PHT Quality Improvement Plan (updated 06/03/2018)

Aim	QIP reference	Delivery Workstream	Action no.	Action	Action Owner	Source	Overall deadline	Status (RAG)	Implementation milestones	Milestone due date	Status (RAG)	Outcome / Evidence of success	Outcome measures (if applicable)	Comment
Valuing the basics	1.1 - Patient at the centre	Patient, families and carers experience	**1**	**Single sex accommodation requirements for patients are maintained and a system to report breaches is in place**	Associate Director of Nursing - Operations	CQC 'musts and shoulds'	Complete	**Complete**	Review the use of Recovery as an escalation area and develop mitigation plans to avoid single sex accommodation breaches.	31/01/2018	**Complete**	All breaches are reported and investigated appropriately	Number of reported breaches	
Valuing the basics	1.1 - Patient at the centre	Patient, families and carers experience	**2**	**Re-launch the protected meal time initiative**	Associate Director of Nursing	29a	31/12/2017	**Complete**	Re launch initiative	31/11/2017	**Complete**	Ensure meal times are protected enabling improved nutrition.	Compliance with the protected mealtime initiative. Improvement on last year audit results Reduction in the number of complaints and incidents related to nutrition	
									Quarterly audit to review standards completed through the Clinical Friday's initiative (audit cycle will include yearly PLACE and mealtime audit and spot audits together with compliance target)	31/01/2018	**Complete**			
Valuing the basics	1.1 - Patient at the centre	Patient, families and carers experience	**3**	**Pilot patient centred questions as part of bedside handover to formally recognise patient, family and carer involvement with every shift handover. Patients, families and carers will be involved in care provision.**	Head of Nursing and Midwifery Education	Trust	30/06/2018		1. Practice Educators work with Ward Leaders and Matrons to embed bedside handovers.	30/06/2018		Patients and their families or carers are involved in the care planning process. Hand over processes will be standardised, streamlined and measurable.	Audit into documentation to ensure patient involvement in their own care	Barrier: Of the 2 areas that are not fully compliant the practice educator in Medicine has an action plan and is progressing the roll out across the ward areas. The requirement has been escalated in the other CSC so the leadership team and educator are aware of the expectation and are developing an action plan. Therefore across these 2 CSCs there is still work ongoing to deliver this expectation. Other CSCs are undertaking audits to ensure that this is embedded in practice. **Revised deadline: 30/06/2018** Residual risk: No risk of patient harm, but ongoing risk to patient, family and carer experience Mitigation: Flag to action owner (Debbie Knight) to review and develop further actions around bedside handover and to highlight where further support is required.
									2.Staff to involve patients, their families and carers in the handover process.					
Valuing the basics	1.1 - Patient at the centre	Patient, families and carers experience	**New**	**Further develop skills in mealtime assistance**	Associate Director of Nursing	Trust	30/04/2018	**Complete**	Ensure patients receive the appropriate and adequate support during meal times including protected meal times and appropriate assistance by recruiting and training 150 volunteers for mealtime assistance	30/04/2018	**Complete**	Ensure patients have a better experience of eating and drinking in the hospital	Improved results from hospital food group survey data	Hospital Food Group undertaking monthly ward visits to audit compliance with immediate feedback to clinical teams. Come dine with me initiative commenced. Multi-disciplinary group membership achieved. Social media launch planned for April. First cohort of volunteers recruited and placed. Aim for 150 volunteers recruited by March 2019. Recruitment on-going Pictorial menu cards available. Specialist advice available from dieticians. Challenges when staffing numbers depleted
									Ensure the environment within which patients have meals is conducive to meal enjoyment and completion, including companionship during meal times where possible by encouraging staff volunteers to spend meals with patients	31/03/2018	**Complete**			
									Ensure patients receive physical support to eat where needed or requested by recruiting meal time helpers	31/03/2018	**Complete**			
									Ensure patients receive advice when choosing meals to maximise nutritional benefit whilst at hospital	31/03/2018	**Complete**			
Valuing the basics	1.1 - Patient at the centre	Patient, families and carers experience	**New**	**Patient privacy, dignity and confidentiality maintained in Emergency areas**	Head of Nursing Emergency Medicine CSC	Gaps: CQC 'musts and shoulds'	31/03/2018	**Complete**	Ensure geography of department communicated to all staff, including areas for increased privacy when consulting with patients	31/03/2018	**Complete**	Staff to have a proactive approach to patient cues for increased privacy	ED survey results FFT Decreased complaints related to confidentiality in ED Observation of Care	Building works completed in November/December 2017 to create a private consultation area in ED reception. Patients are moved to the STAR suite for examination during times of operational pressure to maintain privacy and dignity. It continues to be challenging to provide privacy and dignity when patients are held in corridors. Staff are aware to use the STAR suite when possible.
									Conversations between the navigator nurses should be held in a private area to preserve the patient's dignity and respect	31/03/2018	**Complete**			
Valuing the basics	1.2 - Holistic care	Nursing documentation and care plans	**1**	**Patients receive individualised nursing care**	Deputy Director of Nursing	Trust	31/12/2017	**Complete**	Deep dive by the Documentation Group leads into quality of individualised care plans	14/12/2017	**Complete**	Every patient has an individualised nursing care plan	90% of care plans reviewed are of a good standard (When care plans are read, do you know what problems the patient has and can you deliver care based on the care plans)	
Valuing the basics	1.2 - Holistic care	Patient, families and carers experience	**2**	**Improve dignity for patients through improvements in continence care**	Associate Director of Nursing	Trust	31/03/2018	**Complete**	Phase 1 continence project	01/12/2018	**Complete**	Dignity maintained for patients	Reduction in number of complaints related to continence Reduction in trust spend on Inco pads Audit of continence aid use on wards (baseline use in the community or required due to acute and short-term clinical need)	Phase 2 continence programme has been moved into a new action with revised deadline of 30/03/19.
									Combine phase 1 continence project with an audit assurance programme	31/03/2018	**Complete**			
Valuing the basics	1.2 - Holistic care	Nursing documentation and care plans	**3**	**Review nursing documentation to facilitate the provision of holistic care**	Deputy Director of Nursing	29a	31/03/2018	**Complete**	Meetings with Falls and TVN to review additional documentation to clarify if needed as these two areas have been identified as areas of risk within documentation audits and incidents	28/02/2017	**Complete**	Streamlined documentation which supports and evidences care provision	90% of care plans reviewed are of a good standard (When care plans are read, do you know what problems the patient has and can you deliver care based on the care plans)	
Valuing the basics	1.2 - Holistic care	Nursing documentation and care plans	**New**	**Ensure documentation relating to Falls and TVN fit for purpose**	Deputy Director of Nursing	Trust	30/04/2018	**At risk**	Documents relating to Falls and TVN modified following meetings	30/04/2018	**At risk**	Documentation around falls and TVN risks more robust and able to prevent incidents	Reduction in number of Falls Reduction in serious harm following a fall	**April update:** **Pressure ulcers:** implemented Purpose T across the organisation to assess and manage tissue vialbility status in patients.Specific paperwork for pressure ulcer assessment has been developed. The Trust is in the process of merging the Trust nursing documentation with the Purpose T documentation. This is in progress. **Falls:** The revised falls assessment has been agreed by the Documentation Group and is in the process of being incorporated into the Trust nursing documentation. The falls care plan has been developed and is out for consultation. The document will be revised according to feedback as required and go to the documentation group for approval. Once approved, will be implemented. Minimal clinical risk as existing care plan still in use. **Revised nursing documentation booklet:**New documents have been approved through Documentation Group. Out for final comments across the organisation. Pilots commenced in C5 and F2 in April with full roll out across the organisation following pilots and run down of old stock.
									Implementation of modified documentation	30/04/2018	**On track**			
Valuing the basics	1.2 - Holistic care	Patient, families and carers experience	**New**	**Continue to improve dignity for patients through improvements in continence care**	Associate Director of Nursing	Trust	30/03/2019		Continue with 2 phase continence project combining with an audit assurance programme.	30/03/2019		Improved patient dignity around continence	Reduction in number of complaints related to continence Reduction in trust spend on Inco pads Re-audit of continence aid use on wards (baseline use in the community or required due to acute and short-term clinical need) to check progress	

Valuing the basics	1.2 - Holistic care	Nursing documentation and care plans	**New**	**Comms issued identifying clear lines of accountability for nursing care plan documentation through Matrons and Heads of Nursing**	Deputy Director of Nursing	29a	31/03/2018	**Complete**	Weekly 'Hot Topics' audit which includes review of nursing signature on care plans to confirm discussed with patient	31/03/2018	**Complete**	Nurses are clear around lines of accountability for ensuring documentation and nursing plans are completed to a required standard	Audit results show an increase in patient involvement in care plans Audit of minutes show attendance by at least 75% of Ward Matrons		
									Results of audit brought to meetings with Head of Nursing	31/03/2018	**Complete**				
									Minutes of meetings with Head of Nursing audited to ensure attendance by Ward Matrons	31/03/2018	**Complete**				
Valuing the basics	1.3 - Courageous discussions	Patient, families and carers experience	**1**	**Embedding the principles of 'No decision about me without me' so patients are involved in making decisions about their care and treatment**	Head of Patient Experience	Trust	30/06/2018		1. Involve patients, families and carers in service development and improvement	31/03/2018	**Complete**	Care will be delivered in partnership with patients to meet their needs and appropriate advocacy as required	Improve on the National survey question "involved in decisions about care "to "about the same" or "better than" as benchmark	Development of new Duty of Candour guidance. Advised on role of patients in Portsmouth Improvement Academy. Implementation of autism awareness training by Autism Ambassadors to support active involvement of patients in decision making Patient representatives on care quality reviews eliciting feedback from patients. Volunteer led discharge survey to establish patients experience of being involved to be completed 31 March.	
