and the visibility of the individual divisional capital replacement programmes.	A
TW 25.1.5 Review all equipment service contracts to ensure they meet requirements	A team has been recruited to work within the CE department to manage the trusts MD contracts. The start date for the team is 17/09/2018, following the start date the team will work with the procurement department on a half day official handover of the information.	G
TW 25.1.6 Robust business continuity plans are in place for managing equipment breakdown which impacts on service delivery.	A current business continuity plan for CE is in place.	G
TW 25.1.7 Establish Trust wide Medical Equipment Management Group	This group has been established, Richard Goodwin is the confirmed chair. Copy ToR in evidence repository.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
The trust has no overall visibility of the data held locally with the users.	To be incorporated into measurement of compliance against Outpatient Standards.	

Medical Director work streams

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Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Sara Shorten	2nd January 2019	31st March 2019	G	G	80%
MUST DO Recommendation:	TW 2.1 The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards					
We will have achieved GOOD when:	i) QAA evidence that staff have appropriate understanding of MCA/DOLs, know when, how and why to invoke the guidance and can talk with confidence about a positive MH culture ii) > 90% of appropriate staff are compliant with MCA & DOLs training iii) Audit - 100% compliance with accurate recording of MCA/DOLs decision in patient notes iv) Reduction in complaints related to contravention of MCA/DOLs guidance					
Exec Summary:	• Actions are being completed and on track for delivery for January 2019. • Trust wide knowledge is increasing but further training is required to ensure compliance and adherence to the MCA.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 2.1.1 To design a suite of training packages suitable for all areas of work and roles	• The training is now available as either a classroom or e-learning module. • Bespoke packages are available on request.	B
TW 2.1.2 To ensure there is sufficient resource to deliver and sustain training levels.	Classroom training sessions take place once a month for 50 delegates. This is sufficient supply as there is no waiting list.	B
TW 2.1.3 Undertake Training Needs Analysis	Completed July 2018	B
TW 2.1.4 Develop and agree an improvement trajectory (risk stratified)	Agreed by August OAG	B

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 2.1 The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 2.1.5 Write training plan	• 10 point action plan written and distributed	B
TW 2.1.6 Deliver training Plan	• Ongoing actions being completed inline with plan.	B
TW 2.1.7 Quarterly audit to monitor improvement	• Audit paperwork has been developed by MCA lead and audit schedule approved. • 4 audits are in progress and another has been completed	G
TW 2.1.8 Review process for MCA assessment and documentation to ensure that it is easy to use and covers all requirements	• Included in action plan and is being developed.	G
TW 2.1.9 Complete Trust wide baseline audit of compliance	• MCA and DoLs mandatory training compliances are monitored and reported quarterly to Safeguarding Adults dashboard. • Compliance is increasing July18=80.5%, Sept=82.95	B
TW 2.1.10 Agree improvement trajectory	• Agreed at August OAG	B
TW 2.1.11 Review current training provision and content to ensure that it is fit for purpose	• East of England standard used based on Bournemouth competencies and monitored by CCG Safeguarding Board.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Amanda Williamson	1st October 2018	31st January 2019	R	A	60%

MUST DO Recommendation:	TW 5.1 The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.
We will have achieved GOOD when:	i) QAA evidence that staff have appropriate understanding of audits local to their area, and can talk with confidence about audit action plans and outcomes ii) Documentary evidence (meeting minutes, action logs etc.) to show that audit outcomes are discussed widely (Divisional, Directorate, Departmental, Clinical Governance and Team meetings), that action plans are drawn up, and that the learning/feedback loop is closed, and learning disseminated through a regular Audit OWL
Exec Summary:	All actions either complete or on track for delivery

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 5.1.1 The Trust will have an agreed annual clinical audit plan that identifies the local and national audits that will be completed each year	Trust has annual audit plan. Approved by the Clinical Standards Group (CSG) and Clinical Safety and Effectiveness Sub-Board (CSESB) each year. Quality account, national and local Audits identified on Trust Audit Plan.	B

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Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 5.1 The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.		
Open Actions (Page 2 of 2)	**Actions already in place**	**Next Steps**	**Action RAG**
TW 5.1.2 The outcomes of clinical audits will be reviewed and considered in Divisional Management Board meetings.	• CSG report to be added to Directorate Governance folders bi-monthly from November • Divisional Governance Managers will ensure Bi-monthly Clinical Standards Group and Annual Audit Report are submitted to Divisional Board bi-monthly • Standard agenda item		G
TW 5.1.4 The clinical audit team will undertake two random audits a year to determine if the actions from a completed audit were implemented across Trust	• Annual Audit of Organisational Compliance with Clinical Audit Policy already undertaken annually (since at least 2012) and reported to CSG and CSESB. Further audit of Organisational Compliance with Clinical Audit Policy to be undertaken December 2018 • Trust Clinical Audit Policy http://trustdocs/Doc.aspx?id=978 amended to reflect bi-annual audit		B
TW 5.1.5 Scope the use of Datix / other electronic system for recording audit activity.	• DatixWeb full implementation has been agreed with the CIO. This will include the facility to utilise the PALS (patient advice and liaison service) module on Datix and build an audit function. This can be linked into the actions module allowing audit actions to be easily tracked • Technical specifications for the system have been forwarded to IT. Request for IT services form has been completed and we will be pursuing full Datix web implementation. Procurement processes to be completed.		G
TW 5.1.6 Develop a clear process for disseminating the learning from audits throughout the organisation	• Audit Learning Forum to be held 29th January 2019. All staff invited. Poster on Trustdocs and publicised in communication circular. • Two audit OWLs planned per annum. First audit OWL drafted. To be submitted to CSG in October for approval prior to being disseminated		G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Karen Kemp	1st October 2018	31st March 2019	R	A	30%
MUST DO Recommendation:	TW 12.1-12.3 The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents					
We will have achieved GOOD when:	i) QAA evidence that staff have appropriate awareness of incidents and know when, how and why to log incidents and 'great catches' on DATIX and can talk with confidence about a positive safety culture ii) Increased recording of incidents and 'great catches' on DATIX iii) Minuted evidence of incident reviews & RCAs, e.g.. a SI OWL iv) Evidence that SIs are being discussed at Departmental Clinical Governance meetings v) Documentary evidence of dissemination of learning and closing the loop across divisions					
Exec Summary:	Trust wide knowledge of new processes is increasing but further training is required					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 12.1.1 Develop use of and fully roll out use of action module on Datix	• Module 'built' and is in test but issues with email cascade which is essential in ensuring the module works effectively. • Datix administrator has requested remote assistance. • Datix work by risk management consultancy scheduled w/c 12th Nov	A
TW 12.1.2 Set up suite of standard management reports	• This action cannot progress until action 12.1.1 is complete	R

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 12.1-12.3 The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 12.1.3 Divisions to maintain a manual system of monitoring until action module on Datix is fully functional	• All SIs are forwarded to Directorates for discussion at Governance meetings. • Divisional Governance Managers are continuing with local tracking systems to monitor progress against actions until the Datix system action module is operational • All are monitored via a Trust-wide log maintained via the Patient Safety team.	G
TW 12.1.4 For all specialties / departments and divisions to review progress against actions in their governance meetings and that this is clearly documented in the standardised minutes template and action log.	• Serious Incident Group (SIG) meets every weekday chaired by MD or CN to encourage rapid identification and reporting of incidents in real time • Divisional representatives present cases of concern for discussion and shared learning. All staff are encouraged to attend. • All SI's are reviewed and an action plan agreed with the MD and CN	G
TW 12.1.5 Review Board reports	• Divisional CG leads regularly provide assurance on completed actions from SIs to Associate Director of Q&S for assurance report to HMB	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Delay in rolling out the action module due to staff sickness	Local tracking systems are in place, but quality is not yet uniform across depts/divisions	

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Karen Kemp	1st December 2018	31st March 2019	A	A	30%
MUST DO Recommendation:	TW 16.1 The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.					
We will have achieved GOOD when:	i) QAA evidence that junior doctors and nursing staff have appropriate awareness of importance of TRA and can explain how to carry out & record a TRA and how to administer appropriate thromboprophylaxis ii) Documentary evidence of dissemination of learning and closing the loop (e.g. RCAs and incident reporting)					
Exec Summary:	Concerns remain about quality of data recording and timely administration of appropriate thromboprophylaxis.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 16.1.2 Review of current compliance	• The review is complete, and has highlighted areas of poor data recording.	B
TW 16.1.3 Agree improvement trajectory	• The focus is on reviewing the data collection process, identifying gaps and where and how to make improvements in the recording of data in order to get a true understanding of compliance across the whole trust and all patients • Data from Orsos (Theatres) and PAS is added to the EPMA data. Access to Badgernet (Maternity) is currently being investigated	A

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 16.1 The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed	
Open Actions (Page 2 of 2)	**Progress Update and Next Steps**	**Action RAG**
TW 16.1.5 Review of process in place with recommendations for improvement.	• MD and Trust VTE team met and agreed actions required to implement revised NICE guidance on TRA and thromboprophylaxis an overall improvement action plan. Process mapping o see whether the process can be improved has been arranged for 6th November	G
	• Specific training is given on TRA completion to all the new FY1 doctors as part of the preparation for professional practice sessions..	B
	• This years mandatory training for all FY doctors includes a session on thromboprophylaxis.	B
	• Slides for Consultant mandatory training, given as part of medicines management specifically to explain TRA completion, have been updated	B
	• The NG89 baseline assessment tool (March 2018) has been completed. The tool can be used to evaluate whether practice is in line with the recommendations, reduce the risk of hospital-acquired DVT or PE and also help to plan activity to meet the recommendations.	G
	• Relevant trust guidelines are being updated.	G
	• It is expected that there will be a number of non-conformities which will require divisional governance boards to take decisions on.	G

Risks/Issues	**Mitigating Actions**	**Escalation & Decisions for QPB**

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Amy Eagle	1st November 2018	1st May 2019	A	G	0%
MUST DO Recommendation:	TW 17.1 Mental Health risk assessments are completed					
We will have achieved GOOD when:	i) QAA evidence that staff have appropriate understanding of MH risk assessments, know when, how and why to conduct & record them, and can talk with confidence about a positive MH culture ii) >90% of appropriate staff are compliant with MH risk assessment training iii) Audit - >90% compliance with accurate recording of MH risk assessments in patient notes iv) Reduction in complaints related to contravention of MH policies v) Evidence of appropriate training to Agency / Locum staff					
Exec Summary:	• Staffing issues are being addressed • The deliberate self harm policy has been recirculated via divisional nurse directors.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 17.1.1 Review of current mental health risk assessments against recommended best practice guidance and revise as required.	• Policy review underway, encouraging wards to be engaged via ward awareness walk arounds.	A
TW 17.1.2 Baseline audit of compliance	• Ward awareness walk rounds continue. Initial finding indicates limited knowledge of policy and therefore limited use. Audit proforma circulated	A

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 17.1 Mental Health risk assessments are completed

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 17.1.3 Agree Improvement trajectory	• Work commencing with mental health liaison and ED to ensure a joint risk assessment is completed at first assessment point. • Mental Health matron to start in post November 2018. • NSFT Liaison Matron remains away from work. Engaged with NSFT management team but no offers to cover/replace this post • Draft process to audit compliance under discussion	R
TW 17.1.4 Monitor compliance monthly	To be pursued once new matron in post	R

Risks/Issues	Mitigating Actions	
At risk due to continued staffing issues	Suggested new deadline 1st February 2019	

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Highlight Report to: NOVEMBER QPB

