The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

**NHOSC Report**
**The Quality Improvement Plan Progress Update: January 2019**

## Quality Improvement Programme

### Background and Context

The Care Quality Commission (CQC) report published on 13th September 2018, confirmed the Trust's rating of 'Inadequate' and NHS Improvement (NHSi) placed the Trust in Special Measures, with the appointment of an Improvement Director: Philippa Slinger.

To effectively deliver the 'Must' and 'Should Do' actions outlined in the CQC report, a Quality Improvement Programme was established and a Quality Improvement Plan (QIP) developed. The Trust appointed Louise Notley; Associate Director of Quality Improvement as it's Programme Director.

### Quality Improvement Plan (QIP)

The QIP is split into 5 workstreams, each with an Executive Lead, accountable for the delivery of the required improvement actions. The Musts and Shoulds have been aligned to the respective workstreams and themed where duplicate actions have been identified.

### Workstreams and Executive Leads

| Trust Quality Improvement Plan (QIP) | | | | |
|---|---|---|---|---|
| **People** | **Caring Safely** | **Environment** | **Performance** | **Governance & Learning** |
| **Exec Lead Karen Charman** | **Exec Lead Emma Hardwick** | **Exec Lead Roy Jackson** | **Exec Lead Jon Wade** | **Exec Lead Nick Lyons** |

Based on these workstreams, a 'high level' Quality Improvement Plan (QIP) has been developed which details the actions the Trust has agreed to undertake to address both the immediate actions and some longer term quality improvement actions. The plan also includes the Section 29A Warning Notice from May 2018 and the subsequent actions following the Maternity Section 31 Enforcement Notice.

The need to immediately address regulatory compliance breaches has generated a QIP which is largely transactional in its delivery. Whilst it is recognised this approach is required during the early stages of our improvement journey, it is essential that staff and patients play a central role in the development and delivery of the quality improvement programme going forwards. The QIP therefore recognises the need to develop a Quality Improvement Strategy to support a culture of continual quality improvement and learning in the organisation.

A Quality Improvement Team has been established led by the Associate Director of Quality Improvement and currently supported by an existing Quality Project Manager and three interim Quality Improvement Managers. The Quality Improvement Managers are aligned to specific workstreams and its respective accountable Executive. The Trust is in the process of recruiting three Quality Improvement Managers to replace the interim staff in place, for a

fixed period of eighteen months to support the Trust's immediate and longer-term quality improvements and initiatives and the required cultural change which is an essential component of the Trust's work to engage with staff and sustain change. The aim is to complete the recruitment phase of this process by mid-January 2019 with all three staff in post by March 2019, depending on negotiated notice periods.

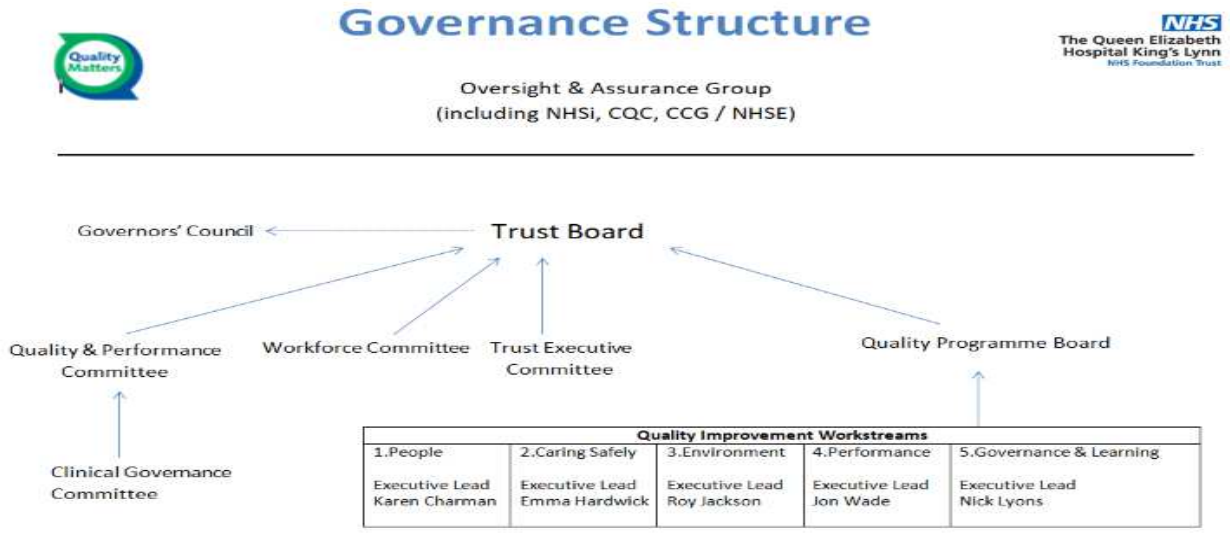
**Governance Arrangements**

The governance and reporting arrangements for the Quality Improvement Programme have been finalised and are fully operationalised. This includes the establishment of a Quality Improvement Evidence Group with staff, patient and CCG representatives to review the evidence of actions submitted as complete.

As work has commenced progressing the QIP and exploring actions in detail, there has been a need to alter a number of action owners and deadline dates where it has been identified that the issue is more complex than first thought or that more detailed work is required to effectively address the Must or Should action. In turn, it is anticipated that a number of actions will need to be added to ensure that the impact of actions are evaluated. A Change Control Process, adopted from the NNUHT, has been established to ensure there is a clear audit trail of any changes and provides complete transparency of changes to the original QIP.

A Metrics Dashboard is under development which will capture and track the monthly outcome metrics of specific improvement actions such as Mandatory and Cardiotocography (CTG) training (a Section 31 Action). An early draft of this dashboard was presented to the Quality Programme Board (QPB) in December with the launch of the dashboard planned for the January QPB. The dashboard will evolve with the QIP.

**Governance Structure for the Quality Improvement Programme.**




**Unannounced CQC Inspection Maternity December 2018**

There was an unannounced CQC Inspection on the 4th December to review the Section 31 conditions and progress against Section 29A for Maternity Services.

The Trust is awaiting formal feedback.

Initial verbal feedback:

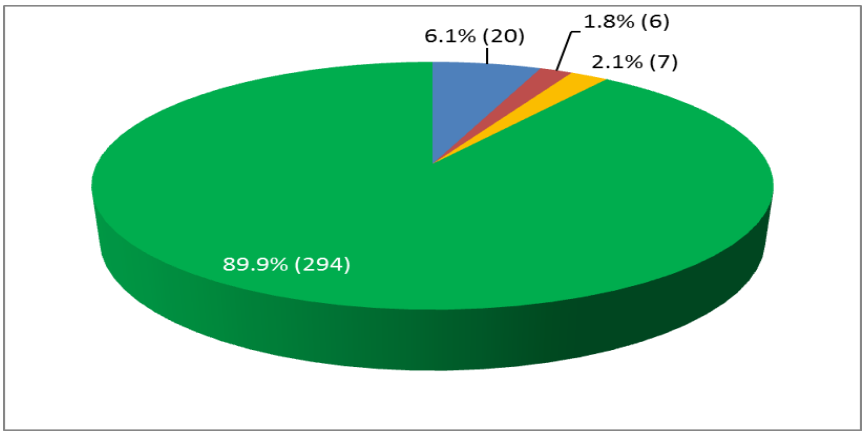
- A positive visit – 'palpable difference'
- Evidence of improvements provided a level of assurance
- The strengthening of leadership within the department is making a difference
- Progress must be sustained to ensure improvements embedded in practice

There remains continued support with onsite visits from NHSI Maternity Advisors and improvement work to progress the actions within the QIP continues.