									2. Increase the involvement of patients, families, carers and members of the local community in care quality monitoring with a specific focus on patient involvement in decision making	31/03/2018	**Complete**		Patient representatives involved on care quality review visits		
									3. Introduce core questions for all local experience surveys to include "involvement in decision making"	30/06/2018			Core questions included in all local patient experience surveys		
Valuing the basics	1.3 - Courageous discussions	Patient, families and carers experience	**2**	**Implement the principles of Achieving Priorities of Care (APOC)**	Consultant Geriatrician - End of Life Lead	Trust	30/06/2018		1. Consultant body training sessions on the use of APOC	28/02/2018	**Complete**	Allowing patients and families to have a dignified death in line with their wishes	Increase of appropriate use of APOC document in End of Life Care Improved outcomes as identified in the bereaved relatives survey results (6 month delay in results due to timing of survey). Monitor PALS and complaints trends. - how many	Training completed within respiratory. Formed part of grand round. Training on-going with cardiology a forthcoming focus. Liaising with Safety Team re use of MRP to pick up EoLC and APOC usage. National benchmarking audit for EoLC due July. Audit of APOC documentation to commence April	
									2. Audit of quality of completion of APOC documentation	30/04/2018	**On track**				
									3. Continue to monitor usage of APOC across the organisation	30/06/2018					
									4. Facilitate use of the bereaved relative survey to ensure ongoing improvement of care	30/06/2018					
Valuing the basics	1.4 - Involving patients, families and carers	Patient, families and carers experience	**1**	**Implement patient engagement strategy Get Involved (2017-2020) to strengthen patient engagement across all services at PHT**	Head of Patient Experience	Trust	31/12/2018		1. Ratified Patient Engagement Strategy 2017-2020 by Trust Board	31/05/2018		Patient engagement strategy to be ratified by the Board so that patients and carers will be involved in all service re-design/improvement initiatives	Compliance with the agreed milestones in the implementation plan	Barrier: Discussed with Chief Nurse in light of plans to publish Trust strategy and how this strategy will align. Revised deadline May 2018 Residual risk: Nil Mitigation: Previous strategy still in place	
									2. Develop implementation plan in partnership with Patient Family and Carer Collaborative (PFCC) and local community groups	31/05/2018					
									3. Quarterly monitoring of progress against agreed milestones at PFCC reporting to the Trust Governance and Quality Committee	From July 2018 (quarter 1 report)					
									4. Complete Patient Engagement Strategy	31/12/2020					
Valuing the basics	1.4 - Involving patients, families and carers	Patient, families and carers experience	**2**	**Promote the Friends and Family Test (FFT) throughout the organisation, with particular focus on the Emergency Department, to increase the response rate to at least the England average of 12% and to ensure compliance with the contractual requirements**	Head of Patient Experience	Trust	31/08/2018		1. Ensure the development and implementation of a robust sustainable system for the collection of FFT feedback from patients who use Emergency Departments	Complete	**Complete**	Increased FFT response rate and positive recommendations for Emergency Department to be at, or above, the England average	Positive recommendations for the Emergency Departments to be at or above the national average. Negative (not recommends) to be at or below the national average Response rate to be at or above the national average aiming for upper quartile by August 2018	Templates drafted and engaged with the Patient Collaborative for feedback. Awaiting feedback from Healthwatch which has delayed implementation. Interim changes made to template letters inviting questions/concerns from patient/family to inform the	
									2. Ensure the implementation of systems of daily monitoring of feedback including rapid response to expressions of concern and early warning of reduced number of responses	Complete	**Complete**				
									3. Ensure weekly reporting in-line with agreed protocol	30/11/2017	**Complete**				
									4. Share FFT protocol across the organisation once tested	31/12/2017	**Complete**				
									5. FFT to move to text response in ED	31/08/2018					
Valuing the basics	1.4 - Involving patients, families and carers	Nursing documentation and care plans	**3**	**Strengthen and embed the Being Open Policy**	Deputy Director of Nursing	29a	31/03/2018	**Complete**	1. Weekly 'Hot Topic' audit which includes question regarding patient involvement in care planning	30/10/2017	**Complete**	Staff actively involve and discuss care issues with patients and families in an open and meaningful way as part of their everyday care	90% of care plans demonstrate involvement of patient, families and/or carers SIRI report Terms of Reference include patient concerns		
									3. Revise Duty of Candour letters to include patients/families concerns in scope of investigation and make explicit the contact arrangements. Use the Patient Collaborative to inform and shape letters.						
									4. Revise the Duty of Candour posters for clinical areas						
Valuing the basics	1.4 - Involving patients, families and carers	Safe Staffing	**New**	**Ensure compliance with Section 31 safe staffing enforcement notice**	Deputy Director of Nursing	29a Gap Analysis	28/02/2018	**Complete**	AMU and ED action plan in place and safe staffing reviews and response sent fortnightly to CQC	28/02/2018	**Complete**				
Valuing the basics	1.4 - Involving patients, families and carers	Safe Staffing	**New**	**Staffing numbers and skill mix of staff working in all areas must reflect patient numbers and acuity which should be adjusted according to variations in need**	Deputy Director of Nursing	Gaps: CQC 'musts and shoulds'	28/02/2018	**Complete**	Formal board report twice annually to agree establishment Continuous review of staffing skill mix in line with funded establishment and identification and documentation of risk/benefits analysis where optimum skill mix and staffing levels not able to be achieved	28/02/2018	**Complete**				
Valuing the basics	1.4 - Involving patients, families and carers	Safe Staffing	**New**	**Workforce reviewed with CSCs to identify and reduce reliance on locum support except under exceptional circumstances - 29a Gap Analysis**	Deputy Director of Workforce and Organisational development	29a Gap Analysis	TBC	**At risk**	To be developed	TBC				**April update:** Discussed with HR to provide milestones for next update.	
Valuing the basics	1.4 - Involving patients, families and carers	Safe Staffing	**New**	**The Registered Provider must ensure that there are a sufficient number (based on demand) of suitably qualified, competent, skilled and experienced clinical staff placed in the corridor/waiting area, of the Acute Medical Unit entrance and GP triage referral area**	Deputy Director of Nursing	AMU enforcement notice	31/03/2018	**Complete**	Complete. Enacted as part of AMU enforcementnotice issued in 2017 and subsequently fortnightly reporting to the CQC	31/03/2018	**Complete**			Fortnightly reporting of position against conditions to the CQC since Enforcement Notice issued. 4 unnanounced spot checks by the CCG and CPN lifted January 2018.	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**1**	**External review of Child Safeguarding in Emergency Department to identify any gaps in safeguarding procedures**	Associate Director of Nursing or Head of Safeguarding	CQC 'musts and shoulds'	31/03/2018	**Complete**	Review completed (31.12.17) and actions identified. Actions to be monitored through the Trust safeguarding Committee and PSCB/PSAB improvement board.	31/03/2018	**Complete**	Fully compliant with safeguarding children procedures	Compliance with action plan, monitored through joint PSAB and PSCB Improvement Board.		
									Develop a large over-arching action plan for Safeguarding in Adults, Maternity and Children's services	31/03/2018	**Complete**				

Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**2**	**External review of safeguarding processes and training material (CCG, Safeguarding Boards and local authorities) for both adult and child safeguarding**	Associate Director of Nursing	CQC 'musts and shoulds'	30/11/2017	**Complete**	External review has taken place. Action plan in place for Adult Safeguarding and development of Child Safeguarding action plan in relation to the CQC LAC report.	30/11/2017	**Complete**	External assurance of internal processes and education programmes	Compliance with action plan, monitored through joint PSAB and PSCB Improvement Board. Further external review to be commissioned for next financial year following delivery of the action plan to demonstrate improvements made.	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**3**	**Increase staff knowledge and awareness of domestic violence in high risk areas (ED, Maternity and Children's Services)**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Establish and commence delivery of a training plan for domestic violence to high risk areas	31/03/2018	**Complete**	Staff can display improved understanding and awareness of their responsibilities in relation to domestic violence	Attendance rate at training of staff in high risk areas exceeds 85%	
									Submit a business case for a 'Family First' worker	31/03/2018	**Complete**			
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**4**	**Strengthen the Adult Safeguarding Team and leadership**	Associate Director of Nursing	CQC 'musts and shoulds'	31/01/2018	**Complete**	Complete . Head of safeguarding to take up post Jan 2018	01/01/2018	**Complete**	To have the capacity and subject matter expertise to support the organisation in delivery of statutory requirements.	Safeguarding Leadership roles filled	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**New**	**Ensure staff in high risk areas for encountering patients living with domestic violence have a named staff member with skills in this area**	Associate Director of Nursing	CQC 'musts and shoulds'	30/09/2018		Recruit to 'Family First' worker post	30/09/2018		Family First' worker in post	Family First' worker in post	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**New**	**Ensure progress made following External Safeguarding review in December 2017**	Associate Director of Nursing	CQC 'musts and shoulds'	30/09/2018		Further external review to be commissioned for next financial year following delivery of the action plan to demonstrate improvements made.	30/09/2018		Overarching action plan has been successful in delivering actions identified from last external review	10% increase (in comparison to last year) in number of safeguarding concerns flagged to Safeguarding team	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**New**	**Evaluate effectiveness of 'vulnerable adults day'**	Associate Director of Nursing	29a Gap Analysis	31/03/2018	**Complete**	Gather feedback at Vulnerable Adults day	31/03/2018	**Complete**	Staff feel that the Vulnerable adults day has increased their knowledge and skill in management of these patients	Feedback shows that staff feel more confident in managing vulnerable patients	**April update:** Very minimal feedback received from 2 people. Information to be collated and evaluated for end of April. Trust intelligence suggests on-going variability in staff knowledge and understanding. **Need new action to be agreed with the Chief Nurse**
									Review and evaluate feedback	31/03/2018	**Complete**			
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**New**	**Commence weekly clinical training sessions on vulnerable adult safeguarding**	Associate Director of Nursing	29a Gap Analysis	31/03/2018	**Complete**	Host weekly MCA and DoLS training for staff in areas where these patients are encountered most commonly	31/03/2018	**Complete**	Staff are able to apply use of the MCA and DoLS appropriately	Training completed of staff in ED and MOPRS	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**New**	**Safeguards must be put in place when children or young people are admitted into adult environments, such as EDU, to ensure they are sufficiently safeguarded from avoidable harm**	Associate Director of Nursing	Gaps: CQC 'musts and shoulds'	31/03/2018	**Complete**	SOP issued that no patient under the age of 18 is to be placed on the Observation Ward without a risk/benefit being documented by the Consultant responsible	31/03/2018	**Complete**	Children or young people are not kept in adult areas and are safeguarded from avoidable harm	All patients under 18 admitted to the observation ward have documented risk/benefit by Consultant	
Supporting vulnerable patients	2.1 - Safeguarding	Safeguarding and mental health procedures	**New**	**The trust's own protocol for the management of actual or suspected bruising must be followed in all situations where an actual or suspected bruise is noted in an infant that is not independently mobile**		Gaps: CQC 'musts and shoulds'	31/03/2018	**Complete**	Set up training on bruising / birth marks for paeds and ED staff and make sure all staff in paeds and ED have been made aware of the importance of bruising protocol.	31/03/2018	**Complete**	Staff are compliant with the trust bruising protocol	10% increase (in comparison to last year) in number of safeguarding concerns flagged.	