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Caroline Barry	1st March 2019	1st April 2019	A	G	60%

MUST DO Recommendation:	TW 22.1 Review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.
We will have achieved GOOD when:	i) QAA evidence that staff feel confident of their ability to discuss and document preferred treatment outcomes with patients towards the end of life; including DNACPR decisions and those made in a patient's best interests. ii) Audit - clear documentation of capacity and best interests in the clinical notes at point of DNACPR decision iii) Reduction in complaints related to communication of DNACPR decisions. iv) Clear mechanism for communication of valid DNACPR orders between partner agencies
Exec Summary:	Decision regarding STP funding to implement ReSPECT across the STP awaited

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 22.1.1 Review current DNACPR documentation to ensure it covers all requirements including MCA and national guidance	• DNACPR documentation updated in line with MCA & national guidance. • Trust wide education document prepared -for circulation by ED • Trust wide patient-facing poster campaign to raise awareness of separate forms • IT prompt approved to trigger awareness of community form on admission. • DNACPR policy being updated	A
TW 22.1.2 Complete Trust wide baseline audit of compliance (Senior Matrons and Resus Team)	• Baseline audit completed of all wards by senior matrons. Results – being collated • Next step – incorporate DNACPR compliance checks into weekly matron safety rounds	A
TW 22.1.3 Review current training provision and content to ensure that it is fit for purpose	• DNACPR teaching added to Foundation training curriculum. • DNACPR teaching incorporated into mandatory training	G

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 22.1 Review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 22.1.4 Trust wide amnesty of all old Patient care records V1 Sept 2013.	Completed	G
TW 22.1.5 Introduce a treatment options form (ReSPECT) so that ceilings of care can be clearly documented	• NNUH funding approved for 1 WTE post for implementation • STP wide approval for implementation of ReSPECT • STP business case for 2 WTE band 7 posts prepared; awaiting funding decision	A

Risks/Issues	Mitigating Actions	
If dedicated resource is not made available from community organisations, it is likely that ReSPECT will not be effectively implemented across the STP.	Director of Nursing and Quality NCHC to seek funds from HEE	To be discussed at STP clinical reference group.

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Clive Beech	2nd January 2019	28th February 2019	A	G	70%
MUST DO Recommendation:	TW 24.1 The trust must ensure that medicines and contrast media are stored securely and in line with national guidance					
We will have achieved GOOD when:	i) QAA evidence that staff have appropriate understanding of the storage of medicines and contrast media, and are compliant with SOPS ii) Audit - Improved audit outcomes					
Exec Summary:	Action plans for individual areas/themes need to be consolidated into one single overarching action plan.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 24.1.1 Review of current medicines storage capacity with recommendation for improvement	• During October Medicine Management audits of all wards and departments will include the question, Is there enough storage space to support segregated storage in line with national guidance and if not what is required. The results will then be submitted to the hospitals Medicines Management Committee and progressed	A
TW 24.1.2 Implement recommendations for safe storage of medicines	• A Medicines Policy is in place.	B
	• ITU automated drug cabinets awaiting installation	G
	• Most radiology minor works requests are approved and waiting completion. Staff are actively chasing others.	A
	• Radiology will continue to store cardiac arrest kits in all scan rooms. They will be locked in drug cupboards when examination rooms are unoccupied.	B

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 24.1 The trust must ensure that medicines and contrast media are stored securely and in line with national guidance

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 24.1 3 Peer monthly audit of compliance with safe storage of medicines.	These are taking place, and feedback is given following each audit.	B
TW 24.1.4 Agree a training delivery plan	No formal training delivery plan is in place, but the feedback loop that follows each peer monthly audit ensures that learning is disseminated appropriately	B
TW 24.1.5 Implement a robust system of incident review within the team with an agreed response time target for incident review and monitor compliance Levels.	Medicines-related incidents are reviewed within the team and the learning is shared appropriately.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Actions could be duplicated or overlooked because of the number of specialty/theme specific action plans	Consolidate into one overarching action plan.	

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Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Erika Denton	Berenice Lopez	1st Sept 2018	30th June 2019	R	A	10%
SHOULD DO Recommendation:	TW 30.1: Ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.					
We will have achieved GOOD when:	i) Evidence to show that Morbidity and Mortality meetings are multi-disciplinary, attended by the appropriate people, minuted, and the outcomes/learning are disseminated appropriately ii) Improved Hospital Standardised Mortality Ratio (HSMR)					
Exec Summary:	• Examples of good practice are required to promote standardisation of processes and to encourage dissemination of learning. • Clear expectations are needed around M&M meetings (format, frequency, content and multi-disciplinary input)					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 30.1.1 Schedule regular M&M meetings in all Directorates	• This is not standardised across all divisions. • The Associate MD is working to review entire process.	R

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 30.1: Ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 30.1.2 Provide sufficient support to enable robust meeting administration	• In Medicine each directorate has their own approach . Meetings are often poorly documented and appropriate people not always in attendance to ensure an effective discussion takes place. • In Surgery M&M is a standardised agenda item, evidence of inclusion is monitored to confirm dissemination of learnings • M&M minutes are not consistently recorded because of a lack of admin support. • Not all teams are using standardised template for CG meetings which includes mortality • A standardised template for reporting to the mortality surveillance committee is currently being drafted.	R

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Lack of clear expectations and standardised processes	Standardised templates and examples of good practice are required	Request completion date be extended to end of June 2019

Chief Nurse work streams

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by target date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Karen Kemp	1st October 2018 for strategy	31st January 2019	R	G	70%
MUST DO Recommendation:	TW 4a.1: The trust must ensure that there is an effective process for **quality improvement** and risk management in all departments					
We will have achieved GOOD when:	• We have a Trust Wide QI Strategy with an implementation plan in place, communicated to staff					
Exec Summary:	RAG status is green as an initial draft of the QI strategy has been reviewed and a series of workshops are being planned with staff to review the strategy and plan prior to Board submission for approval. Communication plan to be agreed for launch.					

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
TW 4a.1.1 Develop a Board agreed Trust Wide Quality Improvement Strategy that clearly articulates the QI approach to be used within the Trust, identifies the learning and development needs of staff to deliver the strategic goals and includes an implementation plan	An initial draft of the QI strategy has been reviewed by the Chief Nurse and a series of workshops are being planned with staff to review the strategy and plan (Nov – Dec 2018). Revised target completion date 31/01/19 to reflect workshops being carried out and requirement for Board sign off.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
DIPC (Chief Nurse)	Sarah Morter	1st August 2018	31st December 2018	R	G	80%

MUST DO Recommendation:	TW 13.1: The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.
We will have achieved GOOD when:	- QAA evidence that staff, patients and visitors have appropriate awareness of IP&C guidance, act in accordance with guidance and policy, and can talk with confidence about a positive IP&C culture - Metric: Remain within the NHSI objectives for MRSA and C. diff. - Documentary evidence of dissemination of learning and closing the loop (e.g. IP&C OWLs) - Improved IP&C audit outcomes, in particular the HII audits which should attain a minimum of 80% - Reduction in complaints related to IP&C
Exec Summary:	Assurance is green as the HICC meeting monthly meeting is in place and the water safety group is bi-monthly. There is evidence that dissemination of learning is taking place.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 13.1.1 External review of IPC systems and processes in the Trust	NHSi conducted an on-site review of IP&C 20/02/2018 & assessed the Trust as NHSI IP escalation level GREEN on the understanding that plans to improve IP governance were delivered. Progress is monitored by monthly PRM submissions to Monitor. The CCG, IP&C nurse were also present throughout this review.	G

QIP Workstream Highlight Report

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 13.1: Ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 13.1.2 Clarify the roles of Infection Control Doctor, Microbiologist and DIPC	DIPC roles are clarified in the Code of Practice on the prevention and control of infections and related guidance. Requires a business plan to increase the ICD sessions given the increase in IP&C workload.	B
TW 13.1.3 IPC team to provide enhanced support to Urgent and Emergency Care to ensure compliance with the Hygiene Code.	Senior Nurse, Infection Prevention and Control has been undertaking weekly visits. IP&C have reduced visits to as required and when undertaking audits.	G
TW 13.1.5 Review IPC training compliance in U&EC care, set improvement trajectory & monitor compliance	2017/18 baseline data is available and will inform the improvement trajectory.	G
TW 13.1.6 Programme of senior-lead environmental inspections in place	• A fortnightly programme of IPC practice inspections has now commenced. Commode and Hand Hygiene audits are carried out and results are published on the new Quality / Safety Dashboard and IP&C dashboard • When the Perfect Ward programme commences it will provide further assurance of IP&C practices and cleanliness in the clinical areas. Querying with IT hardware compatibility / requirement	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Perception that cleaning has deteriorated since the NHSI site inspection on 20/2/18		

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Niall Pearcey	1st October 2018	31st December 2018	R	A	40%

MUST DO Recommendation:	TW 11.1: The trust must ensure that resuscitation equipment is checked in accordance with trust policy.
We will have achieved GOOD when:	• The policy has been reviewed, updated and is available on the intranet • Trolleys have been replaced and meet current standards • A baseline compliance audit of checking equipment has been completed • A process for ongoing monitoring has been agreed (including real time dashboard visibility to identify check status) and communicated by Divisional Nursing Directors following audit analysis
Exec Summary:	Overall RAG status is amber based on audit results, the problem has not been resolved and an action plan is required. Following the audit areas have been identified where the checks are being carried out well so they can be reviewed to see if lessons can be shared with other areas to increase compliance.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 11.1.1 Review Trust Policy to ensure that checking procedures are clear	Policy reviewed and updated on Trust docs. Circulated to Ward Sisters. Evidence provided.	B
TW 11.1.2 Baseline compliance audit of checking equipment	Baseline audit carried out by a Clinical Audit Facilitator. Evidence of audit findings provided.	B
TW 11.1.3 Agree improvement trajectory	Target completion date: 30/09/18. This action is to be agreed following the baseline audit analysis and review of results. Process for ongoing monitoring to be agreed by Divisional Nursing Directors.	R

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 11.1: The trust must ensure that resuscitation equipment is checked in accordance with trust policy.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 11.1.4 Regular audit of compliance schedule agreed and in place	Target completion date: 30/09/18 Process for ongoing monitoring to be agreed by Divisional Nursing Directors following audit analysis.	R

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Current paper based systems do not allow real time monitoring of compliance with checking	Electronic system in place to monitor in real time	N/A

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Karen Kemp	1st March 2019	1st March 2019	G	G	15%
MUST DO Recommendation:	TW 4b.1: The trust must ensure that there is an effective process for quality improvement and **risk management** in all department					
We will have achieved GOOD when:	• The Trust has an informed understanding of high operational risks, reflected through a revised risk register and managed through an effective risk management group • Risk management systems are fit for a high performing health organisation • Risk information flows from specialities through Divisions to the board and is aligned to the Board Assurance Framework • Board members provide strong leadership in a risk-based approach embedded within the quality governance framework and set a clear expectation to all staff regarding the management of risk					
Exec Summary:	RAG status green as actions on track for overall target date.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 4b.1.1 Robust Governance review to include Trust committee structure to ensure that information maps through ('Ward to Board' and 'Board to Ward') all levels of the organisation	Target completion date: 30/11/18 PwC review of Board Governance has taken place.	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 4b.1: The trust must ensure that there is an effective process for quality improvement and risk management in all departments