**Combined QIP Workstreams Progress Report as Presented to Quality Programme Board December 2018**

**ASSURANCE - all workstreams**

**(December)**




**ACTION BRAG STATUS (current month)**

| Red | Amber | Green | Blue |
|---|---|---|---|
| 6 | 7 | 294 | 20 |
| 1.6 % | 2.1% | 89.9% | 6.1% |

**BRAG Status and Definitions**

A comprehensive and productive discussion was held by members of the QPB on 6th December regarding the BRAG status of actions following recalibration of the QIP. As part of this discussion there was concern that the current workstream highlight reports do not accurately reflect actions with an 'inherent risk', or where there is 'a risk of effective delivery' and that Blue ratings do not accurately reflect improvement actions which are complete, evidenced and where there is assurance that the required outcome has been achieved and embedded.

Following a detailed discussion, the QPB agreed to amend the AMBER and BLUE BRAG definitions, to ensure that they accurately reflect that the progress of quality improvement actions is having the desired impact, addressing both the original concern and providing the required level of assurance that actions have improved the quality of care patients receive.

Clarity to the BLUE and AMBER BRAG definitions agreed:

- AMBER – 'inherent risk or risk to effective delivery'
- BLUE – 'complete, evidenced, required outcome assured / sustained'

It is anticipated that a number of GREEN actions within each workstream will move to BRAG status of AMBER in the January QPB report to accurately reflect the level of inherent risk within the action, or risk of its effective delivery. It is also anticipated that a number of BLUE actions will move to a BRAG status of GREEN to accurately reflect work completed and evidenced, but where evidence that actions are embedded in practice is still required.

## BRAG Status Definition Revision

**Table 1**

| Original QIP BRAG Status | |
|---|---|
| Blue | Completed and Evidenced |
| Red | Overdue |
| Amber | At Risk of Delivery |
| Green | On Track |

**Table 2**

| Revised QIP BRAG Status | |
|---|---|
| Blue | Complete, Evidenced and Required Outcome Assured / Sustained |
| Red | Overdue |
| Amber | Inherent Risk or Risk of Effective Delivery |
| Green | On Track |

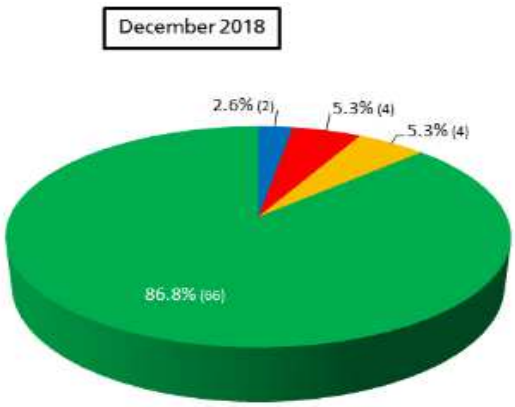
It was agreed at the QPB that these revised BRAG definitions will be applied to individual workstream highlight reports as of **January 2019** for reporting to the January QPB and Oversight and Assurance Groups (OAG). Therefore the workstream highlight reports captured in this report, reflect the action status of the original BRAG definitions as detailed in **Table 1** above.

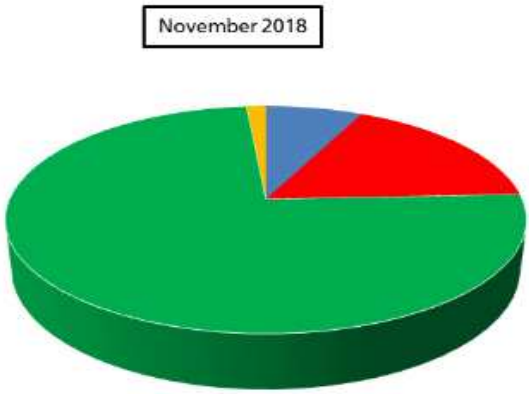
### Number of actions by BRAG status in each CQC domain

| CQC Domain | Red | Amber | Green | Blue | TOTAL |
|---|---|---|---|---|---|
| **Safe** | **1** | **3** | **146** | **10** | **160** |
| Safe, previous 6 months | 17 | 29 | 91 | 17 | Nov-2018 |
| **Effective** | **0** | **1** | **33** | **3** | **37** |
| Effective, previous 6 months | 3 | 5 | 25 | 3 | Nov-2018 |
| **Caring** | **0** | **0** | **1** | **4** | **5** |
| Caring, previous 6 months | 0 | 0 | 1 | 7 | Nov-2018 |
| **Responsive** | **1** | **1** | **57** | **1** | **60** |
| Responsive, previous 6 months | 5 | 8 | 41 | 6 | Nov-2018 |
| **Well-led** | **4** | **2** | **57** | **2** | **65** |
| Well-led, previous 6 months | 15 | 4 | 37 | 7 | Nov-2018 |

**People Workstream**

Executive Lead Karen Charman; Director of HR and OD



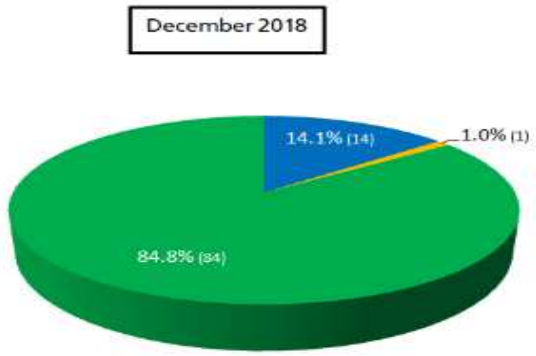



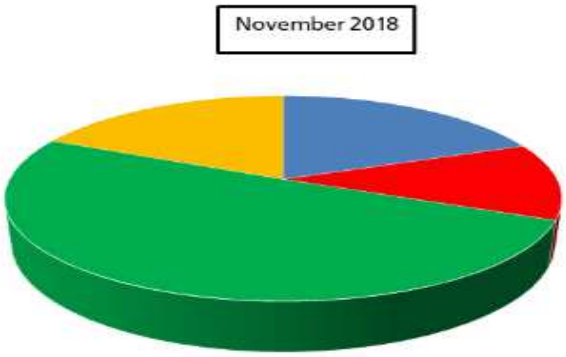

**ACTION STATUS (current month)**

| | Red | Amber | Green | Blue |
|---|---|---|---|---|
| No. | 4 | 4 | 66 | 2 |
| % | 5.3 | 5.3 | 86.8 | 2.6 |

**Caring Safely Workstream**

Executive Lead Emma Hardwick; Chief Nurse

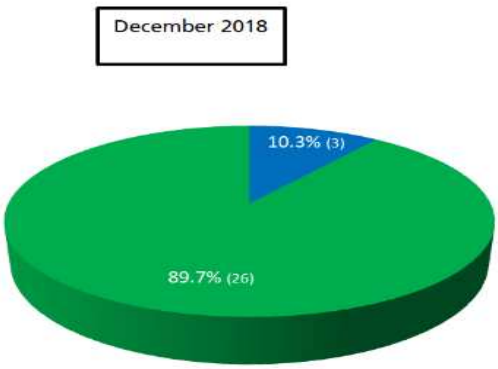


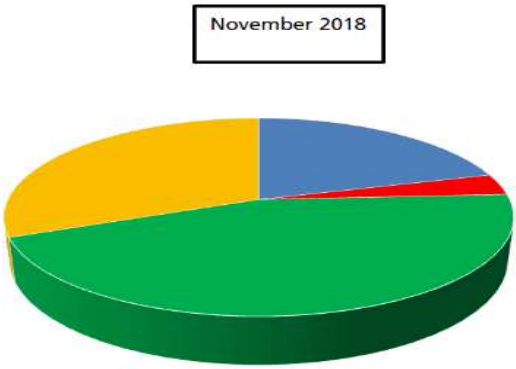




**ACTION STATUS (current month)**

| | Red | Amber | Green | Blue |
|---|---|---|---|---|
| No. | 0 | 1 | 84 | 14 |
| % | 0 | 1 | 84.8 | 14.1 |

