# SUMMARY REPORT

Plymouth Hospitals NHS
NHS Trust

## Cornwall Overview & Scrutiny Committee

November 2015

| | |
|---|---|
| **Subject** | **Plymouth Hospitals NHS Trust: CQC Action Plan** |
| **Prepared by** | Lee Budge, Director of Corporate Business |
| **Approved by** | Lee Budge, Director of Corporate Business |
| **Presented by** | Lee Budge, Director of Corporate Business |

## Purpose

The purpose of this report is to update Cornwall's Overview and Scrutiny Committee on the progress that we are making in delivering the action plan which has been developed to address the issues arising from the CQC's inspection of Plymouth Hospitals NHS Trust.

| | |
|---|---|
| **Decision** | |
| **Approval** | |
| **Information** | ● |
| **Assurance** | ● |

## Corporate Objectives

| Quality Care | Inspired People | Healthy Organisation | Innovate & Collaborate |
|---|---|---|---|
| ● | | | |

## Executive Summary

The Care Quality Commission (CQC) rates healthcare providers against five domains of care. Following an inspection in April 2015, the CQC published a report in July 2015 on the care provided by Plymouth Hospitals NHS Trust. The summary ratings were as follows:

| Ratings | |
|---|---|
| Overall rating for this trust | Requires improvement |
| Are services at this trust safe? | Requires improvement |
| Are services at this trust effective? | Good |
| Are services at this trust caring? | Outstanding |
| Are services at this trust responsive? | Inadequate |
| Are services at this trust well-led? | Good |

The Trust has developed a comprehensive action plan and supporting governance arrangements to address the findings contained within the CQC's report. Regular progress monitoring reports are submitted to the Trust's Safety and Quality Committee and externally to the CQC and the NHS Trust Development Authority. The latest monitoring report is attached for the Committee's information, whilst the following table summarises overall progress with the actions.

| Action status | No. | % |
|---|---|---|
| Completed and closed on receipt of appropriate evidence | 35 | 22% |
| Completed – evidence to be submitted and reviewed | 31 | 20% |
| On Track | 77 | 49% |
| Revised timelines for completion: PHT | 11 | 7% |
| Revised timelines for completion: CCG | 3 | 2% |
| | 157 | 100% |

## Key Recommendations

The Committee is asked to note the Trust's response to the CQC's recommendations.

## Next Steps

The Trust is in the process of implementing the action plan and will continue to report progress through the established governance framework.

Plymouth Hospitals NHS
NHS Trust

# CQC Action Plan Monitoring

## October 2015

# Contents

# Quality Summit Actions

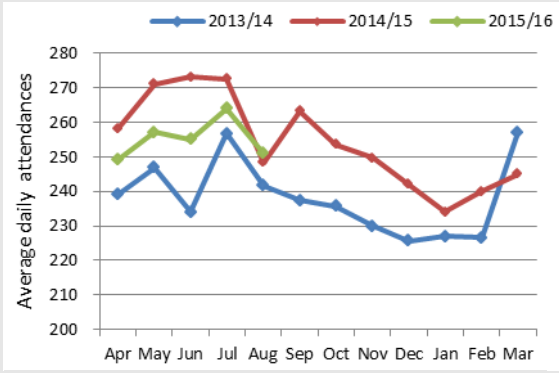
**Urgent Care - reframing the goal around risk and how to achieve this.**

**An urgent care system should be sustainable and able to plan, and collectively manage, the risk, of any unexpected or sustained increases in demand. How could we secure a different mechanism to manage the levelling up of clinical risk across our system and to ensure that the component parts of the network work as one?**

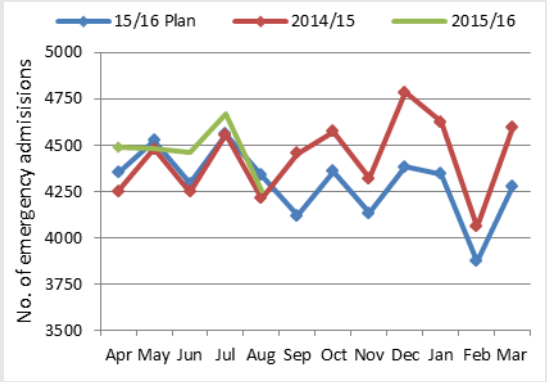
## Current Performance

**Understanding the operational context (source: Integrated Performance Report to Trust Board September 2015):**

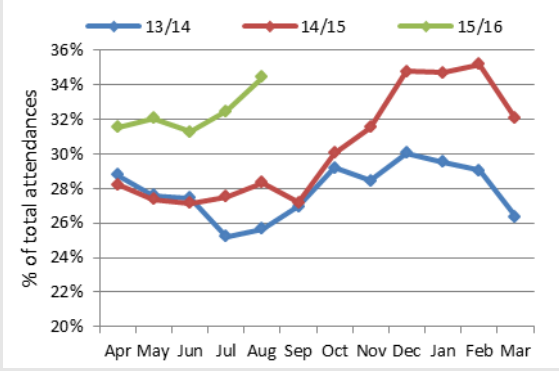
### Non-elective: Emergency Dept Attendances