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**1**	**Ensure adequate staff with the correct skills to care for patients with acute and specialist mental health needs**	Associate Director of Nursing	CQC 'musts and shoulds'	01/04/2018	**Complete**	Short term solution complete. Now working with ED and SHFT to strengthen arrangements going forward. Working with partners to deliver the requirements of the ACS MH workstreams which includes a specific workforce workstream	01/04/2018	**Complete**	Patients cared for by appropriately trained and skilled staff	Reduction in incidents and complaints relating to management of patients with specialist mental health needs. Weekly CQC metrics	Risk mitigated on a daily basis either with agency MH staff or reallocation of ED staff. Wider piece of work linked to the ACS MH workstream monitored through the MH and MC Board
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**2**	**Improve governance, oversight and key stakeholder relationships**	Associate Director of Nursing	CQC 'musts and shoulds'	Complete	**Complete**	Complete	Complete	**Complete**	Identify Executive lead for Mental Health and Establish Mental Health and Mental Capacity Board chaired by a Non-Executive Director	Identified Executive Lead. MH&MC Board established and operating within the Terms of Reference	
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**3**	**Ensure risk assessment of patients with acute and specialist mental health needs in the Emergency Department are undertaken**	Associate Director of Nursing	CQC 'musts and shoulds'/ED enforcement notice	31/03/2018	**Complete**	Continued weekly monitoring of the percentage of patients in the ED receiving a risk assessment. This risk assessment and plan must include, but is not exclusive to, the following: - Assessment of risks across a broad range of mental health issues and the identification of any specific risks for the individual patient and others in the department (patients, carers, staff, members of the public) and any safeguarding concerns. - The environmental risks to the patient and mitigating actions - Robust immediate risk management/care plan documenting the appropriate frequency of observation, specific intervention (care and treatment) required to meet the patient's needs and escalation plans should the patient's condition deteriorate. - An identified time and date for review specific to the individual patient's needs.	30/11/2017	**Complete**	By March 2018 the percentage of patients being risk assessed will exceed 90% consistently	>90% of mental health patients in the Emergency Department are risk assessed. Reduction in incidents relating to Mental Health within ED.	
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**4**	**Ensure appropriate care plan and intervention in place for patients with acute and specialist mental health needs in the Emergency Department**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Perform weekly sample audits on Oceano	31/12/2017	**Complete**	Individualised care plans and intervention based on accurate risk assessment to improve safety	>90% appropriate care plans and interventions are in place in the Emergency Department	
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**5**	**Trust-wide environmental review to assess the risks of managing patients with acute and specialist mental health needs**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Overarching risk assessment of the Trust complete	31/03/2018	**Complete**	All areas appropriately risk assessed and mitigating actions taken as appropriate.	90% Risk assessments completed in high risk areas Reduction in incidents relating to Mental Health	Trust-wide ligature risk assessment placed on risk register and associated work plan agreed at the April Mental Health and Capacity Board.
									Document over-arching risk assessment in line with Trust Policy	31/03/2018	**Complete**			
									Commence Audit and risk assessments in high risk areas	31/03/2018	**Complete**			
									Share learning from audit	31/03/2018	**Complete**			
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**6**	**Enhance staff education and awareness regarding mental health**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Introduce basic MH e-learning awareness training for all staff through induction and Essential Skills	31/03/2018	**Complete**	Staff can display improved understanding and awareness of their responsibilities under the Mental Health Act	85% of staff in ED have undertaken the Mental Health e-learning training with a pass mark 50% of patient - facing trust staff have undertaken the MH e-learning	Basic mental health awareness training now available for all staff with a focus on high risk areas e.g. ED
									Ensure further promotion and completion of e-learning for those working in high risk areas	31/03/2018	**Complete**			
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**New**	**Identify lead for MH within ED and AMU with appropriate training and skills**	Associate Director of Nursing	ED enforcement notice	31/03/2018	**Complete**	MH lead appointed for Emergency Medicine and AMU	31/03/2018	**Complete**	Lead appointed	Lead appointed	
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**New**	**Staff within the emergency and medical areas must have sufficient knowledge of the Mental Health Act, 1983, so they understand their responsibilities under the Act**	Associate Director of Nursing	Gaps: CQC 'musts and shoulds'	31/05/2018	**Complete**	Staff within the ED offered training sessions on Mental health	31/03/2018	**Complete**	Staff within the ED feel more confident in how to manage patients with respect to the MCA and use the MCA appropriately Staff report improved relationship with MH Liaison team	Reduction in incidents relating to use of the MCA	
									Staff in ED are made aware of roles of the Mental Health Liaison and Duty Hospital Manager on induction	31/03/2018	**Complete**			
									A lead for the MCA identified for ED	31/03/2018	**Complete**			
									Staff within the ED required to complete the Mental Health e-learning module	31/05/2018	**Complete**			

Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**New**	**Gauge staff understanding of managing patients with mental health issues, following trust training**	Associate Director of Nursing	Trust	31/08/2018		Initiate survey monkey survey, with initial focus on ED staff	31/08/2018		Demonstrable improvement in staff knowledge and confidence in managing patient with mental health needs	Staff demonstrate improved confidence within the survey	
Supporting vulnerable patients	2.2 - Mental Health	Safeguarding and mental health procedures	**New**	**Ensure high risk patients with mental health concerns or vulnerable safeguarding issues are identified, monitored and observed across the hospital and Trust must have oversight of the location, and areas of detention where appropriate**	Associate Director of Nursing	ED enforcement notice	31/03/2018	**Complete**	Set up a dashboard in the Ops centre detailing where high risk patients are located and if DoLS enacted	31/03/2018	**Complete**	Staff have oversight of where high risk mental health patients are located within the hospital and these patients are appropriately monitored	Dashboard complete and in use	
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**1**	**Recruit a lead Dementia Nurse Specialist**	Chief Nurse	29a	28/02/2018	**Complete**	To source funding for Dementia Nurse Specialist post.	31/01/2018	**Complete**	There is adequate staff support to undertake measures to improve dementia care within the Trust	1 FTE in place	**April update:** Lead nurse has soruced funding for Dementia post, through existing resources and has included the role in the Trust re organisation, which has been to EMT – therefore this is now amber on the rag rating . The Chief Nurse has also reviewed draft JD with NHSE
									If funding not available the backfill with available staff to support with dementia care initiatives	28/02/2018	**Complete**			
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**2**	**Trust Dementia strategy aligned to the NHS Dementia Assessment and Improvement Framework and the National Dementia Challenge 2020 delivery plan**	Dementia Nurse Specialist	Trust	31/05/2018		Dementia Nurse Specialist to develop strategy with stakeholder engagement once in post.	31/05/2018		Develop and delivery of a strategy in line with NHS Improvement Dementia Assessment and Improvement Framework (October 2017)	The strategy is delivered in line with the NHS Dementia Assessment and Improvement Framework and the National Dementia Challenge 2020 delivery plan.	**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**3**	**Audit the consistent use of the 'This is Me' document**	Head of Nursing MOPRS	29a	31/12/2017	**Complete**	Put in place a method for auditing whether the 'This is Me' document is being used consistently (use the Quality Care Reviews to do this).	01/12/2017	**Complete**	Completion of audit. Evidence of continuous improvement	Quality Care Review results.	**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**New**	**Ensure the consistent use of the 'This is Me' document**	Head of Nursing MOPRS	29a	30/06/2018	**Complete**	Ensure that all wards have access to the 'This is Me' form	20/11/2017	**Complete**			**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
									Re-launch of Dementia champions Trustwide	31/12/2017	**Complete**			**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
									Promote use via Matron/ Ward Managers/ Dementia Champions	Ongoing	**Complete**			**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**4**	**Implement reminiscence trolleys in every ward where patients have dementia**	Head of Nursing MOPRS	29a	31/12/2017	**Complete**	1. Identify funding source, when identified HoN to order trolleys and contents.	30/11/2017	**Complete**	Trolleys available in all wards	Every adult in-patient ward has a reminiscence trolley	**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
									2. Ward Managers, with support from Dementia Champions, to implement trolley use to include training for staff to use the resources.	TBC	**Complete**			**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**5**	**Increase activities available for patients living with dementia**	Head of Nursing MOPRS	Trust	31/03/2018	**Complete**	1. Re-invigorate Memory Lane to support social activities.	01/01/2018	**Complete**	A variety of activities available to support stimulation and distraction therapies	Activities are available to support stimulation and distraction therapies for patients living with dementia	**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
									2. Undertake 12 month HEE QI fellowship to embed social activities to reduce deconditioning.	01/01/2018	**Complete**			**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
									3. Review the requirements for other patients with dementia outside of MOPRS CSC and put in place appropriate plans to support their needs.	31/03/2018	**Complete**			**April update:** All actions related to dementia have been closed following visit from National Dementia Lead on 23.04.2018. Following visit, the Demetia Strategy is being developed with an associated workplan to address all areas requiring improvement. This will be presented at the Dementia Steering Group in May 2018.
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**6**	**Review the dementia screening process to ensure it fits with clinical practice**	Head of Nursing MOPRS	Trust	31/03/2018	**Overdue**	1. Identify medical lead to work with HoN to provide challenge to medical colleagues.	30/11/2017	**Overdue**	Achieve the national standards for dementia screening to meet or exceed 90%	Improved compliance with dementia screening to >90%	Dependent on lead Dementia Nurse being in post.
									2. Review with medical lead progressing the current screening process to BedView- will require support to influence this action.	31.03.2018	**Overdue**			
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**7**	**Improve the support for carers of patients living with dementia**	Head of Nursing MOPRS	29a	31/03/2018	**Complete**	1. Scope current concerns from Dementia Audit and work with Head of Patient Experience to understand feedback from patient groups/ volunteers/ Healthwatch etc.	31.03.2018	**Complete**	Appropriate signposting and improved awareness of the Carers Cafe	Improved attendance at the carers café for carers of patients living with dementia. Carer feedback.	Dependent on lead Dementia Nurse being in post.
									2. Implement action plan with deadlines to address concerns.		**Complete**			
									3. Work in collaboration with Carers lead to increase utilisation of Carers Cafe.		**Complete**			
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**New**	**Ongoing improvement in support for carers of patients living with dementia**	Head of Nursing MOPRS	Trust	30/04/2019		Practice Inquiry Project to breakdown and understand why the process of early carer identification using the nursing documentation is not being used.	30/04/2019		All carers identified early in patient care	Improved carer feedback Patient collaborative feedback	
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**New**	**Patient with Dementia have a 'This is me' document in place and this is used effectively**	Associate Director of Nursing	29a	30/06/2018		Use the Patient collaborative to undertake and Observation of Care in MOPRS	30/06/2018		All appropriate patients have a 'This is me' document in place	Patient collaborative feedback	Barrier: Resource limitations and demands on staff **Revised deadline: 30/06/2018** Residual risk: Risk to patient experience Mitigation: Extending deadline to ensure relevant individuals resourced
Supporting vulnerable patients	2.3 - Dementia	New care models e.g. Dementia	**New**	**External visit from National Dementia lead and identification of gaps**	Associate Director of Nursing	29a Gap Analysis	31/05/2018		External visit from National Dementia Lead	31/03/2018	**Complete**	Gaps in Dementia care identified and plan on delivering improvements initiated	Completion of Health watch self-assessment	National dementia Lead visited the Trust on 23/04/2018.