**Environment Workstream**
Executive Lead Roy Jackson; Director of Resources and Finance

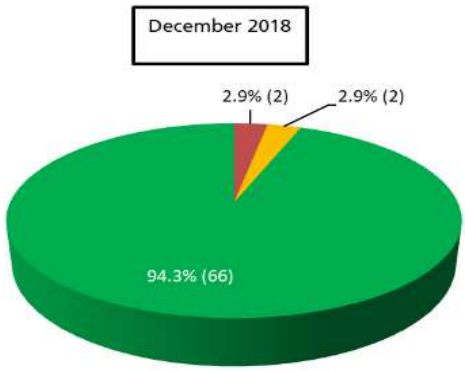


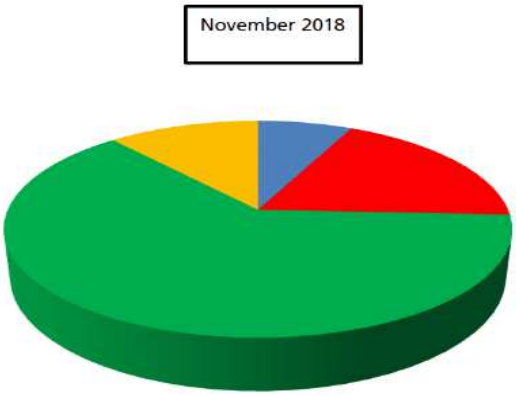




**ACTION STATUS (current month)**

| | Red | Amber | Green | Blue |
|---|---|---|---|---|
| No. | 0 | 0 | 26 | 3 |
| % | 0 | 0 | 89.7 | 10.3 |

**Performance Workstream**
Executive Lead Jon Wade; Chief Operating Officer

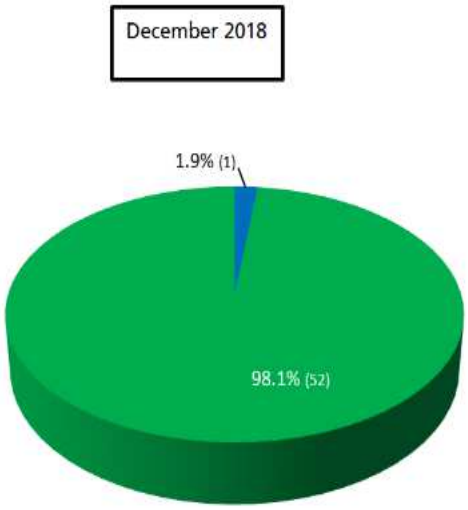


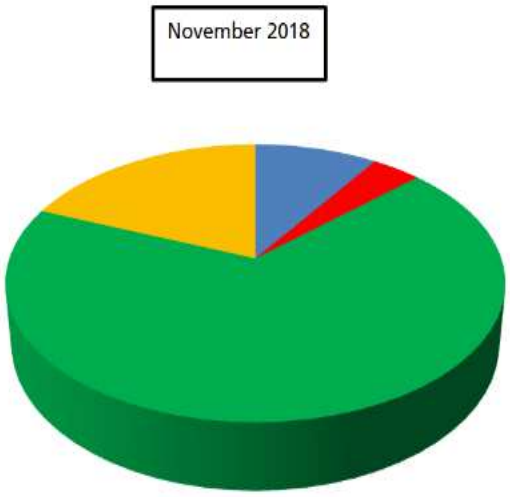




**ACTION STATUS (current month)**

| | Red | Amber | Green | Blue |
|---|---|---|---|---|
| No. | 2 | 2 | 66 | 0 |
| % | 2.9 | 2.9 | 94.3 | 0 |

**Governance and Learning Workstream**
Executive Lead; Nick Lyons Medical Director




**ACTION STATUS (current month)**

| | Red | Amber | Green | Blue |
|---|---|---|---|---|
| No. | 0 | 0 | 52 | 1 |
| % | 0 | 0 | 98.1 | 1.9 |

The CQC inspection covered 7 core services and stipulated 94 Must and Should Do actions in total. A number of these Musts and Shoulds were identified in more than one core service, these were therefore combined and themed within the overarching QIP.

A varying number of actions have been assigned to each Must and Should, depending on the extent of the issue and work required. The QIP is therefore made up of the 98 Must and Shoulds supported by a total of 327 individual actions. The progress of these individual actions are BRAG rated each month and progress against each is detailed in a highlight report. These detailed workstream reports are presented to the QPB each month where the Workstream Executives Directors are accountable for updating on the progress of their workstreams, focusing on the Red and Blue actions, risks and mitigations.

Two example workstream highlight reports have been included to illustrate the varying number of individual actions and level of information provided to both the QPB and OAG.

# Highlight Report to: December QPB

| Domain |
|---|
| Safe |

| Action RAG Rating | | | |
|---|---|---|---|
| Overdue or not on track | At risk of delivery | On Track | Complete & Evidenced |

| Workstream | Executive Lead / Senior Responsible Officer (SRO) | Improvement Manager | Completion date submitted to CQC on QIP | |
|---|---|---|---|---|
| Environment E6 | Roy Jackson | José García Escudero | Initial | Revised |
| | | | 01/10/2018 | 01/10/2018 |
| **MUST DO Recommendation:** | **Must 3.30** 30. Surgery - The trust **must** ensure that plans to improve arrangements for disposing of waste on Surgical Assessment Unit (SAU) and Elm ward are implemented, to ensure compliance with infection prevention and control (IPC) procedures. | | | |
| **We will have achieved GOOD when:** | • Installation of new sluice on Elm ward facilities to be undertaken as part of ward cleaning enabling works. | | | |
| **Issue:** | SAU and Elm Ward did not have appropriate facilities for disposal of clinical waste. | | | |
| **Exec Summary:** | Actions completed. | | | |

| Actions | Progress update and next Steps | Action RAG |
|---|---|---|
| **E6.1** Review of facilities and install new sluice which meets IPC standards and ensures the appropriate disposal of waste. | **Progress:**<br>Action completed, new sluice installed<br>**Next steps:**<br>• Action recommended for closure.<br>**Evidence:**<br>• Sluice pictures: IMG_20181123_125936, IMG_20181123_125941, IMG_20181123_125955, IMG_20181123_125959 and IMG_20181123_130016.<br>• Sluice IPC compliance confirmation- email. | |

| Risks/Issues | Mitigating Actions | Escalation & Decisions for QPB |
|---|---|---|
| N/A | | |

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

**Highlight Report to: December QPB**

| Domain |
|---|
| Well-led |

| Action RAG Rating | | | |
|---|---|---|---|
| Overdue or not on track | At risk of delivery | On Track | Complete & Evidenced |

| Workstream | Executive Lead / SRO | Improvement Manager | Completion date submitted to CQC on QIP | |
|---|---|---|---|---|
| Governance & Learning GL1 | Nick Lyons | José García Escudero | Initial | Revised |
| | | | 31/12/2019 | 31/03/2019 |
| **MUST DO Recommendation:** | **Regulation 17, Must 5.4, Must 5.36, Must 5.40, Should 5.86**<br>4. Trust Overall - The trust **must** ensure that there is an effective process for governance, quality improvement and risk management in all departments.<br>36. Surgery - The trust **must** ensure there are clear governance processes in place, particularly in relation to the monitoring of safety checks in theatre, identification and management of risk and reporting of performance to the board.<br>40. Maternity - The trust **must** ensure that there are effective processes in place for quality improvement and risk management.<br>86. Outpatients - The trust **should** ensure that there is an effective process for quality improvement and risk management. | | | |
| **We will have achieved GOOD when:** | • Updated ToR and Agenda approved and distributed to all Divisional and CBU Triumvirates<br>• 100% of Divisional and CBU Triumvirate attend one of the workshops planned.<br>• Accountability Framework to be introduced with an implementation strategy and support for Divisional and CBUs to work in line with this framework.<br>• Report and recommendations to be submitted to Clinical Governance Committee for consideration and action to ensure effective arrangements for the Divisions are in place.<br>• Divisional organograms will be updated and displayed within ward/depts. | | | |
| **Issue** | Arrangements for governance and performance management do not operate effectively and new Divisional Structure needs to become embedded within the organisation | | | |
| **Exec Summary:** | Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised.<br>The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream. | | | |