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 4b 1.2 Risk Management Masterclass for : - Divisional Triumvirates, Governance Managers and Corporate Leads	The Trust has commissioned specialist risk management consultancy firm Facere Melius (FM) to conduct a risk management diagnostic review and provide an improvement package. FM will commence this work week commencing 29/10/2018. Training scheduled to commence week commencing 10/12/2018 through week commencing 04/02/2019. Target action completion date updated to reflect advised dates and plan 08/02/19.	G
TW 4b 1.3 Risk Management Masterclass for : - Divisional Triumvirates, Governance Managers and Corporate Leads		G
TW 4b 1.4 Review Risk Management Training for all staff and ensure Risk Management is a core element of mandatory training for all staff	Target completion date: 01/03/19 Training will be provided by FM	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Nancy Fontaine / Karen Kemp	1st February 2019	30th April 2019	A	G	5%

MUST DO Recommendation:	TW 20.1: The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care. This will integrate the 'Patient Voice'
We will have achieved GOOD when:	• Divisions have easy access to their complaint and PALS enquiries via Datix system • A monthly complaints synopsis is discussed at Monthly Governance meetings • Documentary evidence of dissemination of learning and closing the loop (e.g. OWLs)
Exec Summary:	Overall RAG status green timescales will be dependent on the implementation of Datix web and staff will then require training.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 20.1.1 Enable Divisions to have easy access to their complaint and PALS enquiries via Datix system by moving complaints module from 'Rich Client' to Datixweb.	Request for IT services form has been completed and we will pursuing full Datix web implementation. Target date: to be revised to 30/04/19 as training will impact original delivery date	G
TW 20.1.2 Divisions to discuss patient feedback at monthly Governance meetings and the information used to triangulate with incidents, SIs, risks and mortality reviews to inform decision making.	Target date: 30/01/19 Dependency on division access to complaints and PALS. New report complaints, litigation, incidents and compliments will be produced. Discussed with Litigation and Complaints Manager.	A

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Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 20.1: The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care. This will integrate the 'Patient Voice'.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 20.1.3 Recruitment of a Lead for Patient Engagement and Experience to move NNUH to a transformation approach to listening, responding and co-designing service improvements with patients and carers.	Target date: 30/01/19. Lead for patient engagement and experience advertised week commencing 1/10/18. Shortlisting has taken place and interview date set.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Issue - Using current version of Datix precludes divisions & risk team from accessing complaints data and inhibits triangulation of data	Switch to a different version of Datix	

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Domain
Caring

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Debbie Whittaker	1st April 2019	1st April 2019	A	A	15%
MUST DO Recommendation:	TW 21.1: The trust must ensure that patients are treated with dignity and respect at all times (links to TW 20.1)					
We will have achieved GOOD when:	• QAA evidence and collection of feedback which reflects patients are treated with dignity and respect and in accordance with guidance and policy • Patients involved as core members of all quality committees • Formal Patient Panel has been implemented					
Exec Summary:	Overall RAG status amber due to dependency on Trust wide action 20.1 and requirement for inception of central Patient Experience Team to move NNUH from a transactional transformational focus.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 21.1.1 Analyse patient complaints and feedback to identify themes	Dependency on TW 20.1. Monthly reports on FFT, PALS and Complaints to CaPe in place, all Divisions actively monitoring feedback, further action required to evidence learning from feedback at both a Divisional and ward / department level, connect complaints, compliments, litigation and incidents. Discussions have taken place with Litigation and Complaints Manager.	A
TW 21.1.2 Undertake an environmental audit to determine if current environments support dignity in care	Target completion date: 30/11/18. Looking at short term secondment coordinator role to support environmental audit.	A
TW 21.1.3 Actively monitor FFT, complaints and feedback data	Target completion date: 28/02/18. Monthly reports on FFT, PALS and Complaints to CaPe in place, all Divisions actively monitoring feedback, further action required to evidence learning from feedback at both a Divisional and ward / department level, connect complaints; compliments; litigation and incidents.	A

Domain
Caring

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 21.1: The trust must ensure that patients are treated with dignity and respect at all times. (links to TW 20.1)

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 21.1.4 Senior Matrons to undertake a Monthly observational audit of staff and patient interaction	Target completion date: 30/11/18. Looking at short term secondment coordinator role to support observational audit.	A
NEW action TW 21.1.5 Formally capture all organisation wide compliments	Target completion date: 30/11/18. PALS team to offer an email address for teams to scan compliments and send through to the team.	A
NEW action TW 21.1.6 Implement Patient Focus Groups to benchmark Quality / Dignity	Target completion date: 31/03/19	G
NEW action TW 21.1.7 Formal Patient Panel to be implemented	Target completion date: 28/02/19. Terms of reference being created.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
(Issue) Completion of actions is dependant on recruitment of people with key skills (Issue) The current complaints process does not allow for oversight of complaints by Nurse and Medical Directors or the Divisions before responses are sent.	Recruitment in progress The Nurse and Medical Directors and Divisions need to see complaint responses before they are finally sent to complainants and learning can then be shared at Divisional or Professional meetings.	

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Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Karen Kemp	1st March 2019	1st March 2019	A	G	15%
MUST DO Recommendation:	TW 23.1: The trust must ensure that incidents are reported and investigated in a timely way by trained investigators					
We will have achieved GOOD when:	• A robust system of incident review is in place with an agreed response time target for incident review and on going monitoring of compliance levels • The Trust have a Serious Incident Group (SIG) in place • Reporting and incident investigation training available to staff and guidance material provided					
Exec Summary:	RAG status green baseline data collected and SIG in place.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 23.1.1 Review the number of staff that have received Datix training.	Target date: 30/10/18 Baseline data collected. Evidence provided.	B
TW 23.1.2 Review datix incident training programme - reporting and incident investigation training	Target date: 30/12/18 Training is delivered on 1:1 basis or small group. Handouts are provided. Scoping exercise underway regarding eLearning for incident reporting.	G
TW 23.1.3 Identify target number of required staff that have investigation responsibility.	Target date: 30/12/18 Following baseline data collection work to be carried out with Divisions to identify target number.	G
TW 23.1.4 Agree a training delivery plan	Target date: 30/01/19 Formal training plan with milestones to be created.	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 23.1: The trust must ensure that incidents are reported and investigated in a timely way by trained investigators.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 23.1.5 Implement a robust system of incident review within the team with an agreed response time target for incident review and monitor compliance Levels.	Policy in place. Compliance is being monitored monthly through reporting to Clinical Safety and Effectiveness Sub Board via the Patient Safety and Quality report.	G
New action TW 23.1.7 Improve culture of timely incident reporting / recognition of incidents	Target date: 28/02/19. Measure through CQC insight	G
New action TW 23.1.8 Implement daily Serious Incident (SI) Group	Action completed. Group in pace with effect from 3/09/18. Output from this group is recorded on Datix. Learning will be shared via Safety Matters Wise OWLs.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Lack of resource to deliver the training	Interim resource, apprentice recruitment. Recent appointment of experienced trainer.	Additional funding of £4K to support resource requirement

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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Clive Beech / Heather Watts	1st November 2018	31st December 2018	A	A	50%

MUST DO Recommendation:	TW 26.1: The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements
We will have achieved GOOD when:	• An audit process is in place that is reported via Medicine Management Committee and feedback is provided to areas • QAA evidence that staff have appropriate awareness of national requirements when completing records concerning temperature charts for blood and medicine fridges
Exec Summary:	Overall RAG status amber with regards to compliance against standards further work taking place as part of audits to agree actions and meet recommendation.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 26.1.1 Review current processes in place with recommendations for improvement.	Pharmacy confirmed audit process in place and reviewed. Work being carried out to review fridge models, numbers and requirements, data has been collected as part of audit.	G
TW 26.1.2 Review compliance levels against standards.	Monthly medicines management audit takes place over 5 days (Wards; ED; ITU). Reported via Medicine Management Committee and feedback provided to areas.	A
TW 26.1.3 Agree actions and an improvement trajectory for each Directorate.	Issues highlighted and further work through audit enables future actions to be agreed and monitored.	A

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 26.1: The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 26.1.4 Regular audit of compliance against trajectory.	Monthly audit for wards and departments ongoing, plan in place for and remaining departments.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Risk - If staff shortages due to staff leaving and recruitment lead in then this could impact ability to carry out audits.		

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Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Debbie Whittaker	1st April 2019	1st April 2019	A	A	20%

SHOULD DO Recommendation:	TW 32.1: The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.
We will have achieved GOOD when:	• We have carried out a comprehensive staffing review, to include the exploration of different roles to support frontline care delivery and against national recommendation • Monthly report to identify recruitment pipeline and recruitment trajectories agreed and in place • Staffing establishment agreed that is fit for purpose and supports a flexible acuity demand with recruitment and retention plan agreed and in place • Three times a day cross divisional staffing meetings and review of red flag events is in place
Exec Summary:	Overall RAG status is amber as actions are progressing, however there are risks listed that could impact the overall target date for the recommendation.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 32.1.1 Comprehensive staffing review to include the exploration of different roles to support frontline care delivery and against national recommendations.	Target date 31/01/19. Establishment review for inpatient areas is still in progress	G
TW 32.1.3 Agree and fund a revised staffing establishment that is fit for purpose and supports a flexible acuity demand.	Will be progressed following establishment review action above. Target completion date: 31/03/19.	G

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Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 32.1: The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 32.1.4 Agree a recruitment and retention plan	Target completion date: 31/12/18. Teleconference with NHSi who have offered support over the next 12 months drawing on examples of national best practice. Next meeting planned for week commencing 19/11/18.	A
TW 32.1.5 Embed use of SafeCare and cross Divisional working	Further work in progress to improve staffing “look ahead”, consistent application of acuity tool, specialling requirements, processes to ensure that SafeCare provides Board assurance. Lead for safer staffing role has been submitted for job matching (aiming to be in post 31/3/19)	G
New action: 32.1.6 Agree plan and phasing of actions following establishment review	Target completion date: 31/01/19	G
New action: 32.1.7 Divisions to agree recruitment trajectories which will be monitored through monthly PRMs	Target completion date: 28/02/19. Trajectories requested from clinical areas that have additional staffing requirements over the winter period (Dec 2018). remainder of areas to be completed following establishment review.	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
- National shortage of trained nurses - Capacity constraints to manage the action plan - Lack of the financial resource to fund increased establishments - Lack of an accurate ESR and single source of truth re. establishments - Lack of senior nurse resource to support safer staffing assurance and consistent use of acuity tool	Recruitment of Lead for staffer staffing approved through special measures money to ensure greater assurance of staff and patient safety.	