									Undertake a Healthwatch self-assessment	31/05/2018				
Supporting vulnerable patients	2.4 - Mental Capacity Act and Deprivation of Liberty Safeguards	Safeguarding and mental health procedures	**1**	**Strengthen the governance arrangements around DoLS to ensure timely assessment**	Associate Director of Nursing	CQC 'musts and shoulds'	31/12/2017	**Complete**	Further vulnerable patient Deep Dive to commence week commencing 11/12/17	31/12/2017	**Complete**	Discharge our legal responsibilities under the MCA/DoLS to keep patients safe in our care	Improvement in the number of patients appropriately assessed as evidenced through the Adult Safeguarding Team weekly audit.	
Supporting vulnerable patients	2.4 - Mental Capacity Act and Deprivation of Liberty Safeguards	Safeguarding and mental health procedures	**2**	**Weekly clinical review of patients under MCA and DoLS, including documentation**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Auditing weekly - feed back directly to clinical teams. Complete	Commenced and on-going	**Complete**	Completion of audit and direct feedback to clinical staff to improve learning	Improvement in the number of patients appropriately assessed as evidenced through the Adult Safeguarding Team weekly audit.	
Supporting vulnerable patients	2.4 - Mental Capacity Act and Deprivation of Liberty	Safeguarding and mental health procedures	**3**	**Implement a revised education and training programme for all clinical staff regarding MCA and DoLS**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Implemented revised training (see action below). Continue weekly clinical reviews by the Adult Safeguarding Team with immediate feedback to staff to facilitate learning	01/01/2018	**Complete**	Staff have the confidence to translate the theory into clinical practice demonstrated through the improved care and safety for vulnerable patients	Improvement noted in the application of MCA and DoLS in practice	Recent Care Quality Review highlighted on-going concerns re staff knowledge. Consider additional actions
Supporting vulnerable patients	2.4 - Mental Capacity Act and Deprivation of Liberty	Safeguarding and mental health procedures	**4**	**Intensive focused training for all staff on application of the MCA in practice (revised training methodology)**	Associate Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Continue weekly clinical reviews by the Adult Safeguarding Team with immediate feedback to staff to facilitate learning	01/01/2018	**Complete**	Improved understanding and documentation regarding Mental Capacity Assessments and Best Interest Decision Making	Improvement noted in the application of MCA and DoLS in practice	
Supporting vulnerable patients	2.4 - Mental Capacity Act and Deprivation of Liberty	Safeguarding and mental health procedures	**New**	**Ensure that patients do not have procedures undertaken on them without appropriate consent being obtained, and best interest assessments are completed where possible**	Associate Director of Nursing	Gaps: CQC 'musts and shoulds'	31/03/2018	**Complete**	Undertake a thematic analysis of the MCA and DoLS audit	31/03/2018	**Complete**	Patients do not have procedures undertaken on them without appropriate consent	Thematic analysis shows a drop in these behaviours	Thematic analysis completed. MCA/DoLS overarching action plan to address improvement areas

Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**1**	**Freedom to Speak Up promotion week**	Deputy Director of Workforce and Organisational development	CQC 'musts and shoulds'	Complete	**Complete**	Complete	Complete	**Complete**	Staff feel confident and know how to raise concerns	Visible promotion and social media activity with involvement from staff	
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**2**	**Identification and training of 16 Freedom to Speak Up advocates**	Deputy Director of Workforce and Organisational development	CQC 'musts and shoulds'	Complete	**Complete**	Complete	Complete	**Complete**	Staff feel confident to raise concerns without recrimination	Staff are aware of the advocates role and how to access them measured through the number of contacts made. The advocates report that staff contact them for advice and support and are able to resolve any issues raised	
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**3**	**Appointment of Freedom to Speak Up Guardian**	Deputy Director of Workforce and Organisational development	CQC 'musts and shoulds'	31/12/2017	**Complete**	Recruit to post	30/11/2017	**Complete**	Staff feel confident to raise concerns without recrimination	Freedom to speak up Guardian appointed and fulfilling remit of role	
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**4**	**External review of leadership behaviours to identify areas where leadership values and behaviours need challenging and improving**	Director of Workforce and Organisational Development	CQC 'musts and shoulds'	31/05/2018		Commission an external review of Bullying and Harassment	30/11/2017	**Complete**	Staff feel that the workplace culture is improved	Improved national staff survey results Reduction in employee relations' cases Reduction in bullying and harassment concerns raised by staff	Barrier: 6 month piece of work commenced in January. Field work will be complete 6 April with a full report issued for Trust Board by 31 May with recommendations **Revised deadline: 31/05/2018** Residual risk: Minimal risk Mitigation: Supported by Respect Me capmpaign
									To commence workshops with Professor Lewis	26/02/2018	**Complete**			
									Review completed with recommendations shared and further actions developed	31/05/2018				
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**New**	**Refresh 'Respect me' campaign**	Head of Organisational Development	29a Gap Analysis	31/03/2018	**Complete**	Refresh in line with recommendations from Professor Lewis	31/03/2018	**Complete**	Staff feel respected and heard in the workplace and feel able to raise concerns without recrimination	Improvement in National Staff Survey	Respect Me Campaign was refreshed in Autumn 2017 and is on-going with a resource centre for staff positioned on the homepage of the intranet. This work also aligns with the externally commissioned deep dive into B&H by Prof Duncan Lewis
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**New**	**Increase profile of resilience training and coaching offered to staff through Aquillis counselling service**	Head of Organisational Development	29a Gap Analysis	31/03/2018	**Complete**	Advertise resilience training	31/03/2018	**Complete**	Staff aware of how to access resilience training through Aquillis	Increased uptake of Aquillis resilience training	
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**New**	**Promote FTSU e-learning programme during induction process**	Head of Organisational Development	29a Gap Analysis	31/03/2018	**Complete**	FTSU guardian to speak at staff Trust induction and promote e-learning	31/03/2018	**Complete**	Increased staff awareness on joining the trust of FTSU initiative and available learning resources	Increased uptake of FTSU e-learning programme	
Organisation that learns	3.1 - Zero tolerance of bullying	Organisational Development, including staff engagement, culture & leadership	**New**	**Ratification of the new 'Raising Concerns' Policy**	Head of Organisational Development	29a Gap Analysis	31/03/2018	**Complete**	Raising concerns' Policy to be signed off by CEO	31/03/2018	**Complete**	Staff understand the pathways available to raise concerns	Ratification of the policy by CEO sign off	This was ratified by Policy group in January 2018 and is on the policy framework on the intranet
Organisation that learns	3.2 - Behaviours and compassion	Organisational Development, including staff engagement, culture & leadership	**1**	**Implement Multidisciplinary Schwartz round**	Consultant Geriatrician	Trust	Complete	**Complete**	Complete. Two completed. Next planned for 24/11/2017	Complete	**Complete**	Provide a safe and supportive environment for staff to share and learn from their experiences, improve staff morale and team working	Increased number of attendees Increased range of staff groups attending as the rounds embed	
Organisation that learns	3.2 - Behaviours and compassion	Organisational Development, including staff engagement, culture & leadership	**2**	**Provide education on embedding trust values and behaviours into Job Planning rounds with consultants**	Associate Medical Director - Consultant Radiologist	Trust	31/03/2018	**Overdue**	1. Launch new job planning round with presentation to CDs and Business Managers	20/10/2017 - complete	**Complete**	Increased compliance with Job planning on CRMS to 90%	> 90% of Consultants have approved in-date job plans on CRMS (current level 77%)	**April update:**Policy not ratified however, job planning process completed. The role of the job planning consistency panel, Chaired by the Deputy Medical Director, is to ensure that departments use the job planning process to make best use of resources, encourage team working (and skill mix, where appropriate, valuing everyone's contribution) and make sure that job plans are focused on patient care. Therefore, Trust values have been incorporated into the job planning process.Propose action is closed.
									2. Launch new PHT Job Planning Policy document	30/11/2017	**Overdue**			
									3. Job Plan Review meetings to be held	31/03/2018	**Complete**			
Organisation that learns	3.2 - Behaviours and compassion	Workforce Strategy, recruitment and induction	**3**	**Map all recruitment processes and align to trust standard**	Head of Employee Resourcing	Trust	30/09/2018		Recruitment and retention strategy to be developed in line with the workforce strategy	30/09/2018		Ensure value based recruitment process is applied to all staff groups	Strategy developed and implemented by 31 March 2018.	Barrier: To form part of the Workforce Strategy **Revised deadline: In line with overall Trust Strategy TBC (review September 2018)** Residual risk: None Mitigation: Review deadline to align to Workforce Strategy
									Draft strategy to be issued	31/10/2018				
Organisation that learns	3.2 - Behaviours and compassion	Organisational Development, including staff engagement, culture & leadership	**4**	**Implement NHSI Culture and Leadership Programme**	Head of Organisational Development	Trust	31/04/2018	**Complete**	1. Lead a session with EMT to seek a decision to implement	15/11/2017	**Complete**	Develop a culture that enables and sustains continuous improvement of safe, high quality and compassionate care	EMT and Trust Board approval Change team in place Formal launch evident and programme is effectively implemented	
									2. Lead a session with Trust Board to provide clarity of the programme, the role of the Board and the timeframe	30/11/2017 31/01/2018	**Complete**			
									3. Recruit staff to be 'change agents' as part of the 'culture change team'	30/04/2018	**Complete**			
									4. Formally launch the culture programme	30/04/2018	**Complete**			
Organisation that learns	3.2 - Behaviours and compassion	Organisational Development, including staff engagement, culture & leadership	**5**	**Revision of Nursing, Midwifery and Allied Health Profession Strategy**	Deputy Director of Nursing	Trust	31/07/2018	**On track**	Create and launch a patient care strategy	31/12/2017	**Complete**	Improve compassionate care and engagement with frontline staff	Patients and staff can say that they are treated with dignity and respect.	Strategy to be revised once the Trust Strategy is in place **Further April position update:**Decision made to revise the Patient Care Strategy prior to the development of the Trust Strategy. This will then be circulated independently of the Trust Strategy. Deadline revised to meet this change in plan to July 2018.