| Actions | Progress update and next Steps | Action RAG |
|---|---|---|

| Actions | Progress update and next Steps | Action RAG |
|---|---|---|
| **GL1.1** Review and update the TOR and agendas for the new Divisional Board and CBUs to ensure ward to board quality governance and performance is robust. | **Progress:**<br>ToRs and agendas have been reviewed, updated and made available to be used in relevant meetings (sent out as part of a 'pack' to all Triumvirate teams and available on the intranet).<br><br>Initial examination of evidence indicated that further work is needed in embedding the templates developed (approved templates are not always used, some items in the agenda are never covered in the meeting, ToRs have been modified from the template and not approved, etc.).<br><br>**Next steps:**<br>• To implement documents and evaluate impact.<br>• To complete the recruitment of the band 3 administration support role.<br><br>**Action changes**:<br>• Deadline moved to 28/02/19.<br>• Action status changed from 'Overdue or not on track' (red) to 'On track' (green). | |
| **GL1.2** Divisional Board and CBU Chairs and administrators to attend Governance and Chair / administrator Training Workshops to support the effective working of these meetings. | **Progress:**<br>Training materials for 'Chairs' have been developed and training was provided to some of them on the 09/10/18 and for 'Administrators' on the 18/10/18.<br><br>N**ext steps:**<br>• Evaluation of the action has not been completed yet, however, when examining the evidence for the action above, it has been found that the effectiveness of these meetings could be improved.<br>• Training to be completed for all identified individuals.<br><br>**Action changes**:<br>• Deadline (31/12/19, typing error) to be changed to 31/01/19. | |
| **GL1.3** Accountability Framework to be developed and introduced into the organisation with a clear implementation strategy with support and training for the Divisional Boards and CBU leads to ensure this is implemented effectively. | **Progress:**<br>Accountability Framework due to be presented at Trust Executive Committee (TEC) for approval on the 13/12/18 (it was planned for November's meeting, but meeting was cancelled).<br><br>**Next steps:**<br>• See risks section. | |

| Actions | Progress update and next Steps | Action RAG |
|---|---|---|
| **GL1.4** To carry out a review of the Risk and Governance resource and support to the Divisions to ensure they effectively support Divisional ability to work in accordance with the Accountability Framework in respect of risk management, quality improvement and governance. | **Progress:**<br>Review has been carried out. It is in the process of being documented.<br><br>**Next steps:**<br>• See risks section for GL1.3. | |
| **GL1.5** Divisional organograms to be updated to reflect new divisional structure, CBUs and Specialties to support staffs understanding of where they sit with the new operational and governance structure. | **Progress:**<br>Divisional organigrams have been updated and distributed to the relevant colleagues for displaying in relevant areas and communication to team members. There are plans to make these documents available in the intranet and to formally define the document management arrangements for them.<br><br>The impact of the action has not been evaluated yet.<br><br>**Next steps:**<br>• To evaluate the understanding of colleagues in relation to the structure and composition of their senior team and their reporting lines. This evaluation is to be integrated within the current Quality Assurance Visit process.<br><br>**Action changes**:<br>• Deadline moved to 31/03/19.<br>• Action status changed from 'Completed & evidenced' (blue) to 'On track' (green). | |

| Risks/Issues | Mitigating Actions | Escalation & Decisions for QPB |
|---|---|---|
| **GL1.3:** Deadline stack for actions GL1.4, GL4.3, GL8.3 and GL13.3 will prevent the completion of actions within their deadline since they all depend of GL1.3 being completed. The deadline for the former is later or the same than the deadline for GL1.3. | Deadline review for all related actions. | Actions GL1.4, GL4.3, GL8.3 and GL13.3 are of high importance. By reviewing the deadlines for these actions, the margin of time for implementation prior to the expected CQC inspection will be reduced significantly. |

# Must & Should Do Actions
# Summary Update as of December 2018

| 'MUST/SHOULD' Action | Workstream | Update |
|---|---|---|
| 1. Trust Overall<br>The trust must ensure that mandatory training attendance, including training on infection prevention and control and<br>Safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices. | People<br>ID : P1 / P2 / P3<br>Actions : 3 / 3 / 3<br>(see also 56) | An implementation plan for improved access to Mandatory Training via e-learning is being submitted to the November 2018 Workforce Committee. Full promotion and comms to support in early January 2019. Developing mandatory training trajectories by Divisions and CBUs and will be validated by the increased access via e-learning. Dashboards will be presented at Divisional Board Meetings to monitor improvement trajectories to ensure compliance by 31/05/19 |
| 2. Trust Overall<br>The trust must ensure patient care records are accurate, complete and contemporaneous. This includes the accurate and consistent completion of weight and nutritional assessments and fluid balance charts. | Caring Safely<br>ID : CS1 / CS20<br>Actions : 10 / 7<br>(see also 81) | Nursing Assessment launch delayed at printers and new deadline set for end of December 2018. Following Policy launch in November, proposed to test embedding of Record Keeping Policy over 6 months period.<br>Deadline for full implementation revised to end of April 2019 to measure impact across 3 audit phases. |
| 3. Trust Overall<br>The trust must ensure mental capacity assessments are consistently and competently carried out where required. | Caring Safely<br>ID : CS3<br>Actions : 9<br>(see also 51, 56) | Review of Mental Capacity Act / Deprivation of Liberty Safeguards (MCA/DoLS) actions required following appointment of new Action Owner 19/11. Develop new approach to ensure processes and assessments are embedded in practice. This includes the establishment of new MCA/DoLS Group to report directly to Adult Safeguarding Committee. Group will oversee all MCA/DoLS activities Trust-wide. New assessment tool is in place. New actions will be developed to reflect enhanced approach and revised deadlines identified. |
| 4. Trust Overall<br>The trust must ensure that there is an effective process for governance, quality improvement and risk management in<br>all departments. | Governance - Learning<br>ID : GL1 / GL3<br>Actions : 5 / 9<br>(see also 36, 40, 86) | Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised.<br>The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream. |
| 5. Trust Overall<br>The trust must ensure that processes for incident reporting, investigation, actions and learning are embedded across all services. Including effective monitoring of incident categorisation, grading, trend analysis and processes for staff to learn from incidents. | Governance - Learning<br>ID : GL4 / GL5<br>Actions : 6 / 1<br>(see also 6, 7) | Although deadlines for most actions are not until 31/12/18 or later, the implementation of some actions has not started. In other cases the full development and implementation of actions depend on the development and implementation of the Accountability Framework, for which deadline is the same or later than the one which relates to these depending actions. The amount of actions that are the responsibility of one individual owner may affect the capacity for delivering actions as planned.<br>Deadline has been extended to allow documenting findings and developing of action plan. |
| 6. Trust Overall<br>The trust must ensure that serious incidents are identified, reported and investigated in a timely manner. | Governance - Learning<br>ID : GL4<br>Actions : 6<br>(see also 5, 7) | See Above |