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Karen Kemp	1st December 2018	1st December 2018	G	G	10%

SHOULD DO Recommendation:	TW 34.1: The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training
We will have achieved GOOD when:	• A rolling programme of RCA training with sufficient capacity to meet demand has been established • Protected time for staff to undertake training in place • Target number of staff agreed within each specialty • Uptake and compliance monitored
Exec Summary:	Overall RAG status green. 180 individuals in the organisation have received RCA training with further sessions booked, and an overall target of 223 to be trained by 31/03/19.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 34.1.1 Establish rolling programme of RCA training with sufficient capacity to meet demand	Dates in place for 2018 / 2019 delegates. RCA investigation training continues to be delivered alternate monthly by the Quality & Safety Team. 180 individuals in the organisation have received RCA training.	G
TW 34.1.2 Agree a target number of staff trained in each specialty	Divisions to identify the number of people who require training in how to carry out an RCA and feed into the training programme.	G
TW 34.1.3 Ensure protected time for staff to undertake training	Divisions have been asked to ensure those who have committed to a place are released to attend.	G

Highlight Report to: NOVEMBER QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 34.1: The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training. G

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 34.1.4 Monitor uptake and compliance	Work to be carried out in November to monitor uptake and compliance.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
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Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Karen Kemp	2nd January 2019	2nd January 2019	G	A	0%

SHOULD DO Recommendation:	TW 35.1: The trust should ensure that staff carrying out Duty of Candour applications receive appropriate training.
We will have achieved GOOD when:	• Training provision reviewed, alternative approaches utilised and clear guidance for staff on their responsibilities provided • Divisional Governance Managers trained to ensure that there is a local 'expert' to support staff • All COS / Ward and Department leads trained in DoC
Exec Summary:	Overall RAG status amber as target outcome date at risk due to conflicting priorities for resource required to complete actions.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 35.1.1 Review current training provision	Target date: 30/10/18. Gap analysis to be completed.	R
TW 35.1.2 Review delivery, methods of courses to understand if alternative approaches could be utilised.	Target date: 30/11/18. E-Learning package sourced via Royal College of Surgeons. Exploring licensing options so that evidence of training figures can be captured.	G
TW 35.1.3 Review current Being Open policy to ensure that it gives clear guidance for staff on their responsibilities.	Target date: 30/09/18. Being Open policy reviewed, some revision required. Will be scheduled for approval at November Clinical Safety and Effectiveness Sub board.	R

Highlight Report to: NOVEMBER QPB

SHOULD DO Recommendation:	TW 35.1: The trust should ensure that staff carrying out Duty of Candour applications receive appropriate training.

Open Actions (Page 2 of 2)		Action RAG
TW 35.1.4 Train Divisional Governance Managers to ensure that there is a local 'expert' to support staff.	Target date: 31/12/18	A
TW 35.1.5 Ensure that all COS / Ward and Department leads have training in DoC.	Target date: 02/01/19 Information required from divisions for number of delegates.	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Issue – Lack of resource to deliver the training	Increase use of e-learning	

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Domain
Caring

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Nancy Fontaine	Debbie Whittaker	1st April 2019	1st April 2019	A	A	15%

SHOULD DO Recommendation:	TW 36.1: The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss (Links to Trust being non-compliant with National Accessible Information Standard 2016)
We will have achieved GOOD when:	• We self assess against national accessible information standards and action plan in place • Patients and carers involvement • Identify pilot site for next phase to test
Exec Summary:	Overall RAG status is amber. Work continues with the self assessment action plan to identify any gaps in provision that may impact on the ability to deliver against all measures within this standard. IT actions form the foundations for phase 2 to be progressed however, further additional multi skilled resource is required to progress actions. Until resource in place we will not have an awareness of all and risks associated.

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
TW 36.1.1 Self assessment against national accessibility standards (AIS)	Target completion date: 30/11/18. Self assessment carried out.	G
TW 36.1.2 Clear recommendation for improvement	Target completion date: 30/11/18. Accessible Information Standards (AIS) steering group meeting in place to progress actions within action plan, next planned meeting 30/10/18	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Workforce Director work streams

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by submitted CQC completion date		% Evidence in repository
				Oct	Nov	
Jeremy Over	Sarah Pask	2nd January 2019	31st March 2019	R	A	20%

MUST DO Recommendation:	TW 1.1-1.3 The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices. The Trust must ensure that staff compliance with mandatory training improves significantly. This includes basic life support, paediatric life support, Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS), prevention and management of aggression (PMA) and infection, prevention and control training. The Trust must improve staff compliance with level three children's safeguarding training. The Trust must ensure that staff caring for children in the recovery area have appropriate safeguarding training in line with national guidance and trust policy. The Trust must ensure that safeguarding training compliance for both medical and nursing staff improve in line with the trust's targets. The Trust must ensure staff complete appropriate mandatory training including safeguarding training to a level appropriate to their job role.
SHOULD DO Recommendation:	The Trust should ensure that both medical and nursing training compliance is improved in line with the trust targets. The Trust should review its e-learning system to ensure staff can access training programmes.

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	TW 1.1 The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.
We will have achieved GOOD when:	• Trust Mandatory Training compliance is above 90% with no significant pockets of low achievement either by department or course, and all staff complete the appropriate level associated with their roles.
Exec Summary:	Overall status is AMBER. There continues to be an improvement in mandatory training compliance – currently 83.63% (up from 81.5% in May 18) although **the pace of improvement is behind trajectory**. HMB considered in August the support required to seek further improvement and requested a further update and proposals to be presented to HMB in October. The most significant risk is staff not booking onto training and staff who DNA in spite of holding a booked place.

Open Actions (Page 1 of 4)	Progress Update and Next Steps	Action RAG
TW 1.1.1 Service review of the resuscitation service to identify if the resourced provision meets the needs of the Trust and to ensure there is adequate supply to meet demand	The provision for Resus training offered by the central team has doubled since August this year and staff can also access training locally via Key Trainers. There are currently 104 spaces available to book for October, however, now that the capacity is available staff do not appear to be booking onto the available dates or do not attend the session they're booked for. A targeted communication will go out to non-compliant staff with a view to filling the unfilled places.	G
TW 1.1.2 Review current Mandatory Training course prospectus to ensure the suite of training is fit for purpose	In addition to the previous review of the Mandatory Training portfolio which mirrors the national Core Skills Matrix which all Trusts are expected to comply with, a full review of the current prospectus will be undertaken during October.	G

QIP Workstream Highlight Report

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 1.1-1.3: The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.

Open Actions (Page 2 of 4)	Progress Update and Next Steps	Action RAG
TW 1.1.3 Review delivery methods of courses to understand if alternative approaches could be utilised to include e-learning, web based approaches that can be accessed from any area etc.	Many of the Mandatory Training topics are accessible in alternative formats except where the skills being taught need a practical element. This is kept under constant review and new eLearning packages are routinely in development. Current examples include; Health Record Keeping (which is subject to testing & planned to be launched end Oct), Diabetes Inpatient Training, Epidural Update for Midwifery, Counter Fraud and MRI Safety Training.	G
TW 1.1.4 Robust review of existing mandatory training databases and develop a single training administration system.	Review has being undertaken with IT to ensure that ESR can operate effectively on NNUH systems. Update: compatibility view settings being fixed, popup blockers switched off and the majority of computers moved to IE11. ELearning now moved to web-based (non-JRE) which means all eLearning can be launched on any device, any browser, anytime via N3 network and internet (remote access) and java is no longer needed to launch eLearning. Consequently, we have seen a significant reduction in eLearning technical queries, with most queries focussing on forgotten passwords and subscription expiry issues. Following these improvements there was a noticeable spike in eLearning completions for August of 8,200 compared with around 2,500 units completed each month.	G
TW 1.1.5 Ensure there is clarity of the mandatory training requirements for each role within the Trust.	Each member of staff can review their learning requirements on the personal learning record on ESR. The Training Directory and Staff Mandatory Training policy also offer a helpful guide for staff.	G

QIP Workstream Highlight Report

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 1.1-1.3: The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.

Open Actions (Page 3 of 4)	Progress Update and Next Steps	Action RAG
TW 1.1.6 Increase compliance with safeguarding level 3 training for staff in paediatric recovery	The Safeguarding team have undertaken targeted work in these areas by offering bespoke sessions, emailing compliance lists to Divisions. Compliance has also been discussed at Divisional Boards, Safeguarding Assurance meeting & Clinical Safety sub-group.	G
TW 1.1.7 Increase surgery nursing and medical compliance with safeguarding children training.	As TW1.1.6 plus a bespoke trainer is now available in A&E.	A
TW 1.1.8 Increased surgery nursing and medical compliance with mandatory training	Mandatory training is part of the governance template and being monitored through directorate meetings	A
TW 1.1.9 Increased Trust wide mandatory training compliance	See HMB paper Aug 2018. Staff need to be supported to attend training and attend when booked – DNA rates are an issue. Improvement in compliance is behind trajectory.	R
TW 1.1.10 Increase Urgent and emergency care mandatory training compliance	ED are increasing their compliance by reviewing how they schedule mentor days. By making these more regular half days they are less likely to be cancelled.	A
TW 1.1.11 Increase compliance with safeguarding level 3 training	As TW1.1.6	G
TW 1.1.12 Increase diagnostic imaging mandatory training compliance	Each SOM and Governance lead is given a list of their staff nearing and over due for appraisal Each SOM is held to account in the Directorate IPR and required to provide a plan to ensure staff are training now and in the future	

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QIP Workstream Highlight Report

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 1.1-1.3: The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.

Open Actions (Page 4 of 4)	Progress Update and Next Steps	Action RAG
TW 1.1.13 (The trust should review its e-learning system to ensure staff can access training programmes)	See point - TW 1.1.4. An average of 35,000-40,000 units of eLearning are completed each year with an average of only 3% of staff not following the guidance correctly.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Staff not completing MT or being released to attend MT sessions.	HMB to review further proposals in Sept.	To note

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Domain
Well-Led

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by submitted CQC completion date		% Evidence in repository
				Oct	Nov	
Jeremy Over	Sarah Gooch	1st October 2018	30th November 2018	R	A	0%
MUST DO Recommendation:	TW 10.1: Ensure consistency processes are in place for recruitment, fit and proper persons regulation and line management at executive level.					
We will have achieved GOOD when:	• We have reviewed Fit and Proper Persons regulation and ensured all executives are compliant on an annual basis. • At least 90% of Directors have current appraisals in line with the Trust target. • All Directors have a current Personal Development Plan.					
Exec Summary:	Research and preparation for personal audit are on track.					

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
TW 10.1.1 Review existing executive and non executive directors against the fit and proper persons requirements	We have reviewed Fit and Proper Persons regulation and ensured all executives are compliant on an annual cyclical basis. We have undertaken a review of our policy against a selection of hospital trusts rated 'outstanding'. There are no significant recommendations arising, although a number of minor improvements have been identified.	A
TW 10.1.2 Review NNUH FPPR policy against examples from CQC 'outstanding' trusts and adopt improvements		

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
Well-Led

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by submitted CQC completion date		% Evidence in repository
				Oct	Nov	
Jeremy Over	Cursty Pepper	1st October 2018	31st March 2019	R	A	10%
SHOULD DO Recommendation:	TW 33.1: Review the support managers provide to support staff in times of increased demand.					
We will have achieved GOOD when:	• Review and implementation of revised 24/7 on-call managerial arrangements • Review and implementation of new escalation policy, with clear actions and pathways for those who are managerially responsible for supporting staff					
Exec Summary:	Overall status is AMBER. A review of the on-call structure and approach has been completed with recommendations for change approved at management board. Updated escalation policy to be discussed at the next HMB meeting on 16/10/18. Rated AMBER as slippage against target completion date..					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 33.1.1 Review the on call management structure with a view to understanding the layers and spans of control within the Trust managers in conjunction with the revised escalation and full capacity protocol.	New on call system commences in November- training package and supporting policy in development.	G

Domain
Well-Led

Overall RAG Rating

Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

SHOULD DO Recommendation:	TW 33.1: Review the support managers provide to support staff in times of increased demand.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 33.1.2 To review the Trust on call leadership development training to ensure it is fit for purpose, is accessed by all the relevant staff and embraces the principles within Developing People, Improving Care, the NHS Leadership approach with a specific focus on clear lines of accountability, roles and responsibilities including business as usual.	Revised escalation policy due for HMB ratification on 20th November – high levels of clinical and operational engagement	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by submitted CQC completion date		% Evidence in repository
				Oct	Nov	
Jeremy Over	Carole Rowe	1st February 2019	1st February 2019	G	G	20%
MUST DO Recommendation:	TW 3.1: The Trust must ensure that staff annual appraisal completion improves					
We will have achieved GOOD when:	• Trust appraisal completion for AfC staff is at or above 80%. • There is an associated improvement noted in respect of staff survey questions KF11 and KF12					
Exec Summary:	Overall status is GREEN. Appraisal compliance to 30 September 2018 was 74.5% - up 6.1% since 30 June and, up 11.0%, with two divisions above 80% for both August and September and corporate departments improving 26.3% since 31 March.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 3.1.1 Conduct baseline assessment of compliance	Completed and in 24th of July HMB paper	B
TW 3.1.2 Set Departmental improvement trajectories agreed at Divisional performance review	Clear expectations set that appraisal completion will exceed 80% by December 2018	B
TW 3.1.3 Agree a delivery plan to achieve target	Top tips issued as part of regular data provision to senior leaders	B

QIP Workstream Highlight Report

Domain
Effective

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 3.1: The Trust must ensure that staff annual appraisal completion improves

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 3.1.4 Deliver the plan	HR staff are working closely with divisions and departments to support the delivery of appraisals. Management information relating to compliance rates is regularly circulated, along with top tips to help appraisers.	G
TW 3.1.6 Monitor compliance		
TW 3.1.5 Review of appraisal databases, develop a single administration system and streamline processes for documentation and recording.	ESR is the appraisal database utilised, with electronic links from the intranet supporting recording. A compliance review was conducted in June which confirmed the robustness of published data.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
A tail off in the rate of appraisal compliance.	Continue with plan and regular communication to leaders.	