									Ensure 'patient care strategy' is in line with revised 'Trust strategy' through Director of Strategy approval	31/07/2018	**On track**			
Organisation that learns	3.3 - Right staff, right skills	Workforce Strategy, recruitment and induction	**1**	**Further overseas recruitment**	Head of Employee Resourcing	Trust	20/04/2018	**Complete**	Continue to work with clinical leaders to ensure maximising recruitment opportunities	30/04/2018	**Complete**	Reduction in vacancy rate and temporary workforce spend	Reduction in vacancy rate 5% by April 2018 Reduction in temporary staff spend by 5%	
Organisation that learns	3.3 - Right staff, right skills	Workforce Strategy, recruitment and induction	**2**	**Implement plans for revised and new roles to support difficult to recruit posts**	Head of Nursing and Midwifery Education/Director of Medical Education	Trust	31/01/2018	**Complete**	1. Continue to support development of advanced practice/ apprenticeships.	On-going	**Complete**	Education programmes are available to support the development of staff into new roles to fill hard to recruit posts	Reduction in vacancies in difficult to recruit roles	
									2. Seek and implement education programmes to develop staff into roles when identified in CSC/Trust workforce plans.					
Organisation that learns	3.3 - Right staff, right skills	Workforce Strategy, recruitment and induction	**3**	**Audit compliance with local induction process**	Head of Nursing and Midwifery Education/Director of Medical	Trust	31/01/2018	**Complete**	Complete (currently monitor compliance and this is shared via the education dashboard)	31/12/2017 The data on compliance relies on managers submitting the information. Therefore	**Complete**	Monthly induction audit completed	All monthly induction audit data available on Education dashboard	
Organisation that learns	3.3 - Right staff, right skills	Workforce Strategy, recruitment and induction	**4**	**Revision of workforce strategy**	Director of Workforce and Organisational Development	Trust	30/09/2018		Workforce Strategy to be refreshed in line with organisational strategy	30/09/2018		Clear and current written strategy in place to address workforce priorities	Workforce strategy approved and implemented	**Barrier:** Strategy needs to follow the Trust Strategy **Revised deadline:** 30/09/2018 **Residual risk:** None **Mitigation:** None required.

Organisation that learns	3.3 - Right staff, right skills	Workforce Strategy, recruitment and induction	**5**	**Recruitment and Retention event**	Lead Workforce Nurse	Trust	31/08/2018	**Complete**	Complete	Complete	**Complete**	Improved understanding by staff of opportunities to develop their careers and the benefits available to new employees	Reduced vacancy rates	
Organisation that learns	3.3 - Right staff, right skills	Organisational Development, including staff engagement, culture & leadership	**6**	**Board / Director development programme to be developed and implemented**	Chief Executive Officer and Trust Chair	Trust	31/08/2018		Relevant Board development programme to be identified when Trust Board fully populated.	31/03/2018	**Complete**	New Board are clear on priorities, their shared and individual objectives and are effectively executing their responsibility as a board	Board development plan in place	**April update for discussion:** Board development programme commenced in March 2018. 12 month programme in place. A draft Board development programme has been produced and awaits further discussion by the Board and formal adoption by 31.05.18
									Implement Board development programme	30/06/2018	**Complete**			
									Board development programme completed with actions identified	31/08/2018				
Organisation that learns	3.3 - Right staff, right skills	Nurse training programme / Medical training programme	**New**	**New staff receive their local induction within the first 3 months of employment**	Director of Education	Trust	31/03/2018	**Complete**	Review monthly audit data and identify and target at risk area	31/03/2018	**Complete**	All staff will receive local induction	All Staff have received local induction within 3 months as per Trust Policy	Established process that ensures managers are followed up for non-compliance against Trust expectation
Organisation that learns	3.3 - Right staff, right skills	Nurse training programme / Medical training programme	**New**	**Ensure that staff are assessed and signed off as competent to deliver patient care**	Director of Education	Gaps: CQC 'musts and shoulds'	30/06/2018	**Complete**	Audit compliance with generic competency compliance	31/03/2018	**Complete**	All staff are assessed and competent to deliver patient care	All staff compliant with generic competencies	Barrier: Competency framework in place. Need to audit compliance **Revised deadline: 30/06/2018** **April update:** Snap shot audit undertaken of the nursing and midwifery competency framework policy. Variance in adherence noted. Outcome to be shared with clinical educators to create local action plans for the CSCs to enact. Re-audit to be undertaken in June 2018. See new action.
Organisation that learns	3.3 - Right staff, right skills	Nurse training programme / Medical training programme	**New**	**Ensure that staff are assessed and signed off as competent to deliver patient care**	Director of Education	Gaps: CQC 'musts and shoulds'	30/06/2018		Re-Audit compliance with generic competency compliance	30/06/2018		All staff are assessed and competent to deliver patient care	All staff compliant with generic competencies	
Organisation that learns	3.3 - Right staff, right skills	Nurse training programme / Medical training programme	**New**	**Staff mandatory training should be above the hospital target of 85% across all clinical workforce**	Director of Education	Gaps: CQC 'musts and shoulds'	31/03/2018	**At risk**	Ensure annual booklet and corresponding test issued to all clinical staff	31/03/2018	**Complete**	All staff have flexible opportunities to complete areas of missing compliance training	Essential skills training compliance at 85% for nursing, medical/dental and AHP	**April update:** Actions delivered, training compliance not achieved for all staff groups.
									Establish face to face training	31/03/2018	**Complete**			
									Establish Pick 'n Mix days for compliance training	31/03/2018	**Complete**			
									Ensure line managers identify all medical and dental staff who are non-compliant with essential skills training and offer any support required	31/03/2018	**Complete**			
Organisation that learns	3.3 - Right staff, right skills	Workforce Strategy, recruitment and induction	**New**	**Professional Forum updated on Essential skills in Education update**	Director of Education	29a Gap Analysis	31/03/2018	**Complete**	Ensure profession forum occurs on a monthly basis	31/03/2018	**complete**			
Organisation that learns	3.4 - Staff engagement	Organisational Development, including staff engagement, culture & leadership	**1**	**Introduce monthly forums for the junior doctors to meet the Medical Director and Chief Registrar**	Medical Director	Trust	Complete	**Complete**	Complete	Complete	**Complete**	To improve staff engagement with the Junior Medical staff who work in a transient role	Monthly forums occur and there is improvement in the Deanery report	
Organisation that learns	3.4 - Staff engagement	Organisational Development, including staff engagement, culture & leadership	**2**	**Introduce monthly forums for the Consultants to meet the Medical Director and Chief Executive Officer**	Medical Director	Trust	Complete	**Complete**	Complete	Complete	**Complete**	To improve staff engagement with the Senior Medical staff	Monthly forums occur and there is an improvement in the medical engagement scale results	
Organisation that learns	3.4 - Staff engagement	Organisational Development, including staff engagement, culture & leadership	**3**	**Widen the attendance at the professional forum for Nurses and Midwives**	Chief Nurse	Trust	30/11/2017	**Complete**	Matrons to be invited	31/12/2017	**Complete**	To improve engagement with the Nursing and Midwifery workforce to strengthen Board to Ward	Increased attendance and staff feeling engaged	
Organisation that learns	3.4 - Staff engagement	Organisational Development, including staff engagement, culture & leadership	**4**	**Staff Big Conversations personally hosted by the CEO**	Chief Executive Officer	Trust	31/12/2017	**Complete**	Staff engagement events to take place	31/12/2017	**Complete**	Staff report feeling more engaged and able to make changes happen in their own area of work	Actions identified with 'you said we did' communications Staff engagement levels increase as reported by the national staff survey	
Organisation that learns	3.4 - Staff engagement	Organisational Development, including staff engagement, culture & leadership	**5**	**Introduce an annual staff engagement calendar of events**	Head of Organisational Development	Trust	31/12/2017	**Complete**	Complete	Complete	**Complete**	Staff report increased levels of engagement	Events calendar on intranet	
Organisation that learns	5.1 - Leadership at all levels 5.2 - Role clarity, responsibility and accountability	Organisational Development, including staff engagement, culture & leadership	**2**	**Improve the compliance rate and quality of appraisals**	Director of Workforce & Organisational Development	Trust	31/03/2018	**Complete**	Monitor compliance as part of monthly performance reviews, taking appropriate action to ensure improvements are made.	Monthly and on-going	**Complete**	Meeting or exceeding 85% target and that staff report a meaningful appraisal	Compliance rates reach 85% by 31 March 2018. Increase in staff reporting they had a quality appraisal in the national staff survey report published in March 2018.	Moved to Organisation that learns from Good Governance.
									Provide additional training for managers to include how to have a coaching style conversation and set SMART objectives					
Organisation that learns	5.1 - Leadership at all levels	Organisational Development, including staff engagement, culture & leadership	**3**	**Support the Trust key leadership programmes**	Head of Organisational Development	Trust	31/03/2018	**Complete**	Ensure leadership programmes available are aligned to organisational priorities and address any skills gaps identified through the annual training needs analysis	28/02/2018	**Complete**	Staff in leadership roles will feel confident to lead and manage their services Leadership development offering is clear and aligned to organisational needs A number of individuals are being supported through a talent pipeline A supportive programme of development is in place for a new organisational structure	Leadership and management course attendance. Overall staff engagement levels improve as measured by the national staff survey.	Moved to Organisation that learns from Good Governance.