| 'MUST/SHOULD' Action | Workstream | Update |
|---|---|---|
| 7. Trust Overall<br>The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. | Governance - Learning<br>ID : GL4<br>Actions : 6<br>(see also 5, 6) | See Above |
| 8. Trust Overall<br>The trust must ensure that recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed. | Governance - Learning<br>ID : GL9 / GL11<br>Actions : 3 / 1<br>(see also 45, 65, 83, 87) | Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019.<br>The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action. |
| 9. Trust Overall<br>The trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff. | Governance - Learning<br>ID : GL7<br>Actions : 5<br>(see also 69) | These actions can be linked to GL4.6 although deadlines for them are far more restrictive. No progress has been reported for these actions but reviewed deadlines and consistency of ownership will allow effective implementation. Work on stacking deadlines across different topics within the workstream is being carried out so deadline changes optimise the sequence of actions.<br>New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases. |
| 10. Trust Overall<br>The trust must 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. | People<br>ID : P19<br>Actions : 1 | The review is completing w/e 02/12/18 with the draft report likely in the first half of December. The CEO had thought it might be possible to complete the action, which is the development of a formalised development and support plan for both current and future execs. Whilst in theory, it is possible to have this agreed in December, it is likely this will be late Jan to mid Feb. |
| 11. Trust Overall<br>The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance. | Governance - Learning<br>ID : GL12<br>Actions :3<br>(see also 22,43) | Extensive work undertaken in Maternity to ensure policies are in date. Reviewed as part of recent CQC unannounced Section 31 visit.<br>Funding has been approved for the Datix document management module and that a project manager for implementation is available. Once the Datix module is implemented, deadline for this action will be more accurate. |
| 12. Trust Overall<br>The trust must ensure that the information used to monitor, manage and report on quality and performance is<br>accurate, valid, reliable, timely and relevant | Performance<br>ID : PF10<br>Actions : 8 | Deadline changed to reflect month end closure report run to provide up to date evidence. Roll out commenced with 30 licenses for Senior Ops Managers with wider roll-out to be confirmed. Deadline will need revisit with IT and SRO. |
| 13. Trust Overall<br>The trust must continue to 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 any escalation areas when in use. | Performance<br>ID : PF1<br>Actions : 7<br>(See also 62) | Review of all actions has identified original deadlines required review/confirmation. Pathways are in place, evidence for one action to be presented for closure in January. On track for completion for all other actions. |
| 14. Trust Overall<br>The trust must improve the culture, working relationships and engagement of consultant staff across all services. | People<br>ID : P13<br>Actions : 6 | Engagement Survey sent out to all medical staff for three weeks. Results will be assessed and a set of agreed actions will follow. Representatives from QEH FT are fully signed up to participate in the NHSI Leadership and Culture Change programme. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 15. Trust Overall<br>The trust must ensure that effective process for the management of staff grievances and complaints are in place, ensuring timely management in line with trust policy. | People<br>ID : P16<br>Actions : 9 | New Freedom To Speak Up Guardian (FTSUG) appointed on 03/09/19. From staff sessions, an Action Plan will be developed for improving how staff can increase their knowledge on how to raise concerns in different circumstances. A new Trust Whistleblowing Policy is on track for dissemination by 31/01/19. A new reporting system for recording, monitoring and reporting staff complaints is on track for delivery by May 2019. |
| 16. Trust Overall<br>The trust must ensure effective processes are in place to meet all the requirements of the fit and proper person's regulation. | People<br>ID : P20<br>Actions : 2 | Evidence of alignment with current regulatory monitoring and compliance is reported on the Trust website. Evidence of Trust adhering to CQC Report Regualtion5 - Fit and Proper Persons check – evidence of documents signed by all Directors |
| 17. Urgent & Emergency<br>The trust must ensure that resuscitation trolleys are checked in accordance with the trust policy and resuscitation council guidelines. | Caring Safely<br>ID : CS8 / CS9<br>Actions : 4 / 3<br>(see also 49, 52, 90) | Progress continues for Resuscitation Trolleys. Further audit evidence required to ensure daily/weekly checks establish improvements. Deadline date revised to 30/4/19 remains on schedule overall for completion to ensure improvements are embedded. Planning to commission external review of Resuscitation Team and equipment across the Trust for further assurance. |
| 18. Urgent & Emergency<br>The trust must review nursing and medical staffing numbers and plan staffing acuity accordingly. | People<br>ID : P10<br>Actions : 8<br>(see also 25, 75) | Sustainable workforce programme been developed – a number of projects have been identified as part of the roll out of key projects in the programme. New deadline of 31/05/19 suggested as piloting of new models on certain wards will be completed in March 2019 prior to full roll out to other wards in May. |
| 19. Urgent & Emergency<br>The trust must ensure that the environment within the emergency department is appropriate to provide safe care and treatment. | Environment<br>ID : E1<br>Actions : 3<br>(See also 58) | Short term solution and deadline agreed at the ED Review Meeting. However, the proposed solution seemed to affect negatively the department's capacity. Initial option piloted - alternative solution being discussed. |
| 20. Urgent & Emergency The trust must ensure that serious incident action plans are comprehensive and that the completion of actions is monitored. | Governance - Learning<br>ID : GL8<br>Actions : 3 | No issues identified for the implementation of the GL8 actions. Action owner is checking about the possibility of including this within the ToR for the existing Serious Incident Review Panel. |
| 21. Urgent & Emergency<br>The trust must review the arrangements for booking in patients and for the waiting area to ensure that patients at risk of deterioration are identified and escalated appropriately. Non-clinical staff responsible for booking in patients must have clear criteria for escalating patients to clinical staff. | Performance<br>ID : PF6<br>Actions : 6 | Deadline date changed from 31/11/18 to 31/01/19. Evidence of Induction pack and SOP not provided in time for submission to QPB for sign-off. Evidence will be available for closure in January. Streaming for pilot is in place and evidence provided. Need Standard Operating Procedure (SOP) for implementation to confirm full process is in place. |
| 22. Urgent & Emergency<br>The trust must ensure that compliance with new or updated national guidance is regularly assessed and monitored, and improvements made where necessary. | Governance - Learning<br>ID : GL12<br>Actions : 3<br>(see also 11, 43) | Funding has been approved for the Datix document management module and that a project manager for implementation is available. Once the Datix module is implemented, deadline for this action will be more accurate. |
| 23. Urgent & Emergency<br>The trust must improve its performance times in relation to ambulance turnaround delays, four-hour target, patients waiting more than four hours from the decision to admit until being admitted and monthly median total time in A&E. | Performance<br>ID : PF2<br>Actions : 8 | Needs to move to a clinical lead to ensure professional standards are met. Original deadline date was not appropriate or sufficient to measure a change in ED delivery. Report from recent Emergency Intensive Care Support Team (ECIST) visit shared with Trust on 28th November 2019. Action plan being developed to address recommendations |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 24. Medical<br>The trust must ensure the service has enough nursing staff, on all medical wards, to keep people safe from avoidable harm and to provide appropriate standards of care and treatment. | People<br>ID : P10<br>Actions : 8<br>(see also 18, 75) | Immediate Action completed in May 2018, through closing escalation ward. Ward remained closed. The sustainable workforce programme has been developed – a number of projects have been identified as part of the roll out of key projects in the programme. New deadline of 31/05/19 suggested as piloting of new models on certain will be completed in March 2019 prior to full roll out too other wards in May. Associate Medical Directors (AMDs) and Medical staffing have recruited approximately 35 QEH Fellows with a supporting training package to fill the large number of gaps we had. The target was 42. BMA and Royal College of Medicine have issued some new safe staffing guidelines and so a review is underway to check the original assumptions in the Clinical Workforce Strategy. |
| 25. Medical<br>The trust must ensure staff have ready access to required equipment, including resuscitation equipment. | Caring Safely<br>ID : CS10 / E5<br>Actions : 4 / 3<br>(see also 90) | Buddy Trust review to be commissioned by Chief Nurse and deadline for full implementation of any recommendations revised to June 2019. Additional resuscitation equipment has been placed in areas identified by the Trust as a concern. |