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Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by submitted CQC completion date		% Evidence in repository
				Oct	Nov	
Jeremy Over	Cursty Pepper	12th December 2018	31st March 2019	G	G	0%

MUST DO Recommendation:	TW 7.1: Improve the relationship and culture between the site management team and the Senior Nursing and Clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risks to patients and staff.
We will have achieved GOOD when:	• The operational meetings and decision making takes place within Trust policy, which is well known by staff and ensures the best Trust wide safety. • QAA evidence that staff can challenge and raise safety issues within the operational meetings and with the site operational team. Where decisions are made against standard Trust policy they are recorded as to why policy was breached and the mitigating action to return to normal service ASAP
Exec Summary:	Main issue is difficultly measuring improvement tangibly – reliant on subjective reviews but using ECIST will provide external oversight

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
W 7.1.1 Review of roles and responsibilities to ensure that expectations of level of responsibility and accountability are explicit and understood by all staff	Facilitated ECIST event planned for 8th November. This will specifically focus on peoples roles and responsibilities as a starting point. The draft patient flow and escalation policy also includes improved clarity of roles and expectations along with clear reference to the PRIDE values and effective communication	G
TW 7.1.2 Undertake team building exercise with the teams		G
TW 7.1.3 Conduct 360' appraisal with key staff	Agreed to postpone until other work has been completed - will identify specific timescales following sessions with ECIST	A

QIP Workstream Highlight Report

Domain
Well-Led

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 7.1: Improve the relationship and culture between the site management team and the Senior Nursing and Clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risks to patients and staff.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 7.1.4 Set up a regular facilitated forum for staff working within bed management processes to enable a regular dialogue and support the building of trusting relationships.	Weekly winter meetings taking place with regular divisional meetings to discuss issues etc. Weekly RCA/debrief Process agreed to commence from 1 November - appreciative inquiry approach to promote learning and discussion	G
TW 7.1.5 Embed the use of the SBAR tool with clear documentation.	Embedded into new RCA forms and promoting use via SAFER	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
7.1.3: Collation of feedback and supporting teams to constructively use outcomes whilst maintaining morale 7.1.4 Admin resource to collate/organise not yet identified 7.1.5 Training need – to be addressed via ECIST sessions initially until embedded	TW7.1.1 Will be underpinned by clearly documented guidance (SOPs/IPS)	• Support approach to use ECIST to facilitate intensively • Funding required to release sufficient 360 trained personnel to support rapid feedback

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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving outcome by submitted CQC completion date		% Evidence in repository
				Oct	Nov	
Jeremy Over	Amy Knights	Clarity regarding approach to staff engagement by 1 September with expected start of implementation of a Trust wide programme by 2 January 2019	2nd January 2019	G	G	0%

MUST DO Recommendation:	TW 8.1: Review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation
We will have achieved GOOD when:	• We have an updated whistleblowing policy and framework, implementing the recommendations of the King's Fund report • Evidence that concerns and speak up reports are reviewed and actioned as appropriate. • QAA and staff survey (KF31) evidence that all staff know how to raise concerns and would feel they could do so confidently.
Exec Summary:	Overall status is GREEN. Further to Leading with PRIDE events for 650 leaders, the new Communicating with PRIDE (Dignity at Work Framework) was launched 25 October. Communicating with PRIDE briefings scheduled throughout November targeted at all staff. The new Misconduct Policy (launched 3 September) has been well received by staff. Key role of Lead FTSU Guardian has been re-advertised to attract the right candidate for our hospital.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 8.1.1 Implement associated recommendations from King's Fund review	Senior leadership development programmes in place for Trust Board, HMB and Executive Team. Cultural development programme well advanced (see 8.1.2 below). External consultancy support secured to support development programmes.	G
TW 8.1.2 Review options for a Trust wide staff engagement programme that seeks to work with staff to improve the culture of the organisation.		

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QIP Workstream Highlight Report

Recommendation:	TW 8.1: Review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 8.1.3 When options have been considered, secure resources and support to deliver the programme. It is likely that external support will be needed and that any specification will develop measures etc.	• Workshop to co-create approach to bullying & poor behaviour took place on 9 August and informed the Leading with PRIDE events. • Leading with PRIDE events for 700 line managers (w/c 17/24 Sept) completed – positive response and feedback. • New Communicating with PRIDE (Dignity at Work Framework) launched on 25 October. Briefings for all staff scheduled throughout November.	G
TW 8.1.4 To review and refresh the Trust's approach to the delivery of the Freedom to Speak up Guidance, including appointment of a full-time Guardian, giving it a Trust Board profile and access directly through to Non Executive Directors - to undertake a wide campaign of "you said - we did" showcasing the outcomes of matters raised by staff.	Selection for the new Lead FTSU Guardian on 9 October did not result in an appointment. This key role has been re-advertised to ensure the right appointment for our hospital. Formal monthly reporting to HMB implemented (October) Board of Directors reviewed the NHSI / National Guardian Office self-assessment tool (September)	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Failure to embed and spread the cultural change from LwP	Sustainability plan being developed	

CEO work stream

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Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Mark Davies	Jeremy Over	1st March 2019	1st March 2019	G	G	0%

MUST DO Recommendation:	TW 9.1: Improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors. Improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS). Ensure that regular review of the executive portfolio takes place to ensure capacity and capability to deliver requirements.
We will have achieved GOOD when:	• External review of Board Effectiveness has been undertaken • Recommendations from the Board Effectiveness Review are implemented and evaluated
Exec Summary:	GREEN status overall; all actions are on track and should lead to outcomes that provide the necessary assurance that the recommendation has been addressed.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
TW 9.1.1 To design a Board Development Programme aimed at improving constructive debate and challenge within the Board and seeking to ensure the Board sets time aside to consider: How effective its meetings are and those of its sub-committees, the risk management strategy and approach within the Trust, the culture within the Trust and the approach toward becoming a continuously improving organisation seeking to provide outstanding care to patients, and how it best ensures that the voice of the patients and of its staff are central to decision making.	PwC commissioned following formal procurement process to undertake Board diagnostic exercise and propose a Board Development Programme and Plan. A draft report has been produced and feedback provided to inform the final version. An action plan will then be agreed and implemented. Executive Team Development Programme is in place. 3 events held thus far, most recent on 08 August 2018. Outputs from this event are being assimilated with a forward plan to be agreed. Next event scheduled for 14 January 2019.	G

QIP Workstream Highlight Report

Domain
Well-Led

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	TW 9.1: Improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors. Improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS). Ensure that regular review of the executive portfolio takes place to ensure capacity and capability to deliver requirements.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
TW 9.1.2 For each Executive Director to have an appraisal and clear objectives supported by a Personal Development Plan that would include access to Mentors/coaching as required.	Appraisal round being completed, will be complete by end of September. Documentation includes agreement of PDP including access to mentorship and coaching where appropriate.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Chief Information Officer work stream

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Anthony Lundrigan	Steve Kirk and Sarah Egleton	1st December 2018	31st March 2019	G	G	0%

MUST DO Recommendation:	18.1: Ensure that computers are locked and that patient healthcare records are stored securely.
We will have achieved GOOD when:	Patient records and trust computer equipment are secure and protected at all times.
Exec Summary:	Green as actions on track to deliver by deadline

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
TW 18.1.1 Review local notes storage facilities Trust wide	A site survey is being planned which will involve visiting all wards and OP areas to check that notes trollies are appropriately situated and lockable and that notes storage areas are appropriately secure. This site survey will be carried out by the Improvement Team and will be completed by the end of October. Lockable trollies will be ordered to replace any non-lockable ones that are identified, and areas of poor security will be highlighted and addressed. The audit be repeated bi-annually.	G
TW 18.1.3 Explore with IT screen locking timeout functionality of all computers in clinical areas.	The technical changes to enable screen locking have been configured, although not enabled as yet. The relevant policy documentation has also been updated and published. Resourcing issues and a security incident hindered the original implementation timeline of September. A phased implementation approach, due to clinical impact, will being on Monday 8th October, with the final implementation completed by the end of October. This timeline is subject to change pending the needs of the Trust and any major incidents which will divert resources.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

FUNCTIONAL / SPECIALTY AREAS

Outpatients

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NHS Foundation Trust

Domain
Well-Led

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Parker	Roberta Fuller	1st October 2018	31st December 2019	R	A	30%

SHOULD DO Recommendation:	Outpatients 1.1: Ongoing monitoring of the outpatient service, including the redevelopment of an outpatient dashboard.
We will have achieved GOOD when:	Improved outpatient services as evidenced by achievement of key performance targets in the Outpatient Dashboard
Exec Summary:	An Outpatient quality and productivity dashboard is underway.

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
O 1.1.1 Implement outpatient quality & productivity dashboard	A Quality and Productivity dashboard is under development and a draft has been prepared. Productivity measures have been defined and Information Services have developed a draft productivity dashboard in Power BI, which is awaiting Divisional approval. The Quality measures will be defined following development of Outpatient Professional Standards and an Outpatient Charter, both of which are in progress through the Outpatient Transformation Programme.	G
O 1.1.2 Monthly review of dashboard at Governance groups and via IPR at HMB and Trust Board	The reporting of an Outpatient Dashboard is not yet embedded in the IPR, pending further development of the Dashboard. Work is underway to review the reporting pack for the IPR.	A
O 1.1.3 Develop Outpatient Productivity Programme	(Was TW 27.1.1) Productivity dashboard is under development	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Diagnostic Imaging

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	Tracey Fleming	1st October 2018	31st December 2018	R	A	100%

MUST DO Recommendation:	DI 1.1: Ensure that observational audits of the quality of the WHO and five steps to safer surgery checklists are undertaken
We will have achieved GOOD when:	• Refer to recommendation S 3.1 • The WHO and five steps to safer surgery checklists are correctly completed and recorded for every procedure for which they are required. • Learning from checklist completion is disseminated across the organisation
Exec Summary:	Assurance is BLUE. A planned programme of audits is due to commence, with plans for reporting and acting on the findings in place.