									Strengthen succession planning and talent management for critical posts	28/02/2018	**Complete**			
									Embed coaching skills as a core skills development for managers and leaders	28/02/2018	**Complete**			
Organisation that learns	5.1 - Leadership at all levels	Organisational Development, including staff engagement, culture & leadership	**New**	**Launch a programme of development to support the transition to a new organisational structure**	Head of Organisational Development	Trust	31/07/2018		Procure and commission a bespoke development programme	31/07/2018		Development opportunities available to support the new divisional structure	Programmes are launched by deadline	

Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**1**	**Implementation of the Learning from Deaths policy**	Associate Chief Nurse for Patient Safety	29a	31/12/2017	**Complete**	1. Publish Policy on intranet	Complete	**Complete**	Policy published, implemented and embedded in practice	Audit of MRT data to demonstrate MRP, M&M and SJR compliance Learning from deaths reports Reducing HSMR Reduction in coroners referrals from inpatients	
									2. Communicate to senior clinical staff	Complete	**Complete**			
									3. Re-publicise policy – targeted at senior medical and nursing staff	30/11/2017	**Complete**			
									4. Programme for all Specialties to present local mortality review process to Mortality review group	30/12/2017	**Complete**			
Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**2**	**Training in Structured Judgement Review**	Associate Chief Nurse for Patient Safety	29a	31/12/2017	**Complete**	1. MR panel review of all adult deaths to be in place for all specialties in Medicine and MOPRS	31/12/2017	**Complete**	Consistent approach to reviewing patient deaths to improve learning	Specialty and CSC governance reports contain evidence of reviews MRG minutes to demonstrate specialty reports	Policy updated to include flow chart, published 16 April 2018
									2. Programmed roll out for all other specialties to commence MRP process by 31/03/2018	31/12/2017	**Complete**			
									3. Recruitment of further MRP members	31/12/2017	**Complete**			
									4. Core Structured Judgement Review trainers to have attended RCP training session	Complete	**Complete**			
									5. Trust SJR training programme to commence	30/11/2017	**Complete**			
									6. Further SJR training sessions booked for first 3 months of 2018	31/12/2017	**Complete**			
									7. Process for identification and evaluation of groups of cases (e.g. Dr Foster alerts) requiring review to be articulated and added to LFD policy	~~31/12/2017~~ Revised deadline: 31/03/2018	**Complete**			
Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**3**	**Further roll-out of the Mortality Reviews across all specialities**	Deputy Medical Director	29a	31/03/2018	**Complete**	Development of the Trust electronic Mortality Review Tool to allow easy analysis of data to identify themes and trends	31/03/2018	**Complete**	Ensure there is a centralised portal for mortality review and that plans are made to disseminate learning	Reduction in avoidable serious harm events This will be calculated by a review of the Datix reports to include the Hogan scale of avoid ability so we can start to quantify. Once we have this we can aim for a % reduction in 1-3 scores.	**April update:** Action related to development of a safety message to share learning now forms part of the communication plan (4.2 Moving Beyond Safe)
									Develop a much more robust approach to sharing learning from cases which will use a variety of media, and to consider: A Patient Safety web-hub/portal on the Trust site where all things patient safety focussed can be accessed by staff, this will include: a) A summary of key themes and key actions from MRP and SJR reviews b) Unusual cases- presented as case vignettes for learning c) All of the previous 'Watch out notices' d) Links to Policies relating to the cases.	31/03/2018	**Complete**			
									Use 'Grand round' presentations to focus on the learning from a variety of cases	31/03/2018	**Complete**			
									Develop a weekly/biweekly safety message for the whole Trust	31/03/2018	**Complete**			
Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**4**	**Implementation of the Time to Act initiative (deteriorating patient pro-forma)**	Consultant Critical Care and Resuscitation Manager	29a	31/07/2018		Scale up Plan launched on the 6 December 2017	31/12/2017	**Complete**	Patient's condition received appropriate escalation to ensure patients receive the correct and timely assessment, monitoring, referral and treatment	Evaluation of the scale up will include audit into: • Number of Ward Cardiac Arrests per 1000 admissions (Outcome) • Escalation according to NEWS Protocol (Outcome/Process) • Number of wards in scale up (Process) • Patients with a new NEWS > 5 – pro forma used (how many & how often) (Process) • Quality of pro forma completion – completed, compliant, escalation plan documented (Process) • Number of staff engaged • Reduction in Safety Learning Events related to delayed escalation (Outcome)	
									Scale up to 60% of the target population: Identified through a proforma in adult in-patient bed units (excluding ICU, Day Case areas, ED Observation Ward) when they first trigger at a NEWS of 5 and above (modification required to the pro forma used in maternity).	31/07/2018				
Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**New**	**Further development of SJR**	Deputy Medical Director	Trust	30/06/2018		Mortality review tool to go live	31/03/2018	**Complete**	Consistent approach to reviewing patient deaths to improve learning	Mortality Review tool is capturing all MR and SJR	
									Audit of submissions to mortality review portal 3 months after go live	30/06/2018				
									Undertake thematic analysis of MR, SIRI and SJR using Mortality Review Tool data	30/06/2018				
Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**New**	**Ensure Learning from Deaths policy is up to date and all specialities aware of mortality review process**	Deputy Medical Director	Trust	31/03/2018	**Complete**	Review Learning from Deaths Policy	31/01/2018	**Complete**		Reduction in no of avoidable Serious harm events Increase number of SIRI reported	Mortality process in ED reviewed. Agreement to keep ED process separate from the other MRP. Deputy Medical Director and ED Mortality Lead will conduct joint second stage reviews to extract learning points.
									Review mortality review process in ED and identify method of dissemination of learning	31/03/2018	**Complete**			
Moving beyond safe	4.2 - No 'avoidable' deaths	Mortality and morbidity	**New**	**Ensure all relevant learning from Regulation 28 coroner reports, MR, SJR and SIRIs communicated to appropriate staff, departments, patients and relatives**	Associate Chief Nurse for Patient Safety	Trust	31/08/2018		Develop a 'communication plan' for the Trust which can be used across MR, SJR and SIRI review panels and appropriate measures within the plan selected and disseminated. This will include: * Mortality review group * Grand round presentations * Safety bulletin * Departmental teaching * Simulation where appropriate	30/04/2018	**On track**	All learning from relevant review panels disseminated to the right staff and has an impact in reducing patient harm and avoidable deaths Patients and/or families feel that the Trust places value in learning from serious incidents and deaths	Reduction in avoidable deaths Reduction in serious harm events Increase in incident reporting Reduction in number of overdue SIRIs	
									Launch the communication plan	07/05/2018				
									Audit use of the communication plan across review panels and track impact of measures through pulse survey	31/07/2018				
									Complete investigation report and feedback to patient and/or family on all SIRIs within 60 days and share with patients after a further 30 working days from CCG sign off.	31/08/2018				
Moving beyond safe	4.3 - Stop harm to patients	Mortality and morbidity	**1**	**Pilot the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle for reducing pressure damage**	Associate Director of Nursing	Trust	31/03/2018	**Complete**	To commence Purpose T risk assessment and care planning tool	31/01/2018	**Complete**	Aid staff in prioritising care, highlighting which patients are high risk of pressure damage	Audit use of Purpose T. Reduction in hospital acquired pressure ulcers	
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**2**	**Establish a senior safety team under the leadership of the Medical Director and Chief Nurse**	Medical Director/Chief Nurse	29a	31/03/2018	**Complete**	Complete. Safety team established December 2017	31/12/2017	**Complete**	Team in place to set the strategic direction for safety and drive the changes needed	Workplan in place with identified accountable leads	
Moving beyond safe	4.3 - Stop harm to patients	Mortality and morbidity	**3**	**Standardisation of clinical handover documentation**	Chief Nurse	Trust	30/04/2018	**Complete**	Best practice standardised tool to be tested and applied	31/01/2018	**Complete**	Consistent completion of handover documentation to ensure patient safety and that handovers are standardised.	Reduction in incidents in relation to transfer and handover	Handover Bundle launched 25.3.18. Time to Act initiative launched Audit of handover standards planned for June 18

Moving beyond safe	4.3 - Stop harm to patients	Mortality and morbidity	**4**	**Introduce a Six Month Safety Sprint concept**	Deputy Medical Director / Consultant in Critical Care	Trust / 29a	31/08/2018	**Future action at risk**	"Time to Act" initiative to be rolled out across Trust with initial pilots on designated medical wards already scheduled.	Commenced roll out December 2017	**Complete**	Improved outcome measures associated with » Deteriorating patients » Sepsis » Learning from events and feedback » Learning from deaths Improved staff awareness of learning from incidents.	Reduction in deaths from Sepsis 100% of SIRI action plans reviewed within two months of sign off with an improvement on action plan completion.	**April update:** Sepsis Nurse Job description complete. Business case being drafted. Implementation of "Sepsis Bleep" with help of Critical Care Outreach is dependent upon this appointment. **Proposed revised deadline: 31 May 2018**
									Combine Deteriorating Patient and Sepsis Groups to ensure coordinated coverage of both agenda Including Sepsis Metrics in CSC Performance Portfolio	31/01/2018	**Complete**			
									6 month appointment of Sepsis Nurse Specialist	28/02/2018	**Overdue**			
									Roll out enhanced critical care outreach response to Sepsis	28/02/2018	**Overdue**			
									Commence a parallel SIRI action review process to allow SIRI action plans to be reviewed in timely manner and clear back log	30/04/2018	**Complete**			
									Complete roll out of Mortality Review Panels to review all hospitals deaths following admission	30/04/2018	**Complete**			
									Complete audit loop of utilisation of Sepsis Pathway	31/07/2018				
									Educate all departmental mortality reviewers in Structured Judgement Review Methodology	31/07/2018				
Moving beyond safe	4.3 - Stop harm to patients	Mortality and morbidity	**5**	**Initiate consultant ward round standards**	Associate Medical Director	Trust	31/05/2018	**Future action at risk**	Send to Mark Roland (11.12.17)	31/05/2018	**At risk**	Improved communication of patient pathway		**Update awaited from Mark with milestones**
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**6**	**Undertake assessment of safety culture using the Manchester Patient Safety Framework (MaPSaF)**	Medical Director	Trust	31/08/2018		Undertake MaPSaF rolling programme across clinical areas	31/08/2018		Baseline assessment complete and improvements required identified with a reassessment date	Quantitative assessment of variation in safety culture around the organisation. Reduction in Moderate harm events Reduction in Severe harm events	
Moving beyond safe	4.3 - Stop harm to patients	Mortality and morbidity	**7**	**Trust-wide roll out of the NHS Improvement Falls Collaborative initiative**	Associate Chief Nurse for Patient Safety	Trust	31/12/2018	**Future action at risk**	1. Review data on all falls/injurious falls and analyse to identify general trends, outlier areas and key points to target interventions	Complete	**Complete**	A prompt review of all patients who have fallen to ensure appropriate strategies are in place to prevent further patient falls A reduction in the number of injurious falls	Reduction in the number of falls with severe harm/death Increase in overall reporting of falls events Increase number of staff attending specific falls related training Improve compliance with falls assessment and falls care plan completion Increase number of patients who have fallen who were reviewed using the SWARM methodology	**April update:** Follow up engagement meetings commenced and on-going.5 CSCs completed(Em Medicine, Medicine, MOPRS and H&N, MSK). 3 to complete (surgery, renal and W&C)
									2. Undertake engagement meetings with each CSC to develop plans in partnership on: a. Ward roll out programme- according to risk/event profile b. Local process to ensure real time post fall review for all inpatient falls c. Local education programme to meet specific needs of each area (mapped to patient group profile)	31/01/2018	**Overdue**			
									3. Roll out falls collaborative work to all CSCs following methodology agreed as above	~~31/12/2017~~ Revised deadline: 31/12/2018				
									4. Undertake review of falls pathway assessment and care plan to simplify process	31/03/2018	**Complete**			
									5. Redesign falls SIRI template document to reflect assessment and post falls review paperwork, to ensure streamlined	31/05/2018				