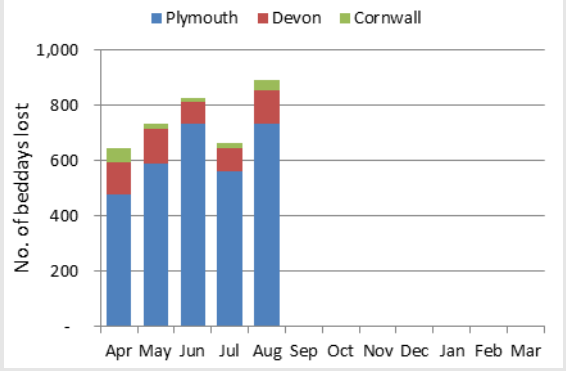

### Non-elective: Inpatient admissions



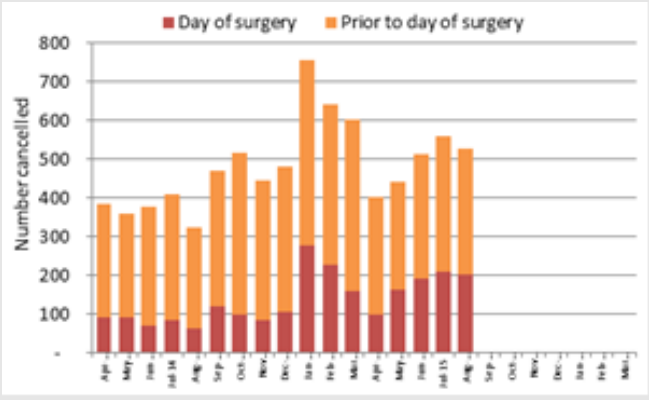

### % ED Attendances with High Triage Category



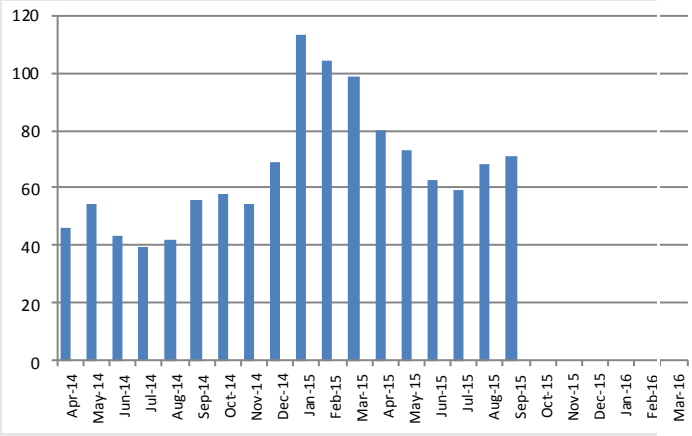

### Delayed discharges




**Cancelled operations. Source: Integrated Performance Report to Trust Board September 2015.**




**Medical outliers. Source: Recovery Plan Update to Trust Board October 2015.**



## Comment on Current Performance

The average number of daily ED attendances reduced in August but remained higher than that in the two previous years whilst the complexity of those patients arriving is at its highest since Winter with over 34% of patients triaged in the highest two categories.