| 26. Medical<br>The trust must ensure there are sufficient and appropriate induction procedures for agency staff and competency checks for both agency staff and substantive staff who are moved from other areas of the hospital. | People<br>ID : P8<br>Actions : 10 | Gap Analysis and next steps completed. A SOP and skills passport is in the early stages of development and seeking agreement from operational teams to ensure the process is fit for purpose and achievable in all clinical areas. A SOP and skills passport is in the early stages of development and the Action Owner will be seeking agreement form operational teams to ensure the process is fit for purpose and achievable in all clinical areas. |
| 27. Medical<br>The trust must ensure there are processes in place to reduce the risk of medicines errors. | Caring Safely<br>ID : CS12<br>Actions : 8 | Mandatory training review completed and new Handbook launched across Trust.<br>Deadline now confirmed for Electronic Prescribing and Medicines Administration (EPMA) implementation of 1/4/20.<br>Education review complete, however evidence required for next steps |
| 28. Medical<br>The trust must ensure the risk register is reflective of all the risks in the service and includes relevant actions to mitigate risk. | Governance - Learning<br>ID : GL6<br>Actions : 2 | The development of a new Risk Strategy and an Assurance Framework required a deadline review. The review of the risk register is on track. Gaps have been identified. The amount of work involved in completing this action (proposal, consultation and approval) would justify a change of deadline. |
| 29. Surgery<br>The trust must ensure that staff follow infection prevention and control procedures in relation to hand hygiene, disposal of intravenous equipment and clothing in theatres. | Caring Safely<br>ID : CS16<br>Actions : 2<br>(see also 53, 91) | Mapping of Hygiene Code is in progress and gap analysis required to provide evidence for variance against Code. |
| 30. Surgery<br>The trust must ensure that plans to improve arrangements for disposing of waste on SAU and Elm ward are implemented, to ensure compliance with infection prevention and control procedures. | Environment<br>ID : E6<br>Actions : 1 | New sluice installed on 21/09/18 and IPC compliance confirmed – Action Completed. |
| 31. Surgery<br>The trust must ensure that staff in theatres have clear guidance, and effective processes are implemented, in relation to the required safety checks for anaesthetic equipment and the malignant hyperthermia trolley. | Caring Safely<br>ID : CS17<br>Actions : 2<br>(see also 36) | Requires 6 months audit data to ensure effective process and checks embedded in practice. Auditing commenced. Deadline changed from 30/11/18 to 30/3/19 |
| 32. Surgery<br>The trust must ensure that medicines are stored, prescribed and administered safely, in line with trust policy. | Caring Safely<br>ID : CS13<br>Actions : 5 | Audits are in place; however evidence shows inconsistencies in performance. Deadline dates to be extended to 30/03/19 to ensure audits are in place and effective improvements are made. |
| 33. Surgery<br>The trust must ensure that patient care records are stored securely in all areas. | Environment<br>ID : E8<br>Actions : 5 | No issues identified for the completion of actions. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 34. Surgery<br>The trust must review the location of the elective admissions unit to ensure that the needs of patients are met. | Environment<br>ID : E2<br>Actions : 5 | As part of the Winter Plan, it has been approved for Leverington ward to become the admission ward. Proposals for improving the situation for Feltwell have been detailed and awaiting approval.<br>23h extended recovery unit was approved by the Board on the 18/12/18. This approval is within the context of the Winter Plan. |
| 35. Surgery<br>The trust must ensure that the world health organisation (WHO) and five steps to safer surgery checklist is used<br>consistently in theatres and that effective process is in place for quality audit of all five steps of the checklist. | Caring Safely<br>ID : CS18<br>Actions : 3<br>(see also 44) | Actions are scheduled for completion against deadline. No risks identified. |
| 36. Surgery<br>The trust must ensure there are clear governance processes in place, particularly in relation to the monitoring of safety checks in theatre, identification and management of risk and reporting of performance to the board. | Governance - Learning<br>ID : CS17 / GL1<br>Actions : 2 / 5<br>(see also 31)<br>(see also 4, 40, 86) | Audit information and minutes of CBU1 Board received as evidence. Requires 6 months audit data to ensure effective process. Deadline changed to 30/3/19.<br>Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream. |
| 37. Maternity<br>The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target. | People<br>ID : P6 / P7<br>Actions : 4 / 2<br>(See also 77, 92, 59) | New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring. |
| 38. Maternity<br>The trust must improve cardiotocography training rates. | People<br>ID : P5<br>Actions : 1 | Action completed as part of Maternity QIP. Staff training tracked monthly. CTG training is part of induction and Mandatory training. Evidenced reviewed as part of CQC unannounced Maternity Section 31 visit in December. |
| 39. Maternity<br>The trust must ensure that the environment at Wisbech hospital and in the early pregnancy unit is appropriate to provide safe care and treatment. | Environment<br>ID : E3<br>Actions : 3 | Most actions recommended for closing and one on track. |
| 40. Maternity<br>The trust must ensure that there are effective processes in place for quality improvement and risk management. | Governance - Learning<br>ID : GL1 / GL3<br>Actions : 5 /9<br>(see also 4, 36, 86) | Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. ToRs and agendas have been reviewed, updated and made available to be used in relevant meetings (sent out as part of a 'pack' to all Triumvirate teams and available on the intranet). The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream. |
| 41. Maternity<br>The trust must ensure that effective arrangements are in place for vulnerable service users. | Caring Safely<br>ID : CS5<br>Actions : 3 | Initial MatQIP evidence received. More up to date evidence required to complete action and recommend for closure. |
| 42. Maternity<br>The trust must ensure that service users with high risk care pathways receive consistent care planning and appropriate consultant review. | Caring Safely<br>ID : CS4<br>Actions : 4 | Initial audit of accessible of care plans demonstrated inconsistencies. Further audit required by April 2019 to ensure recommendations are embedded and care plans are available. |
| 43. Maternity<br>The trust must ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance. | Governance - Learning<br>ID : GL12<br>Actions : 3<br>(see also 11,22) | Funding has been approved for the Datix document management module and that a project manager for implementation is available. Once Datix module is implemented, deadline for this action will be more accurate |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 44. Maternity<br>The trust must ensure that the world health organisation (WHO) and five steps to safer surgery checklist is used consistently within obstetric theatres. | Caring Safely<br>ID : CS18<br>Actions : 3<br>(see also 35) | Actions are scheduled for completion against deadline. No risks identified. |
| 45. Maternity<br>The trust must improve its local audit programme and review national audit outcomes to improve patient outcomes. | Governance - Learning<br>ID : GL9 / GL11<br>Actions : 3 / 1<br>(see also 8, 65, 83, 87) | Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019.<br>The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action.<br>Interim additional senior Governance Project resource secured and in place in November with Maternity expertise. |
| 46. Maternity<br>The trust must review the antenatal booking process to ensure that referrals are tracked | Performance<br>ID : PF7<br>Actions : 2 | Badgernet (Electronic system) in place (new process went live 25/6/18) -for all referrals from Community Midwives and nolonger reliant on paper referrals. Initial audit completed with further audit of referrals planned. |
| 47. Maternity<br>The trust must ensure that leaders within the service collaborate to improve the service and that culture and wellbeing of staff is improved. | People<br>ID : P14<br>Actions : 1 | Interim Clinical Director appointed. New Clinical Lead appointed.<br>Support from NHSi<br>Pastoral care enhanced<br>Advancing Change through Transformation (ACT) Workshop took place 22/11/18<br>Healthcare Leadership Model (360-degree feedback) rolled out across all leadership roles |
| 48. Maternity<br>The trust must ensure that women who have miscarried up to 16 weeks are cared for in a suitable environment. | Environment<br>ID : E4<br>Actions : 4 | Some actions have been carried out but have not been evaluated. Deadlines have been reviewed where necessary to ensure effective implementation and evaluation of actions. |
| 49. Maternity<br>The trust must ensure that resuscitation trolleys are checked daily and that all medicines stored on resuscitation trolleys are in date. | Caring Safely<br>ID : CS8<br>Actions : 4<br>(see also 17, 52, 90) | Further audit evidence required to ensure daily/weekly checks to establish improvements are embedded in practice. Deadline revised to 30/4/19. |