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
DI 1.1.1 Design an observational audit tool	The observational audit tool for Radiology has been completed and is awaiting sign off as part of a wider policy review.	G
DI 1.1.2 Implement an observational audit programme	Observational audits are due to commence on 5th October.	G
DI 1.1.3 Provide regular reporting of output from both compliance and observational audits.	The first set of data will be available in November on the DCSS dashboard. It is intended to produce action plans from the findings	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	TBC	1st December 2018	31st December 2019	G	G	30%
MUST DO Recommendation:	DI 3.1: Ensure that the call bell system within nuclear medicine is fit for purpose.					
We will have achieved GOOD when:	Patients in nuclear medicine are able to alert staff for their need for help in an emergency.					
Exec Summary:	Assurance RAG is Green as the department are on track to procure a new call bell system and have a temporary measure in place in the meantime					

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
DI 3.1.1 Site survey of call bell system in Nuclear Medicine	A site survey has been completed between facilities and Radiology.	G
DI 3.1.2 Implement any required actions	A quote has been received. Revisions have been requested due to audibility issues. Temporary doorbell in place in the meantime.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	TBC	1st December 2018	1st December 2018	G	G	60%
MUST DO Recommendation:	DI 4.1: Ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the IRU					
We will have achieved GOOD when:	• An appropriate environment is maintained in the CT/MRI anaesthetic area.					
Exec Summary:	Assurance RAG is Green as clear actions have been taken to improve systems and processes for equipment storage, medicines management and infection control.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
DI 4.1.1 Robust review of current systems and processes for IPC and Medicines management with recommendations for improvement	Minor works requests submitted for all oxygen cylinder holders. Awaiting date for installation from Facilities. An inventory template has been provided by Pharmacy for drug cupboards and will be used on monthly walk-arounds with Pharmacy, which commenced w/c 10th Sept. A SOP has been written and published on Trust Docs for the management of infectious patients. Datix is being monitored to ensure compliance. Works to the GA bay are starting 8th Oct to improve the environment for patients.	G
DI 4.1.2 Site survey of equipment availability, storage and maintenance in IRU and CT anaesthetics with clear recommendations for improvement.	See DI 4.1.3 below.	G

Domain
Safe

Overall RAG Rating

Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	DI 4.1: Ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the IRU.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
DI 4.1.3 Implement a robust process of checking equipment in IRU area.	All equipment has been removed from the CT/MRI area and is brought by Theatre staff as and when required. Daily checks of oxygen and suction are being completed.	G
DI 4.1.4 Robust review of EME systems and processes for equipment PAT testing, planned preventative maintenance and replacement.	Regular QAAs were reintroduced from Sept in IRU which incorporate checks for all PAT testing and planned preventative maintenance and replacement.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	TBC	1st March 2019	31st March 2020	G	G	100%
SHOULD DO Recommendation:	DI 6.1: Ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme					
We will have achieved GOOD when:	• All diagnostic imaging equipment is fit for purpose, correctly maintained and replaced when necessary					
Exec Summary:	Assurance RAG is BLUE as systems and processes are in place for recording, checking and maintaining diagnostic imaging equipment and Business Continuity plans have been produced.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
DI 6.1.1 Site survey of equipment availability, storage and maintenance in DI.	A full asset register is in place with details of all equipment and schedule for replacement. The Trust is unable to financially resource a capital replacement programme, therefore a project is being commenced by the Director of Strategy with the Norfolk Imaging Alliance to organise a Norfolk-wide managed equipment service.	G
DI 6.1.2 Implement a robust process of checking equipment in DI areas.	All equipment has a service maintenance contract.	G
DI 6.1.3 Robust review of EME systems and processes for equipment PAT testing, planned preventative maintenance and replacement..	A Trust-wide rolling programme is in place to check equipment and undertake maintenance. Departmental Health & Safety inspection checklists are undertaken annually.	G

Domain: Safe

Overall RAG Rating: Overdue or not on track | At risk of delivery | On Track | Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	DI 6.1: Ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
DI 6.1.4 Robust business continuity plans are in place for managing equipment breakdown which impacts on service delivery.	All Business Continuity risk assessments were completed in August 2018 and include a Business Impact Assessment and escalation protocols.	B

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
The Trust's inability to financially resource a Capital Replacement Programme for diagnostic imaging equipment could mean that equipment does not get replaced appropriately and is not fit for purpose.	A project is being commenced by the Director of Strategy with the Norfolk Imaging Alliance to organise a Norfolk-wide managed equipment service.	

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Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Richard Goodwin	TBC	1st June 2019	31st March 2020	A	A	30%
SHOULD DO Recommendation:	DI 7.1: Ensure that diagnostic imaging services are provided on a 7 day basis, in line with national guidance					
We will have achieved GOOD when:	Scheduled seven-day access to diagnostic imaging services is available to inpatients					
Exec Summary:	Assurance RAG is Amber, as work has started on developing the department's ambition for 7 day services and business cases are in progress. However, implementation plans are not yet in place, business cases may not be approved and any required funding may not be available					

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
DI 7.1.1 Robust review of existing service provision with recommendations for improvement as part of the 7 day services work stream	The department is working alongside the Trust lead for 7 Day Services to review existing service provision and develop business cases for enhanced services. Mapping of existing services has been completed. The department is aiming to achieve the national clinical standards for 7 Day Services.	A
DI 7.1.2 Implement 7 day services within DI	A meeting is scheduled for mid November to discuss implementation of 7 day working within Radiology. Any proposals will then have to be discussed and agreed with the consultant body.	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Business cases will be required for enhanced service provision for 7 day services and may not be approved.	To work closely with Trust lead for 7 day services and the Finance department to attempt to resolve.	

Surgery

Domain
Well-Led

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Tim Leary	Michael Irvine	1st May 2019	1st May 2019	A	A	10%

MUST DO Recommendation:	S 1.1: The Trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.
We will have achieved GOOD when:	• Standard operating procedures in place to support consistent approach and accountability from the senior leads across the theatre specialities • An appropriate leadership structure is in place with additional leadership roles of Senior Matron and Operational Manager for Anaesthetics and Theatres within Surgical Division • Theatre OWL (per Specialty) is disseminated monthly by Theatre Governance Facilitator • The Speak Up Guardian role is promoted in theatres • Theatre Safety Huddle in place • All clinical staff groups that work in theatre will have attended Human Factors training to improve communication/team work
Exec Summary:	Overall RAG status amber due to risk of lack of staff engagement. Actions to support staff engagement are attendance and participation at the away day on the 8th November.

Open Actions (Page 1 of 3)	Progress Update and Next Steps	Action RAG
S 1.1.1 Appoint a Chief of Service for theatres	Chief of Service appointed and commenced in post 24th September 2018 – evidence to be provided.	G
S 1.1.3 Create Speak Up Guardian role in theatres	Target completion date: 30/11/18 Currently not in place – discussions are taking place with Director of Workforce.	A

Highlight Report to: NOVEMBER QPB

Recommendation:	S 1.1: The Trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.

Open Actions (Page 2 of 3)	Progress Update and Next Steps	Action RAG
S 1.1.4 Develop theatre professional standards	Target completion date: 30/11/18. Development of Theatre standards currently in progress to be reviewed upon completion by theatre triumvirate and shared with Theatre Management group, before sign off by Divisional Board at the November meeting.	G
S 1.1.5 Develop leadership competency framework that links with Trust wide leadership work	Target completion date: 28/02/19. Competency framework to be in line with trust-wide framework.	G
S 1.1.6 Ensure Divisional Triumvirate representation at Theatre Safety Huddle	Target completion date: 31/12/18. Monthly Safety Huddles to commence on Governance mornings these will be attended by the Divisional Nurse Director. Notes of the meeting will be available for department to display in a 'You said, we did' format.	A
S 1.1.7 Embed PRIDE values within the Division	Target completion date: 28/02/19 • Leading with PRIDE workshops have been carried out in September 2018 • Coaching sessions / encouraging behaviour already established for specific staff members • Trust-wide monthly PRIDE awards in place to celebrate staff behaviour	A
S 1.1.9 Surgical teams to do Human Factors training to improve communication/team work.	Target completion date: 31/03/19. Currently 148 theatre & critical care staff have received the training along with 6 Anaesthetists. Train the Trainer sessions were completed week of 24th September so that in-house courses for all staff who work in theatres can attend.	A

Highlight Report to: NOVEMBER QPB

Recommendation:	S 1.1: The Trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.	
Open Actions (Page 3 of 3)	**Progress Update and Next Steps**	**Action RAG**
S 1.1.10 Develop organisational development programme across the Division.	Target completion date: 31/12/18. External support in place to develop Divisional Strategy & Organisational Development programme. Divisional board away day booked for 8th November. Work has taken place with Upper GI surgical team and Paediatric surgical team for specific workstreams.	G
S 1.1.12 Ensure leadership team and structure in place (action transferred from S1.2)	Operational Manager for Anaesthetics and Theatres created within Surgical Division and interviews have taken place with outcome pending. Senior Matron post has been advertised with no applicants so plan to temporarily "act up" a Matron from the division	G
Risks/Issues	**Mitigating Actions**	**Escalation & Decisions for QPB**
Surgeon buy-in to human factors training		

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Tim Leary	Heather Watts	1st March 2019	1st March 2019	A	A	5%

MUST DO Recommendation:	S 2.1 The Trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.
We will have achieved GOOD when:	• Theatre governance meetings and theatre governance lead role established • Theatre OWL (per Specialty) highlighting risk - disseminated monthly by Theatre Governance Facilitator • Consistent approach across all directorates is evident at Directorate Governance Leads Meetings • Appropriate leadership structure in place with additional leadership roles of Senior Matron and Operational Manager for Anaesthetics and Theatres within Surgical Division • Identified risks acted on appropriately or in a timely manner with supporting actions in place
Exec Summary:	Overall RAG status amber as Divisional governance assurance processes are still currently under review and further actions are planned for November to support achievement of target completion date.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
S 2.1.2 Review reporting structure within Division	Target completion date: 31/10/18 Division-wide Governance review ongoing Directorate Governance Leads Meetings – Governance team reviewing agendas and minutes across all directorates to ensure aligned approach.	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	S 2.1 The Trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
S 2.1.3 Undertake robust Governance review to ensure that information maps through ('Ward to Board' and 'Board to Ward') within the Surgical Division and Theatres	Target completion date: 30/9/18 Review of the governance framework within the division is ongoing awaiting responses from some Directorates.	R
S 2.1.4 For all Directorates to review performance data, risks, adverse incident intelligence and progress against actions in their governance meetings and that this is clearly documented in the standardised minutes template and action log	Target completion date: 30/9/18 • Review of directorate meeting template is taking place • Monthly meeting for check and challenge Actions for November: • Template is still to be agreed in the division • Division to be informed that the standard agenda template should be used and have policy in place for management of governance processes • TORs to be in place for all directorates • Report to be presented to the directorate including speciality IPR	R

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Tim Leary	Heather Watts	1st March 2019	1st March 2019	A	G	10%

MUST DO Recommendation:	S 3.1: The Trust must ensure that the WHO and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice
We will have achieved GOOD when:	• Audit data and learning outcomes are displayed in the department and discussed in Theatre management group • Observational and compliance audit programme in place • Regular reporting of output from both compliance and observational audits is provided • All specialties / departments and divisions review learning from incidents and other forms of intelligence in their governance meetings and this is clearly documented in the standardised minutes template and action log
Exec Summary:	Overall RAG status amber. Audit programme is in place however further work is required regarding breakdown of results.