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Ensure Compliance with HCAI Annual plan 2017/18**	Associate Director of Infection Prevention & Patient Safety	29a Gap Analysis	31/03/2018	**Complete**	Regular review at Infection Control Management Committee Infection Control dashboard identifying patients with HCAI across the trust and weekly updates to wards Infection Control outreach and link nurses complete daily walk rounds Feedback from Committee given to nursing and midwifery Committee meeting on a monthly basis Performance heat map Monitoring of the HCAI plan against trajectories	31/03/2018	**Complete**	There is Trust-wide adherence to HCAI Annual Plan and therefore able to show progress against HCAI	No more than 40 C difficile infections in 17/18 year No avoidable deaths from C diff by 31/3/19 Reduction in MRSA Bacteraemia No avoidable deaths from MRSA	
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Facilitate staff compliance with hand hygiene and PPE protocol and ensure appropriate infection control training takes place**	Associate Director of Infection Prevention & Patient Safety	29a Gap Analysis	30/05/2018		All staff signposted to hand hygiene policy on induction	31/03/2018	**Complete**	All staff are aware of appropriate infection control measures in order to limit spread of HCAI and use of ANTT	Shift in performance from red to green in hand hygiene audit (>95% Green, >85% Amber, <85% Red) Reduction in incidents related to infection after insertion of a medical device	
									Infection Control team to facilitate staff hand hygiene and PPE training	31/03/2018	**Complete**			
									Complete ward Hand hygiene audit using WHO checklist	01/04/2018	**Complete**			
									Develop audit tool to review peripheral venous access device use in order to identify trends in PVAD associated infections	30/05/2018				
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Ensure all staff within Maternity services aware of infection control measures around MRSA**	Associate Director of Infection Prevention & Patient Safety	29a Gap Analysis	31/03/2018	**Complete**	Revised policy on MRSA within Maternity	31/03/2018	**Complete**	Ensure all staff in maternity aware of the importance of infection control measures in the spread of MRSA, and that all relevant patients have been decolonised	Audit of MRSA positive patients and decolonisation regimes show 100% adherence to decolonisation policy	
									Deliver Infection control training to staff working in Maternity including decolonisation procedures for MRSA	31/03/2018	**Complete**			
									Audit infection control training by signatures of nursing staff to confirm compliance with training	31/03/2018	**Complete**			
									Assurance given to CCG that training completed and undertaken by all staff in maternity	31/03/2018	**Complete**			
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Ensure all ward cleaning occurs in a timely manner and to required standards**	Associate Director of Infection Prevention &	29a Gap Analysis	31/12/2018		Complete audits into * Cleaning reconciliations for Enhanced cleans * Twice daily cleans * Domestic cleaning * Cleaning procedures for outbreaks	30/03/2018	**Complete**	All ward cleaning procedures completed to the required standard based on patient infection status	Audit results show that appropriate channels used to request cleaning in 100% of requests Spot checks on wards show appropriate	

	patients				Prevention & Patient Safety				Review of training for domestic workers and their role in infection prevention	31/12/2018			cleaning measures being used	
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Equipment must be checked as per individual ward protocols to ensure it is safe and ready for use**	Associate Director of Infection Prevention & Patient Safety	Gaps: CQC 'musts and shoulds'	31/03/2018	**Complete**	Introduce 'Clean' stickers onto all equipment in clinical areas and decontaminate devices using Hydrogen Peroxide where appropriate	31/03/2018	**Complete**	All clinical equipment is safe for use	Audit of sticker use shows >90 % adherence	Point of care Testing moved as new action below with revised deadline
									Commence MPSA Audit	31/03/2018	**Complete**			
									Point of care testing devices are regularly check as being safe for use	31/03/2018	**Complete**			
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Point of care testing devices are regularly checked as being safe for use**	Associate Director of Infection Prevention and Patient safety	Gaps: CQC 'musts and shoulds'	TBC			TBC				
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Staff on medical wards must follow the Trusts medicines management policy to ensure that medicines are prescribed, stored and administered appropriately**	Associate Director of Infection Prevention & Patient Safety	Gaps: CQC 'musts and shoulds'	30/06/2018	**Future action at risk**	There is regular review at the Medicines management group regarding breaches of safe medicines management	31/03/2018	**Complete**	All medicines managed safely and by appropriate staff	Reduction in patient safety incidents concerning medicines management	Barrier: Detailed planning required. Revised deadline: TBC with Amanda Cooper. Residual risk: Medicine security on medical wards. Mitigation: New action owner identified as Amanda Cooper. Penny Emerit to discuss the requirements with Amanda. To include response from current audit, and the development of an action plan, where required. **April update:** Workstream lead to discuss with Amanda Cooper.
									A Medicines Safety Pharmacist is in post to review medicines optimisation - further work to be undertaken	31/03/2018	**Complete**			
									A Medicines Safety group is in place	31/03/2018	**Complete**			
									To initiate development of staff training around safe medicines management, including assessment of skills	30/06/2018				
Moving beyond safe	4.3 - Stop harm to patients	Patient Safety	**New**	**Develop and execute a plan to address the backlog of radiological investigations and ensure reporting and risk assessments are completed within deadline going forward**	Consultant Radiologist	Gaps: CQC 'musts and shoulds'	21/08/2018	**Complete**	Immediately review the risk associated with reporting of Chest X-rays in radiology including undertaking a patient harm review on all cases not reported on - CQC report gaps	21/08/2017	**Complete**	All radiology images and results are processed in a safe and timely manner	Clearance of Radiology backlog Duty of Candour applied to all relevant patients	
						Radiology enforcement notice			Evidenced based appropriate steps to be taken to resolve the backlog of radiology reporting using appropriately trained members of staff. To include * Clinical review, audit and prioritisation of the current backlog of unreported images (including those taken before January 2017) * Impact assessment of harm to patients * Duty of Candour applied to any patient adversely affected	21/08/2017	**Complete**			
						Radiology enforcement notice			Put in place robust processes to ensure any images taken are reported and risk assessed in line with Trust policy	21/08/2017	**Complete**			
						Radiology enforcement notice			Submit plan to address the backlog to the CQC	21/08/2017	**Complete**			
Good governance	5.1 - Leadership at all levels	Board assurance	**1**	**Introduce Board to Ward Quality rounds**	Chief Nurse	Trust	28/02/2018	**Complete**	Introduce Board to Ward walk rounds using the IHI Safety Tool.	31/01/2018	**Complete**	Standardised approach to Board to Ward rounds that demonstrate engagement with frontline staff.	Board to ward rounds commenced.	**April update:** The Chief Nurse has introduced the IHI board to ward leadership rounds they are taking place in April through the next 12 months, there will be a reporting back to the public Board - this action is completed.
Good governance	5.1 - Leadership at all levels	Board assurance	**4**	**Recruit to board vacancies substantively**	Chief Executive Officer and Trust Chair	29a	31/03/2018	**Complete**	Complete recruitment process for substantive Executive and Non Executive Directors	31/03/2018	**Complete**	Substantive board will be in post with clear portfolios	Improvement in 'Well-led' scoring (self assessment).	Associates still being recruited, but substantive Directors are in place.
Good governance	5.1 - Leadership at all levels	Board assurance	**5**	**Agree and introduce a Board Development Programme**	Director of Integrated Governance	Trust	31/08/2018	**Future action at risk**	Board Development Programme developed and agreed	25/03/2018	**Overdue**	Improved board relationships and establishment of a high performing board.	Delivered the proportion of development activities required by 31/08/2018 as laid out in the Board programme.	**April update for discussion:** Board development programme commenced in March 2018. 12 month programme in place. A draft Board development programme has been produced and awaits further discussion by the Board and formal adoption by 31.05.18
									Board development programme implemented in line with the plan.	31/08/2018				
Good governance	5.1 Leadership at all levels	Board assurance	**NEW**	**New executive leadership team to ensure clarity of roles and responsibilities throughout the organisation**	Director of Communications and Engagement	29a Gap Analysis	31/08/2018		Review Board to ward engagement and develop a programme to address areas of concern.	31/03/2018	**Complete**	Improved engagement between frontline staff and the leadership team.	Staff indicate that they know who the members of the Board are. Potential to measure this through the PULSE survey?	Since December 2017 our programme of staff engagement has been reviewed, including a focus on the impact of current channels for engagement by the Executive team and Board. A number of changes have been made including introduction of a weekly email newsletter and diarising Executive roadshows across all of the Trust sites. The effectiveness of Team Brief has been reviewed as a means of communicating from Board to ward and changes to the format are planned for later in the year to coincide with the Clinical Service Centre restructure.
									Launch the Board to ward engagement programme.	31/04/2018	**Complete**			
									Board to ward engagement programme complete and organisational impact tested.	31/08/2018				
Good governance	5.2 - Role clarity, responsibility and	Nurse training programme / Medical training programme	**1**	**All nursing staff to sign that they have read and understood the NMC – The Code**	Chief Nurse	Trust	Complete	**Complete**	Complete	Complete	**Complete**	Nurses to be aware of their accountability as a Registered Nurse	All nurses understand their responsibilities under the NMC Code of Conduct	
Good governance	5.2 - Role clarity, responsibility and	Nurse training programme / Medical training programme	**2**	**Review and standardise nursing job descriptions**	Head of Nursing - W&C	Trust	30/11/2017	**Complete**	Complete	Complete	**Complete**	Nurses are clear about their role and responsibilities	These are all completed for Bands 5,6,7 and 8a and 8b	
Good governance	5.3 - Standardising and consistency in process	Board assurance	**1**	**Undertake an external governance review**	Chief Executive Officer	CQC 'musts and shoulds'	31/01/2018	**Complete**	Undertake an external governance review.	Undertaken	**Complete**	Actions to improve governance identified.	External governance review report.	
									Introduce revised Board Assurance Framework		**Complete**		1) Trust Board minutes demonstrate discussion regarding BAF and Corporate Risk Register. 2) Entries on BAF and Risk Register are updated promptly 3) Entries on BAF and risk register are re-scored regularly 4) Board members are more effectively sighted on risks and concerns across the	
									Introduce revised and standardised Corporate Governance arrangements	01/03/2018	**Complete**			
									Revise Corporate Risk Register	31/03/2018	**Complete**			
Good governance	5.3 - Standardising and	Board assurance	**New**	**Implement improvement actions identified following the external governance**	Director of Integrated	Trust	30/09/2018		Revise Risk Management Policy and Strategy	06/04/2018	**On track**	Revised Board Assurance Framework, Corporate Risk Register, Risk Management Policy and Strategy, Corporate Governance Arrangements and Divisional		**April update:** 2015/2018 Risk Management Strategy extended by the Trust Board until 31.07.18 to allow for revised strategy to reflect new corporate structure from Q2 07.18. Draft revised risk management strategy

Good governance	and consistency in process	Board assurance	New	**review**	Integrated Governance	Trust	30/03/2018		Introduce revised and standardised Divisional Governance arrangements	01/07/2018		Corporate Governance Arrangements and Divisional Governance arrangements to ensure a standardised integrated approach.	Trust - to be reviewed by internal audit. 5) Divisional management teams are more aware of risks in their areas and manage them to a tolerable level more quickly - to be reviewed by internal audit. 6) The route from clinical frontline areas to Board taken by information about risk and other aspects of clinical governance is shorter	revised strategy to reflect new corporate structure from 02.07.18. Draft revised risk management strategy presented to Q&P Committee for initial consideration 14.04.18
Good governance	5.3 - Standardising and consistency in process	Business Information Unit (revised performance management framework)	**2**	**Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework**	Chief Operating Officer	Trust	30/04/2018	**At risk**	Implement revised Performance Framework, including relaunching Performance and Accountability arrangements as part of the new divisional arrangements.	30/04/2018	**At risk**	Revised performance and accountability meetings in place that monitor deterioration or non-optimal performance.	Review of the Performance and Accountability meeting minutes for evidence of robust performance monitoring.	**April update:**Work commenced, need to agree revised deadline.