| 50. End of Life Care<br>The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance. | Caring Safely<br>ID : CS7<br>Actions : 9 | Significant progress made on DNACPR processes and Policy launch. New form developed by Clinicians and implemented into practice. Resus Committee has oversight of audits and improvement made and embedded through audits in September and November. Further audit in February 2019 to ensure improvements are progressing. |
| 51. End of Life Care<br>The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way<br>this is documented within patients' notes. | Caring Safely<br>ID : CS3<br>Actions : 9<br>(see also 3, 56) | Review of MCA/DoLS actions required following appointment of new Action Owner 19/11 and development of new approach to ensure processes and assessments are embedded in practice. This includes the establishment of new MCA/DoLS Group to report directly to Adult Safeguarding Committee. Group will oversee all MCA/DoLS activities Trust-wide. New assessment tool is in place. New actions will be developed to reflect enhanced approach and revised deadlines identified to complete. |
| 52. Outpatients<br>The trust must ensure resuscitation equipment in the paediatric clinic is checked daily. | Caring Safely<br>ID : CS8<br>Actions : 4<br>(see also 17, 49, 90) | New additional resuscitation equipment in place in Paediatric Resuscitation area in ED. Further audit evidence required to ensure daily/weekly checks to establish improvements are embedded in practice. Deadline revised to 30/4/19. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 53. Outpatients<br>The trust must ensure infection prevention and control audits are completed regularly and action taken to address concerns including cleaning of toys in waiting areas. | Caring Safely<br>ID : CS16<br>Actions : 2<br>(See also 29, 91) | Mapping of Hygiene Code is in progress and gap analysis required to provide evidence for variance against Code. Then need to map variances into an action plan which will then deliver effective change. |
| 54. Diagnostic Imaging<br>The trust must ensure staff lock computer screens to protect patient information when leaving them unattended in the breast care unit. | Environment<br>ID : E8<br>Actions : 5 | No issues identified for the completion of actions. |
| 55. Diagnostic Imagining<br>The trust must provide all patients with the option of a chaperone when undergoing diagnostic imaging in the cardio respiratory department. | Caring Safely<br>ID : CS6<br>Actions :3 | Revised Chaperone Policy is being consulted on for sign-off in December and deadlines dates revised to reflect timescale for implementation. |
| 56. Trust Overall<br>The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and<br>Deprivation of Liberty safeguards | People / Caring Safely<br>ID : P3 / CS3<br>Actions : 3 / 9<br>(See also 1, 3) | Review of MCA/DoLS actions required following appointment of new Action Owner 19/11 and development of new approach to ensure processes and assessments are embedded in practice. This includes the establishment of new MCA/DoLS Group to report directly to Adult Safeguarding Committee. Group will oversee all MCA/DoLS activities Trust-wide. New assessment tool is in place. New actions will be developed to reflect enhanced approach and revised deadlines identified to complete. |
| 57.Trust Overall<br>The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff. | People<br>ID : P11<br>Actions : 4 | This task is on track for delivery by 30/01/19. Action Plan has identified the need for a staff feedback portal on the intranet. Confident of meeting the correct deadline in Launching the staff 'For You' staff (trade) benefits website. |
| 58. Urgent & Emergency<br>The trust should review the layout of the emergency department to ensure that it supports flow and meets the needs of local people. | Environment<br>ID : E1<br>Actions : 3<br>(see also 19) | Short term solution and deadline agreed at the ED Review Meeting. However, the proposed solution seemed to affect negatively the department's capacity. Initial option piloted - alternative solution being discussed. |
| 59. Urgent & Emergency<br>The trust should ensure that staff receive yearly appraisals. | People<br>ID : P6<br>Actions : 4<br>(See also 37, 77, 92) | New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring. |
| 60. Urgent & Emergency<br>The trust should review the hours that the ambulatory emergency care unit, the paediatric assessment unit and the rapid assessment team are available to maximise admission avoidance. | Performance<br>ID : PF11<br>Actions : 2 | All actions on schedule for delivery. No risks identified. |
| 61. Urgent & Emergency<br>The trust should ensure that internal professional standards are created and monitored. | Performance<br>ID : PF3<br>Actions : 2 | Deadline date extended to 30/04/19. Professional Standards to be embedded and tested. |
| 62. Urgent & Emergency<br>The trust should review the policies and protocols in place to manage escalation and crowding. | Performance<br>ID : PF1<br>Actions : 7<br>(See also 13) | Review of all actions has identified original deadlines required review/confirmation. Pathways are in place, evidence for one action to be presented for closure in January. On track for completion for all other actions. |
| 63. Urgent & Emergency<br>The trust should review the service provided for patients with mental health conditions to ensure that they receive timely assessment and treatment. | Performance<br>ID : PF12<br>Actions : 1 | Due to interdependencies, deadline needs to be extended to 31/03/19 to link to renewed contract and embedding in Trust to ensure measurement of performance. |
| 64. Urgent & Emergency<br>The trust should ensure that patients, relatives and carers receive timely emotional support. | Caring Safely<br>ID : CS2<br>Actions : 1 | Action is on track to meet completion deadline, no risks identified. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 65. Urgent & Emergency<br>The trust should ensure the service improves its local audit programme, including audits recommended in national guidance. | Governance - Learning<br>ID : GL9 / GL11<br>Actions : 3 / 1<br>(see also 8, 45, 83, 87) | Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019.<br>The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action. |
| 66. Urgent & Emergency<br>The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss. | Environment<br>ID : E7<br>Actions : 5 | Funding required for an external provider to carry out the Equality Impact Assessment. Provider is prepared to act promptly once the approval is completed and an order placed to complete the assessment for ED department (the overall programme will last 5 years). |
| 67. Urgent & Emergency<br>The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services. | Governance - Learning<br>ID : GL2<br>Actions : 4<br>(see also 76, 84) | ED mortality review will be included within the Medical Structured Judgement Review (SJR) meeting.<br>Weekly meetings are taking place and learning brought from this meeting to the Surgical Clinical Governance Committee. Escalations are made from this Committee to the Mortality Surveillance Group.<br>End of Life Care (EoLC) Quarterly Mortality Audit is being considered. Results are to be reported within the Trust's Mortality Surveillance Group meetings.<br>Mortality Report template is being developed. This will be used by the different specialties when reporting into the CBU mortality meeting and the Mortality Surveillance Group. |
| 68. Urgent & Emergency<br>The trust should ensure that plans in relation to the development of a strategy for the urgent and emergency service are implemented. | People<br>ID : P17<br>Actions : 7<br>(See also 80) | Evidence from the CEO and Governance Office that the vision (and corporate strategy) went and was signed off by Board in September 2018. This has been consulted on with a wide range of stakeholders. The Comms plan has yet to be launched formally and embedded within the organisation. |
| 69. Medical<br>The trust should ensure there are systems in place to ensure the consistent and effective sharing of feedback and learning from complaints and incidents | Governance - Learning<br>ID : GL7 / GL13<br>Actions : 5 / 7<br>(see also 9, 72,88) | These actions can be linked to GL4.6 although deadlines for them are far more restrictive. No progress has been reported for these actions but reviewed deadlines and consistency of ownership will allow effective implementation. Work on stacking deadlines across different topics within the workstream is being carried out so deadline changes optimise the sequence of actions.<br>New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases. |
| 70. Medical<br>The trust should ensure there are systems in place to reduce and manage the high number of medical outliers. | Performance<br>ID : PF4<br>Actions : 8 | Consultant cover is in place for medical outliers with weekly patient reviews indicating medical outliers. Bed modelling projection to provide assurance that projections for Winter are viable. Action owners now confirmed and deadline dates agreed in line with realistic timescale for completion. |
| 71. Medical<br>The trust should ensure call bells are answered promptly to respond to patient risk and need. | Caring Safely<br>ID : CS22<br>Actions : 3 | Call bell audits established and monitored across wards to identify issues/concerns. Immediate actions are taken when issues identified and staff reporting is in place. Proposed for closure. |
| 72. Medical<br>The trust should ensure complaints are managed and responded to in a timely manner and in line with trust policy. | Governance - Learning<br>ID : GL13<br>Actions : 7<br>(see also 69, 88) | New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases. Some improvements in Datix are being implemented so telephone number of complainant will be easily available. |