Open Actions (Page 1 of 3)	Progress Update and Next Steps	Action RAG
S 3.1.1 Review observational audit tool	Observational audit tool in place and with monthly results available.	G
S 3.1.2 Review compliance audit tool	Compliance audit tool reviewed and in place. SOP signed off at TMG to be signed off at Divisional Board November 2018. Target completion date 30/11/18 reflects sign off at TMG.	A

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	S 3.1: The Trust must ensure that the WHO and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.

Open Actions (Page 2 of 3)	Progress Update and Next Steps	Action RAG
S 3.1.3 Refresh observational and compliance audit programme	Audit programme in place to record information from 1st September.	G
S 3.1.4 Provide regular reporting of output from both compliance and observational audits	Reports available through Theatre Management Group.	G
S 3.1.5 All specialties / departments and divisions to review learning from incidents and other forms of intelligence in their governance meetings and that this is clearly documented in the standardised minutes template and action log	Linked to 2.1.4. Target completion date: 30/9/18 Review of directorate meeting template taking place.	R
S 3.1.8 Set up working group to independently audit WHO process as a baseline	Target completion date: 30/9/18. New WHO safety checklist being used. Request for volunteers has been completed and programme is being produced for implementation Nov.	R
S 3.1.9 Audit data and learning outcomes to be displayed in department and discussed in Theatre management group	Audit data and learning outcomes are displayed in department and discussed in Theatre management group. Evidence to be provided.	G
S 3.1.10 Add to agenda for discussion in Departmental Governance meeting	To be added to governance meeting template. Evidence to be provided.	G

Highlight Report to: NOVEMBER QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	S 3.1: The Trust must ensure that the WHO and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.

Risks/Issues (Page 3 of 3)	Mitigating Actions	Escalation & Decisions for QPB

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Tim Leary	Anthony Mutti	1st October 2018	30th March 2019	R	A	0%

SHOULD DO Recommendation:	S 4.1: The trust should ensure that theatre staff adhere to the dress code policy.
We will have achieved GOOD when:	• The theatre dress code policy has been reviewed and updated, where appropriate. • All theatre staff are aware of and adhere to the policy • A regular audit of compliance of dress code in theatres and feedback process is in place
Exec Summary:	Assurance is amber work is ongoing to review the Trustwide dress code policy which includes the theatre dress code policy as an appendix.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
S 4.1.1 Set up working group and review theatre dress code policy which should include when the wearing of theatre scrubs outside of the theatre environment is appropriate	Theatre policy to be written by end of December by Theatre Management Group and will include the theatre dress code policy. Senior Matron body is reviewing Trust wide dress code policy which will include the wearing of scrubs in areas outside of theatres. Target completion date updated to 31/12/18 to reflect above.	A
S 4.1.3 Agree improvement trajectory based on results of compliance audit of dress code in theatres	Trajectory will be based on results of the compliance audit of dress code in theatres (S 4.1.4)	A
S 4.1.4 Regular audit of compliance of dress code in theatres	Audit tool to be produced following working group discussion and baseline audit.	A

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Recommendation:	S 4.1: The trust should ensure that theatre staff adhere to the dress code policy.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
S 4.1.5 Review changing and locker facilities in theatres	Target completion date: 30/11/18 – completed	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Urgent & Emergency Care

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Maggie Pacheco/ Tarek Kherbeck	1st October 2018	1st October 2019	R	A	10%

MUST DO Recommendation:	U 4.1 & 4.2: Review nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly..
We will have achieved GOOD when:	• The medical and nursing numbers within ED reflect the acuity and volume of patients. Allowing all shifts to be equally busy and the ability for 95% of patients to be discharged, transferred or admitted within 4 hours when all policies and procedures are followed. • There is evidence that staff follow policy on weekend and night shifts
Exec Summary:	Even with increased recruitment activity the staffing level is not predicted to be at establishment for 12 months.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
U 4.1.1 Comprehensive staffing review of emergency and urgent care to include the exploration of different roles to support frontline care delivery.	The Nursing staff in ED are being grouped into teams that will work the same shift patterns to build team dynamics. The acuity and activity review is underway and nursing is being matched to the demands of the department. This activity will be completed w/c 28/10/2018 and introduced into Rotas from February 2019. There is now funding for 2 practice development nurses, with the second starting in January 2019. An additional Matron Post for ED has also been agreed for 6 months. The roles will broadly be split between major/resus/RATs and minors/paeds/UCC.	G
U 4.1.2 Agree and fund a revised staffing establishment that is fit for purpose and supports a flexible acuity demand		G

Highlight Report to: NOVEMBER QPB

MUST DO Recommendation:	U 4.1 & 4.2: Review nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly..

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 4.1.2 Cont.	2 ED consultants and the operational manager are reviewing the Medical rotas numbers and demand templates. With numbers and shifts being mapping to demand. The Staff allocation has been changed to reflect this including an additional Doctor in paeds for evenings and an extra medic overnight. Tier 2 Doctors are being pre-allocated to different areas in advance on the daily rota (included in the evidence repository). There is a meeting between ED consultants, operational manager and Medical staffing weekly to identify any gaps and how they can be filled.	G
U 4.1.3 Agree a recruitment plan with achievement trajectory.	A realistic recruitment plan based on current trends has been put into place which with current interventions sees our RN vacancies reduce from 37.14WTE to 0.3WTE In October 2019. This plan needs to be agreed by the directorate.	A
U 4.2.1 Scope the resource required to ensure that an appropriate acuity system is supported and embedded		G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
If the Trust is unable to recruit staff to match the new workforce plan then the departments may not be able to deliver the plan in full.		

Highlight Report to: NOVEMBER QPB

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Claire Gowland/ Ed Aldus	1st August 2018	1st August 2019	R	A	10%

MUST DO Recommendation:	U 9.1 – 9.3: Improve performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in ED.
We will have achieved GOOD when:	ED is meeting all access targets that are either contractual or recommended by the College of Emergency Physicians including: • Percentage of Patients admitted, transferred or discharged within four hours • Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted. • Number of patients waiting more than 12 hours from decision to admit until being admitted • Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment. • Median total time in A&E per patient
Exec Summary:	The Trust has not yet recovered its position again the performance times.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
U 9.1.1 Robust review of current systems and processes used to record and manage performance data to ensure that definitions used are compliant with national recommendations and are clearly understood by all staff	Complete	B
U 9.1.2 Embed the RATS process.		A

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QIP Workstream Highlight Report

Domain
Responsive

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	U 9.1 – 9.3: Improve performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in ED.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 9.1.3 Review the quality of the data recorded and make recommendations to improve if required.		G
U 9.1.4 Ensure that IT systems used are fit for purpose, are easy to use and have functionality to easily extract management reports.	See 2.1.6	A
U 9.1.5 Set improvement trajectory	Complete	B
U 9.1.6 Systematically analyse each breach to target to understand reasons, identify themes, blocks and improvement actions.	Weekly breach analysis meeting in place, feeding into divisional board for identification of blocks and actions.	G
U 9.1.7 Improve the performance against Median Arrival to Treatment to meet the Royal college of Emergency recommendation of 60 minutes.	August performance was 88 minutes. September performance was 86 minutes. October (to the 28th) was 79	R
U9.1.8 Improve the performance against the national standard of 95% ED patients being admitted or discharged within 4 hours.	August performance was 87.7% September performance was 86.3%. October (to the 28th) was 89.5%.	A
U9.1.9 Improve the performance of the Median total time in ED	August performance was 168 minutes. September performance was 175 minutes. October (to the 28th) was 163	R

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Diego Olmo-Ferrer	1st September 2018	1st December 2018	R	A	0%
SHOULD DO Recommendation:	U 12.1: The Trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services					
We will have achieved GOOD when:	• Morbidity and mortality are discussed in a meeting either within another meeting or a separate meeting. • This meeting is fully minuted. • The learning and lessons from these are reported to the divisional and trust wide meetings to share practice.					
Exec Summary:	All actions have been undertaken to ensure these meetings will take place regularly into the future.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
U 12.1.1 Schedule regular M&M meetings in urgent and emergency care.	Discussed within Clinical Governance meetings monthly until May 2018. Quarterly M&M-only meetings are in place, with the first to take place in November 2018	A
U 12.1.2 Identify a clinical lead for mortality	Complete	G
U 12.1.3 Provide sufficient support to enable the robust administration of the meeting.	Complete	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

MUST DO Recommendation:	U 12.1: The Trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 12.1.4 Discuss output from specialty M&M to the Divisional Governance group and Trust Mortality group to ensure learning is shared.	First meeting to take place in November 2019.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

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Domain
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Overall RAG Rating			
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Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Tarek Kherbeck/ Jo Walmsley	1st November 2018	1st October 2019	A	A	30%

MUST DO Recommendation:	U 2.1: Ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. Review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.
We will have achieved GOOD when:	• The RAT column on symphony is used consistently or replaced with another system of identifying RATs patients and their outcomes. • All appropriate patients go through the RATs process in its operational hours or when a RATs staff member is working.
Exec Summary:	The full RATs build is not due to begin until March 2019, a series of temporary solutions have been put into place to enable a service to be provided. It is expected that once the temporary building is in place more embedded practice can be instigated.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
U 2.1.1 Align staffing in the multidisciplinary teams, in the ED and across the Assessment Units to meet demand	The Nursing staff in ED are being grouped into teams that will work the same shift patterns to build team dynamics. All Improving Working lives forms have been reviewed and the number of shift types and start times has been reduced across the department. The acuity and activity review is underway and nursing is being matched to Junior and consultant in RATs dependant on staffing	G
U 2.1.2 Review efficacy of clinical pathways to ensure patients are able to move out of the ED as soon as their emergency care needs have been met	Weekly breach analysis meeting of ED triumvirate to identify reasons for breaches broken down according to ED delays, specialty review, bed delays. To feed into medical divisional board for onward dissemination and learning. Breaches reviewed by Medical lead last week, will be in place with tri from 5th November.	A

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QIP Workstream Highlight Report

Recommendation:	U 2.1: Ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. Review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 2.1.3 i) Continue to embed consultant-led Rapid Access and Treatment Service (RATS) in designated cubicles ii) Audit compliance	RATs temporary build expected to be completed 14th of December, with handover and opening to happen w/c 17th December. Plans for unit included in evidence repository. When this area opens in it's temporary home the ED will remove the obs room function and move the current RATs staffing to man the unit. The permanent build is expected to begin in March 2019. Rota 9-5 but mostly doing till 7pm sometimes till nine. With 1-9 consultant. Weekends 5 or 7 not 9. Dependant on exit block and staffing	A
U 2.1.5 Design Urgent and emergency care dashboard to ensure that regular, robust information reporting on National and local KPI's is available for teams and the Trust Board.	PowerBI with IS	G
U 2.1.6 Review IT hardware and software systems to ensure that they fit for purpose and support recommended changes in practice.	Symphony upgrade expected November	A
U 2.1.7 Review of staffing skill mix and roles to ensure that there is sufficient capability and capacity to deliver the required level of care.	See U 2.1.1 Review of staffing doctors, due to Portakabin. Due to vacancies not able to fill full rota. Currently the tier 2 roles are filled with junior staff who are unable to do all roles as some areas need tier 4-5 and some need tier 3. Staffing rota in place from December.	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
If the Trust is unable to recruit staff to match the new workforce plan then the departments may not be able to deliver the plan in full.		