Good governance	5.3 - Standardising and consistency in process	Clinical governance , risk and complaints	**3**	**Increase the number of staff trained in Root Cause Analysis methodology and risk management**	Director of Education	CQC 'musts and shoulds'	31/03/2018	**Complete**	Develop a training programme process to enable staff undertaking investigations to access root cause analysis training and understand risk management.	31/03/2018	**Complete**	Improve the quality and learning from incident investigations	Staff who undertake serious investigations have the pre-requisite knowledge to do so. Demonstrate learning from every SIRI and process in place for embedding the learning.	Further training booked for 20th April and training will be on-going. Extensive list of trained staff now in place
									Round 1 of training undertaken.		**Complete**			
									Round 2 of training undertaken.	31/03/2018	**Complete**			
Good governance	5.3 - Standardising and consistency in process	Clinical governance , risk and complaints	**4**	**Improve incident management processes to foster learning and improve effectiveness**	Head of Risk Management	CQC 'musts and shoulds'	31/03/2018	**Complete**	Monitoring NRLS rate of events returned following upload where the grade is challenged.	Commenced and on-going	**Complete**	Consistent grading/investigation of incidents and ensuring there is shared, organisational learning. All SIRI investigations undertaken by a trained RCA investigator.	Number of highlighted discrepancies from NRLS data. Percentage of incorrectly graded incidents. Number of investigators trained to investigate SIRIs.	
									Monthly audit of low harm/no harm events submitted for final approval to quality assure grading.	31/12/2017	**Complete**			
									Ensure all investigators assigned to investigate SIRIs have completed RCA training.	31/12/2017	**Complete**			
Good governance	5.3 - Standardising and consistency in process	Clinical governance , risk and complaints	**New**	**Undertake an external review of the SIRI process and implement the identified improvement actions.**	Head of Risk Management	Trust	31/07/2018		External review completed.	31/03/2018	**Complete**	Improved SIRI process and reduced delays.	Reduction in overdue SIRIs to 0 by 31/12/18	
									Action plan developed to address any areas for improvement identified.	15/05/2018				
									Improvement actions implemented.	31/07/2018				
Good governance	5.3 - Standardising and consistency in process 5.4 - Being open and transparent	Clinical governance , risk and complaints	**5**	**Protect patients confidentiality through safe storage of records**	Information Governance Manager	CQC 'musts and shoulds'	31/03/2018	**Overdue**	Identify all areas of note storage around the Trust and external to the Trust. Ensure areas are safe and secure (visual inspection)	31/12/2017	**Overdue**	Confidentiality maintained.	Patients confidentiality is maintained through safe storage and handling of patient records. Compliance with the IG Toolkit	**April update:** Action plan to address outstanding actions and those identified during inspection 17-20 .04.18 produced. To be referred to Data Protection and Data Quality Committee (sub committee of Q&P) at May meeting Action relates to ensuring safe and secure note storage across all sites. **Revised deadline for action: 30.06.18**
									Wards/departments to ensure that notes in use are stored away from patients and public or in an area which is manned 24/7	31/03/2018	**Complete**			**April update action complete:** Programme of surveillance visits to wards in hand and ongoing – will continue as part of routine surveillance
									Bedside notes clipboards or folders have a privacy cover	31/03/2018	**Overdue**			**April update:** Action rellates to privacy covers for bedside notes or folders. Requirement notified to all staff and cover provided 13.04.18. To follow up with audit by 30.06.18
									All patient information taken off site is transported in a sealed bag (audit) with appropriate markings	31/03/2018	**Overdue**			**April update:** Action relates to security of patient information being taken off site. Email reminder sent 20.04.18. To follow up by audit 30.06.18
									Patient notes are not sent via the post from remote sites. (audit & Datix)	31/03/2018	**Overdue**			**April update:** Action relates to patient notes being sent via post from remote sites. Email sent 20.04.18. To follow up by audit 30.06.18
Good governance	5.3 - Standardising and consistency in process	Business Information Unit (revised performance management framework)	**6**	**Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'**	Deputy Director of Nursing	Trust	31/05/2018	**Complete**	Review the Clinical Dashboard to check key nursing metrics are clear and available.	31/03/2017	**Complete**	Front line nursing staff have a clear understanding of the care they are delivering to patients against defined standards	Ward hotboards display most recent clinical metric data and staff can articulate this information and what is being done	
Good governance	5.3 - Standardising and consistency in process	Clinical governance , risk and complaints	**New**	**Risk assessments must be completed to assess the range of risks to patients being cared for in escalation areas, taking into account environmental factors such as restricted access to curtains, bell calls and oxygen.**	Associate Chief Nurse for Operations	Gaps: CQC 'musts and shoulds'	31/03/2018	**Complete**	Clarify the type of risk assessment necessary for each area, and where these are located.	31/03/2018	**Complete**	Appropriate and safe use of escalation areas.	All open escalation areas have a risk assessment in place - assessed through internal audit.	**April update:** Decision log implemented and held in Operations Centre for any escalaltion areas opened and whether this is in line with SoP
									Ensure completion through audit.	31/03/2018	**Complete**			
Good governance	5.4 - Being open and transparent	Board assurance	**1**	**Building relationships with stakeholders and partners in line with the Chief Executive's 100-Day Plan**	Director of Communications and Engagement	CQC 'musts and shoulds'	30/11/2017	**Complete**	Undertake meetings and establish engagement processes with key stakeholders, to include: • Staff • Military colleagues • Local authorities (provider teams and scrutiny committees) • Freedom to Speak Up Guardian and advocates • Other local NHS bodies – CCGs, Ambulance Trust, Community Trust, acute providers • Service users (public meetings) • NHS regulators	Complete	**Complete**	Improved working relationships across the health economy that benefit patients.	75% exec level attendance at (review minutes): 1) Health and wellbeing boards (though review of minutes). 2 Health Overview and Scrutiny Committee 3) FTSU meetings. 4) ACS / LCS meetings 5) QIPOG 6) CQC calls Programme of public meetings in place. Military staff in Trust leadership positions.	
Good governance	5.4 - Being open and transparent	Clinical governance , risk and complaints	**2**	**When significant incidents are being investigated, patients or family will be asked for their input to setting the terms of the investigation, and updated as investigations progress.**	Head of Risk Management	CQC 'musts and shoulds'	30/11/2017	**Complete**	Audit Duty of Candour process.	30/11/2017	**Complete**	Improved involvement of patients and family when significant incidents occur.	Audit the minutes of investigation meetings to ensure inclusion of patient / family / carer input.	
									Include on SIRI checklist patient/family concerns to be requested.	30/11/2017	**Complete**			
									Update Duty of Candour letter templates to include invite to patient/families to communicate any concerns they wish to have included within the terms of reference of the investigation.	30/11/2017	**Complete**			
Good governance	5.4 - Being open and transparent	Clinical governance , risk and complaints	**NEW**	**External review of Duty of Candour template.**	Head of Risk Management	Trust	30/04/2018		Duty of Candour template shared with Healthwatch for review and feedback.	01/03/2018	**Complete**	Improved written response to patients / families.	Updated Duty of Candour template.	Revised templates drafted and engaged with the Patient Collaborative for feedback. Interim changes made to template letters inviting questions/concerns from patient/family to inform the investigation whilst awaiting full revision. **Revised deadline: 30/04/2018**
									Feedback incorporated into the template.	15/03/2018	**Complete**			
									Template signed off by Director of Integrated Governance and launched.	30/04/2018				
Good governance	5.4 - Being open and transparent	Clinical governance , risk and complaints	**4**	**Strengthen and embed the Being Open Policy including the application of Duty of Candour legislation** ***Links to action 1.4 (3) and 5.4 (2)***	Deputy Director of Nursing	CQC 'musts and shoulds'	31/03/2018	**Complete**	Weekly 'Hot Topic' audit which includes question regarding patient involvement in care planning	Commenced 30/10/2017	**Complete**	Staff actively involve and discuss care issues with patients and families in an open and meaningful way as part of their everyday care	80% of care plans demonstrate involvement of patient, families and/or carers SIRI report Terms of Reference include patient concerns	
									Revise Duty of Candour letters to include patients/families concerns in scope of investigation and make explicit the contact arrangements	30/11/2017	**Complete**			
									Revise the Duty of Candour posters for clinical areas	31/12/2017	**Complete**			

Good governance	5.4 - Being open and transparent	Clinical governance , risk and complaints	**New**	**Improve the complaints process, oversight of complaints and reduce the backlog of complaints to ensure patients receive responses in a timely way**	Head of Complaints	Gaps: CQC 'musts and shoulds'	31/12/2018	**Future action at risk**	Review the definition of complex complaints (i.e. 'when multi-agencies are involved') and revise the reporting in line with this.	31/03/2018	**Overdue**	Patients receive a response to complaints in a timely way.	Overdue complaints (excl. complex): <20 by 30th June <10 by 30th September 0 overdue by 31st December	**April update:** Complaints workshop to be held May 2018 to process map and identify areas for improvement. Policy will then require revision. This will include categorisation of complaints therefore suggest **revised deadline of 30/06/2018**
									Ensure the complaints process is part of the new divisional performance and accountability framework.	30/04/2018				
									Monitor the complaints performance and delays.	Ongoing				
Good governance	5.4 - Being open and transparent	Clinical governance , risk and complaints	**New**	**Improved oversight of recommendations, and corresponding action plans arising from audit, SIRIs, complaints and other relevant reviews across the organisation.**	Director of Integrated Governance	Trust	31/12/2018		Develop a system for ensuring oversight of recommendations, and corresponding action plans arising from audit, SIRIs, complaints and other relevant reviews	31/12/2018		Oversight of all recommendations, associated actions, deadlines and responsible owners to ensure timely implementation of improvement actions.	Spot checks in divisions.	
									Embed local QIPs into the performance and accountability process.	30/07/2018				
									Undertake deep dives throughout the year to test whether: 1) the central team are sighted on recommendations 2) recommendations are being acted on in a timely manner. 3) appropriate escalation of overdue actions.	Ongoing				
Good governance	5.4 - Being open and transparent	Clinical governance , risk and complaints	**New**	**Set up Maternity Safeguarding Board**	TBC	29a Gap Analysis	31/03/2018	**Complete**	Set up Board	Complete	**Complete**			[moved from Supporting Vulnerable Patients]