| 73. Medical<br>The trust should ensure there is improved communication and multidisciplinary working with external services. | Performance<br>ID : PF13<br>Actions : 5 | Waiting confirmation joint winter discharge room is established with Social Services, CCG, NHSE and NCHC. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 74. Medical<br>The trust should ensure there are appropriate systems to ensure staff feel supported, engaged and listened to. | People<br>ID : P15<br>Actions : 4 | Ask and Act sessions have been established and the follow up actions are with the Executive Directors. Work progressing to ensure complete embedding of Executive Ward/Dept. Buddy system culture change initiative. Post Implementation Evaluation of how well the findings inform the improvement work are to be carried out quarterly. |
| 75. Surgery<br>The trust should continue to implement plans to maintain sufficient nursing staff to meet the needs of patients. | People<br>ID : P10<br>Actions : 8<br>(see also 18, 24) | Sustainable workforce programme been developed – a number of projects have been identified as part of the roll out of key projects in the programme. New deadline of 31/05/19 suggested as piloting of new models on certain wards will be completed in March 2019 prior to full roll out to other wards in May. |
| 76. Surgery<br>The trust should ensure that regular and minuted mortality and morbidity meetings take place for surgery services. | Governance - Learning<br>ID : GL2<br>Actions : 4<br>(see also 67, 84) | ED mortality review will be included within the Medical SJR meeting.<br>Weekly meetings are taking place and learning brought from this meeting to the Surgical Clinical Governance Committee. Escalations are made from this Committee to the Mortality Surveillance Group.<br>EoLC Quarterly Mortality Audit is being considered. Results are to be reported within the Trust's Mortality Surveillance Group meetings.<br>Mortality Report template is being developed. This will be used by the different specialties when reporting into the CBU mortality meeting and the Mortality Surveillance Group. |
| 77. Surgery<br>The trust should ensure all staff receive an annual appraisal, in line with trust policy. | People<br>ID : P6<br>Actions : 4<br>(see also 37, 59, 92) | New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring. |
| 78. Surgery<br>The trust should ensure strategies to manage access to the service and patient flow through the service are embedded. | Performance<br>ID : PF5<br>Actions : 5 | Hot Review Clinics are established. Ambulatory area in SAU when in operation. |
| 79. Surgery<br>The trust should ensure there are clear processes in place for sharing information with ward staff. | People/Caring Safely<br>ID : P12 / CS19<br>Actions : 1 / 6 | Initial implementation of safety huddles in place. Audit programme required to monitor effectiveness and to be completed over 4 month period to enable accurate measurement of impact.<br>Major challenge to the review of communication mechanisms and tools to inform design and roll out of Trust communication plan due to the nature of work involved and the pending challenges within the Communications establishment |
| 80. Surgery<br>The trust should ensure that plans in relation to development of a vision and strategy for the surgery service are implemented. | People<br>ID : P17<br>Actions : 7<br>(See also 68) | Evidence from the CEO and Governance Office that the vision (and corporate strategy) went and was signed off by Board in September 2018. This has been consulted on with a wide range of stakeholders. The Comms plan has yet to be launched formally and embedded within the organisation. |
| 81. Surgery<br>The trust should ensure that information relating to the individual needs of patients is collected in a timely way. | Caring Safely<br>ID : CS1<br>Actions : 10<br>(see also 2) | Nursing Assessment launch delayed at printers and new deadline set for end of December. Following Policy launch in November, proposed to test embedding of Record Keeping Policy over 6 months period. |
| 82. Surgery<br>The trust should ensure all staff have access to relevant information management systems, to meet patients' needs. | People<br>ID : P8<br>Actions : 10 | Gap Analysis and next steps completed. A SOP and skills passport is in the early stages of development and seeking agreement from operational teams to ensure the process is fit for purpose and achievable in all clinical areas. A SOP and skills passport is in the early stages of development and the Action Owner will be seeking agreement form operational teams to ensure the process is fit for purpose and achievable in all clinical areas. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 83. Surgery<br>The trust should review the implementation of the local clinical audit programme for surgery services. | Governance - Learning<br>ID : GL9 / GL11<br>Actions : 3 / 1<br>(see also 8, 45, 65, 87) | Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019.<br>The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action. |
| 84. End of life Care<br>The trust should ensure morbidity and mortality meeting need to have a focus on the end of life care journey and how to improve end of life care. | Governance - Learning<br>ID : GL2<br>Actions : 4<br>(see also 67, 76) | ED mortality review will be included within the Medical SJR meeting.<br>Weekly meetings are taking place and learning brought from this meeting to the Surgical Clinical Governance Committee. Escalations are made from this Committee to the Mortality Surveillance Group.<br>EoLC Quarterly Mortality Audit is being considered. Results are to be reported within the Trust's Mortality Surveillance Group meetings.<br>Mortality Report template is being developed. This will be used by the different specialties when reporting into the CBU mortality meeting and the Mortality Surveillance Group. |
| 85. Outpatients<br>The trust should ensure that patients commence treatment for cancer within 62 days in line with national guidance. | Performance<br>ID : PF8<br>Actions : 8 | Needs further clarification of evidence from Division that recommendations from Cancer Intensive Support Team (IST) will be taken forward. No Cancer At This Time (NCATT) result evidence required. |
| 86. Outpatients<br>The trust should ensure that there is an effective process for quality improvement and risk management. | Governance - Learning<br>ID : GL1 / GL3<br>Actions : 5 / 9<br>(see also 4, 36, 40) | Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised.<br>The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream. |
| 87. Outpatients<br>The trust should ensure the service improves its local audit programme and review national audit outcomes to improve patient outcomes. | Governance - Learning<br>ID : GL9 / GL11<br>Actions : 3 / 1<br>(see also 8, 45, 65, 83) | Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019.<br>The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action. |
| 88. Outpatients<br>The trust should ensure that the service improves the time taken to investigate complaints in line with its complaints policy. | Governance - Learning<br>ID : GL13<br>Actions : 7<br>(see also 69, 72) | New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases. Some improvements in Datix are being implemented so telephone number of complainant will be easily available. |
| 89. Diagnostic Imaging<br>The trust should ensure the secure storage, prescription and administration of medicines. This includes ensuring that appropriate patient group directives (PGD) are in place for the safe administration of medicines, including the safe administration of saline. | Caring Safely<br>ID : CS14 / CS15<br>Actions : 3 / 4 | MMI inspection schedule in place and issues with storage of medication resolved via staff meeting. No risks to delivery against schedule identified. PGD list and access guidance now live on Trust website. |
| 90. Diagnostic Imaging<br>The trust should ensure that resuscitation equipment in the breast care unit is easily accessible to all staff. | Caring Safely<br>ID : CS8 / CS10<br>Actions : 4 / 4<br>(see also 17, 49, 52) | Equipment available. Further audit evidence required to ensure daily/weekly checks to establish improvements are embedded. |

| 'MUST/SHOULD' Action | Workstream | Update |
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| 91. Diagnostic Imaging<br>The trust should ensure effective processes are established for the cleaning of clinical rooms and equipment in the radiology department. | Caring Safely<br>ID : CS16<br>Actions : 2<br>(see also 29,53) | Mapping of Hygiene Code is in progress and gap analysis required to provide evidence for variance against Code. Then need to map variances into an action plan which will then deliver effective change. |
| 92. Diagnostic Imaging<br>The trust should ensure all staff receives an annual appraisal, in line with trust policy. | People<br>ID : P6<br>Actions : 4<br>(See also 37, 77, 59) | New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring. |
| 93. Diagnostic Imaging<br>The trust should ensure effective processes are in place for the timely completion of diagnostic reports. | Performance<br>ID : PF1<br>Actions : 4 | Review of all actions has identified original deadlines required review/confirmation. One action has completed with evidence to be presented for closure in January. On track for completion for all other actions. |
| 94. Diagnostic Imaging<br>The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner. | Performance<br>ID : PF9<br>Actions : 4 | Need further assurance that current performance levels are sustainable. No risk to delivery identified. Deadline date now confirmed as 31/08/19. |