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Maggie Pacheco	5.1 – 1st October 2018 6.1 – 1st December 2018	1st October 2019	A	A	10%

MUST DO Recommendation:	U 5.1 & 6.1: ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed. Ensure a good skill mix within the children's ED nursing workforce.
We will have achieved GOOD when:	• A children's nurse is available 24/7 within Children's ED in a sustainable manner. This will be noted on roster and also in QAA a paediatric nurse will also be available. • There is a nursing establishment that reflects the Children's ED SOP recommended levels. With shifts rostered to ensure appropriate seniority of staff on shifts.
Exec Summary:	Action is Amber due to risk in recruitment. There are currently not enough paediatric nurses within ED to cover 24/7 as there are only 5WTE therefore steps have been taken to use staff from bank, additional hours from ChED team, CAU or Buxton either through filling vacant shifts, borrowing or swapping ED staff for paediatric trained staff.

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
U 5.1.1 Comprehensive staffing review including skill mix, of all areas with the Trust that care for Children against national staffing guidance.	The Nursing staff in ED are being grouped into teams that will work the same shift patterns to build team dynamics. All Improving Working lives forms have been reviewed and the number of shift types and start times has been reduced across the department. The acuity and activity review is underway and nursing is being matched to the demands of the department.	A
U 5.1.2 Agree and fund a revised staffing establishment that is fit for purpose and supports a flexible acuity demand and reflects intercollegiate standards		G

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Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

QIP Workstream Highlight Report

Recommendation:	U 5.1 & 6.1: Ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed. Ensure a good skill mix within the children's ED nursing workforce.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 5.1.3 Agree a focussed recruitment drive and agree achievement trajectory.	Medical staffing will have a signed agreement from 2nd October to rotate our doctors out into the Air ambulance rota. This will make us very unusual and attractive to potential recruits. Dedicated HR support in ED.	A
U 6.1.1 Comprehensive staffing review including skill mix, of all areas with the Trust that care for Children against national staffing guidance.	The updated college guidelines indicate 2 paediatric trained members of staff should be available on every shift. The Trust is reviewing it's Paediatric nursing strategy and how numbers can be increased as there is a national shortage of these nurses.	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
If the Trust is unable to recruit staff to match the new workforce plan then the departments may not be able to deliver the plan in full. Change in guidance means that we now need 2 paediatric trained rather than 1 as per must do list.		

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Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Jane Evans/ Maggie Pacheco	31st March 2019	31st March 2019	A	A	20%

MUST DO Recommendation:	U 7.1: Ensure audio and visual separation between adults and children being assessed and waiting within the ED and minor injuries unit.
We will have achieved GOOD when:	There are suitable sized facilities for Children to ensure that they can always wait and be treated in a paediatric only environment other than those requiring resuscitation. Children should not have to walk through adult treatment areas to access paediatric areas.
Exec Summary:	This was marked as Blue last month however further information has been presented where we could improve the audio and visual separation between adults and children

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
U 7.1.1 Review current progress against agreed expansion plans and agree a completion trajectory.	Complete	B
U 7.1.2 Ensure that a Children's HDU is included within the Children's ED environment	Complete	B
U 7.1.3 Design a SOP to provide separation during transfers in and out of ChED	An SOP has been written and is currently being reviewed and agreed	A

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Francoise Sheppard	1st September 2018	31st March 2019	R	A	50%
MUST DO Recommendation:	U 11.1: Ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.					
We will have achieved GOOD when:	All audit plans are complete including the dates. That audit samples are appropriate and not too low and all audits have associated action plans. All audits with action plans have a date of repeat audit planned.					
Exec Summary:	Assurance is BLUE. Audit actions have been put into place.					

Open Actions (Page 1 of 2)	Progress Update and Next Steps	Action RAG
U 11.1.1 Review local audit plan to ensure that it covers a range of subjects that align with service objectives and that give the Trust assurance that care is meeting required standards.	Complete	B
U 11.1.2 Appoint a clinical audit lead for Urgent and emergency care to ensure that the audit plan is delivered	Complete	B
U 11.1.3 Ensure that audit output and recommendations are discussed at monthly Governance meetings	Complete	B
U 11.1.4 Ensure that audit recommendations inform a local quality improvement work plan that meets the objectives of the service	Complete	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

MUST DO Recommendation:	U 11.1: Ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.

Open Actions (Page 2 of 2)	Progress Update and Next Steps	Action RAG
U 11.1.5 Undertake improvement work and share learning within the Division and Trust.	Complete	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
Shared entrance to ED for adults and children		

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Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: NOVEMBER QPB

Exec SRO:	Delivery Lead:	Completion date per submitted CQC plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Oct	Nov	
Frankie Swords	Maggie Pacheco	1st December 2018	2nd January 2019	G	A	0%

SHOULD DO Recommendation:	U 14.1: Ensure that sepsis training is available to all staff providing urgent and emergency care
We will have achieved GOOD when:	• All staff have a record of receiving Sepsis training and a standard programme of training is available to deliver the training. • QAA all staff are able to discuss how to identify and treat a patient with suspected sepsis
Exec Summary:	Green as training is in place and on target

Open Actions (Page 1 of 1)	Progress Update and Next Steps	Action RAG
U 14.1.1 Review current training provision	Training plan in place to ensure all mentor groups have received training by November 2018 (8 in September, 4 in October and the remainder in November). Unfortunately not all of these sessions have taken place. It is estimated that 1/3 of all staff will have been trained by 1/12/18 with further training taking place in December.	A
U 14.1.2 Review delivery, methods of courses to understand if alternative approaches could be utilised.	Sarah Wratten the Trust Sepsis lead nurse is working with the ED department Lead Nicola Smith to adapt the Sepsis training programme to be focussed on ED.	G
U 14.1.3 Agree delivery plan (Risk stratified) and set achievement trajectory.	Please see 14.1.1	G
U 14.1.4 Increase ED Sepsis training compliance	Action added to record metrics	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Closed actions

Closed actions

Recommendation	Action	Status
TW 2.1.12 Review existing temporary role of Matron and Named Doctor for MCA and DoLs	TW 2.1.12 Review existing temporary role of Matron and Named Doctor for MCA and DoLs TW 2.1.13 Identify a clinical champion for MCA & DOLS in each Division	Substantive matron appointed Named Doctor identified Work ongoing to identify divisional clinical champions
TW 4a.1: The trust must ensure that there is an effective process for quality improvement and risk management in all departments	TW 4a.1.2 Build a QI faculty to include Improvement coaches, data analysts, training packages and provide support & facilitation to teams to deliver QI projects linked to leadership development & achievement of Trust objectives TW 4a.1.3 Maintain a central record of QI projects mapped to department / division & strategic objectives TW 4a.1.4 Build / source a reporting system to enable teams to clearly demonstrate improvements TW 4a.1.5 Develop a robust plan for spread & sustainability through the QI faculty TW 4a.1.6 Create a QI faculty	The original action is a longer term goal and will span a period of three to five years and will form part of stage 2. Once the QI strategy and implementation plan are agreed there will be a mobilisation plan. Moved to Stage 2 of plan Moved to Stage 2 of plan Moved to Stage 2 of plan Moved to Stage 2 of plan

Closed actions

Recommendation	Action	Status
TW 5.1 The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.	TW 5.1.3 Effective and timely implementation of clinical audit outcomes will be reviewed at Divisional Management Board meetings	Combined with TW5.1.2
TW 13.1: Ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated	TW 13.1.4 Internal self assessment against IPC Governance processes and action taken in accordance with findings	Action closed covered in action plan arising from 13.1.1
TW 16.1The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed	TW 16.1.1 Trust thrombosis lead to review Trust Policy to ensure VTE risk assessment requirements for ambulatory patients is explicit. TW 16.1.4 Monitor compliance monthly to include analysis of individual performance	No mention of VTE assessment of ambulatory patients can be found in the CQC documentation. Covered by other actions
TW 19.1: The trust must ensure that the healthcare records for patients' (requiring assessment for restrictive intervention) *subject to restraint* are complete and in line with the trust's policy and procedure.	TW 19.1.2 Review current documentation and risk assessment in use to determine whether it is easy to use and fit for purpose	Action closed

Closed actions

Recommendation	Action	Status
TW 20.1: The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care. This will integrate the 'Patient Voice'	New action: Patient Experience and Engagement team co designs service improvements with patients and carers	Moved to Stage 2 of plan
TW 22.1 Review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	TW 22.1.6 External review of progress to date since CQC recommendations of 2015.	Move to stage 2 plan DNACPR improvements presented to OAG September 18.
TW 23.1: The trust must ensure that incidents are reported and investigated in a timely way by trained investigators.	TW 23.1.6 Ensure learning is shared via Governance groups and outpatient forum.	Action closed. Part of SIG work. Learning will be shared via Safety Matters Wise OWLs.
TW 27.1: The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	TW 27.1.1 Develop Outpatient Productivity Programme TW 27.1.4 Deliver the Remedial Action Plan for RTT as agreed with CCGs	Added as new action to Outpatients section Moved to Stage 2 Plan
TW 30.1: Ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.	TW 30.1.3 Discuss output from specialty M&M to the Divisional Governance group and Trust Mortality group to ensure learning is shared.	Moved to stage 2 plan

Closed actions

Recommendation	Action	Status
TW 29.1: The Trust should ensure that complaints are responded to in line with the complaints policy deadline of 25 working days	TW 29.1.1 Trust review of Complaints policy and reporting	Action complete
	TW 29.1.2 Review current processes in place with recommendations for improvement and escalation	Action complete
	TW 29.1.3 Implement recommendation	Action closed
	TW 29.1.4 Regular audit of compliance	Action complete
	TW 29.1.5 Agree improvement trajectory	Action complete
TW 32.1: The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.	TW 32.1.2 Review e-rostering policy	Action removed covered in e-Roster project
TW 36.1: The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss	TW 36.1.3 Procure required equipment	Moved to Stage 2 of plan
	TW 36.1.4 Review process of enhanced care provision Trust wide via Mental Health Board	Action removed covered in MH section

Closed actions

Recommendation	Action	Status
S 1.1: The Trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.	S 1.1.2 Embed theatre governance processes S 1.1.8 Source, obtain funding and support then complete culture survey (SCORE) within Theatres S 1.1.11 Put processes in place for regular culture survey.	Remove action - Covered in S 2.1 Moved to Stage 2 of plan Moved to Stage 2 of plan
S 2.1: The trust must ensure patients are treated with dignity & respect at all times.	S 2.1.1 Ensure leadership team and structure in place	Move to 1.1
S 3.1: The Trust must ensure that the WHO and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.	3.1.6 Surgical teams to do Human Factors training to improve communication/team work 3.1.7 SCORE survey	Action removed as covered in S1.1.9 Action removed as covered in S1.1.8.
S 4.1: The trust should ensure that theatre staff adhere to the dress code policy.	S 4.1.2 Complete baseline assessment of non theatre environments across the Division for smart scrubs and/or junior doctor provision of specific coloured scrubs	Remove - wider QIP plan

Closed actions

Recommendation	Action	Status
U 1.1 & 8.1: The Trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children & adults. The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.	U1.1.5 Share Learning with Trust Resus committee and review if ligature cutters should be available in all resus trolleys U 1.1.6 Audit completion of resus trolley checks in all ED areas	Moved to Stage 2 of plan Moved to Stage 2 of plan
U 2.1: Ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. Review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.	U 2.1.4 CoDs to ensure specialty teams are able to meet Internal Professional Standards	Moved to Stage 2 of plan
U 10.1: Ensure there is a medical lead appointed for the service	U 10.1.2 Provide structured support for the new Medical Lead. U 10.1.3 Undertake a training needs analysis to inform a leadership and management training programme to enable them to have the capability and capacity to undertake the role effectively.	Moved to Stage 2 of plan Moved to Stage 2 of plan