The volume of elective cancellations made both on the day and up to 7 days in advance remains a concern and the continued emergency medical demand and resulting medical outliers continues to compromise our ability to improve our elective throughput. This dynamic is also influenced by the delayed discharge position which has deteriorated.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.2 | The System Capacity map does not exist – pick up exact definition and requirements and commission work through SRG. | Jerry Clough CCG | 31-Oct-15 |
| 1.3 | Ensure SRG collective ownership of a comprehensive urgent care system plan including different models of care, 7 day working, 24 hour district nursing and shift of acuity into different care settings. | Jerry Clough CCG | Complete |
| 1.4 | Ensure urgent care plan focuses on key pathways to be discharged from PHT. | Sharon Matson/ Kevin Baber | 31-Oct-15 |
| 1.5 | Review practice in Plymouth to ensure discharge planning commences at the earliest possible opportunity, in line with best practice. To ensure this is not constrained by outdated policy or practice. | Sharon Matson | 31-Oct-15 |
| 1.7 | Senior leaders through SRG to oversee the development of comprehensive list of all patients moving towards discharge and the actions required to make more rapid progress. | Jerry Clough CCG | 31-Oct-15 |
| 1.8 | What is the role of the Urgent and Emergency Care Network? Be clear about key work areas that the SRG would want the UECN to focus on, including the following in the dashboard:<br>• Whiteboard delays<br>• Trauma Network information – patients who are fit to be repatriated after 48 hours but have not been repatriated.<br>• Neuro rehab | Jerry Clough CCG | 31-Oct-15 |
| 1.9 | Investigate opportunities for reducing medical and surgical length of stay. | Kevin Baber | 30-Nov-15 |

## Update on Actions

1.2 This will be completed through a thorough review of the DOS and the production of a whole system capacity plan by Alamac. This work was agreed and supported by the October SRG meeting.

1.3 Revised Governance and Action Plan structures were signed off by October's SRG meeting. These will be fully implemented for the November SRG / UCP meetings. This will include one action plan covering all developments for the Urgent Care System. The action plan includes a range of different service improvements and developments that will support 7 day working. Robin Community Assessment Hub is operational providing an alternative to hospital attendance and/or admission for patients with ambulatory care sensitive conditions and for frail older people. This service will operate 7 days a week from November.

1.4 The CCG is establishing a Tactical Control Centre which will be fully operational by 16 November 2015 (earlier if possible). This will augment the existing Integrated Health and Social Care Discharge Team. The Centre and the teams will have one, complete list of patients and the Centre will be focussed on unblocking pathways and processes to ensure rapid, effective and safe throughput of patients. PHNT have recently commissioned Recovery at Home from PCH. This will focus on patients who need to be discharged with some support but who are not labelled as "complex discharge". Medical responsibility will remain with PHNT. The Trust is implementing the SAFER bundle. PCH is implementing Enhanced Recovery for Medicine.

PHT update 29/10/15: the Discharge to Assess pilot on Monkswell worked well and the community have now agreed to establish 34 Discharge to Assess beds.

1.5 In addition to the activity detailed in 1.4, there have been three pilots undertaken - Discharge to Assess to care home, Discharge to Assess to patients' own home, Criteria Lead Discharge. These pilots are being extended for operationalisation for the surge and escalation period of 2015/16 and will be managed through the Tactical Control Centre. Completion now planned for 16/11/15.

1.7 - 1.4 and 1.5 relate.

1.8 In addition to the given specifics of:

• Whiteboard delays

• Trauma Network information

• Neuro rehab

the UECN will focus on those elements described in national policy/letters of direction such as workforce and accreditation of urgent care delivery centres.

1.9 This forms part of the work on bed reconfiguration. Presentation made to Board and key internal committees setting out the requirement to decrease medical and surgical LOS. Assessment is that medicine needs to decrease LOS by 0.5 of a day to release 24 beds. Surgery needs to address increased LOS for surgical emergencies and this gives an opportunity of 16 beds. Other improvement projects such as work on TTAs and implementation of the Safer Ward Bundle support the above. Safer Ward bundle includes Senior Review – all patients reviewed by 12 midday.

From 19/10/15 all Matrons and General Managers were re-focussed on Plan For Every Patient. General Managers are to ensure that they understand the patients on their wards with a green cross on SALUS i.e. those that are medically fit and awaiting an intervention to allow them to be discharged.

We will be working to deliver planned date of discharge in surgery in the first instance. The golden bed initiative is being implemented; this means a vacated bed before 10 am on 10 wards to enable flow from assessment areas. The patients who are vacating the golden bed will have been identified the night before, the patient informed of the plan to either discharge direct to home or sit in the dayroom or go to Tamar to sit in their seating area whilst waiting for drugs/ transport etc . The site team are monitoring progress. The Service Line Manager and Matrons are reviewing the >14 day length of stay on a daily basis and the Service Line Managers then present those patients to the Head of Operations at 10.30 daily. On a weekly basis the Head of Operations, a senior physician, Site Matron and Operations Manager for Integrated discharge team are also undertaking a grand round of all those patients in medicine >14 days length of stay with no complex discharge icon on SALUS.

**Urgent Care - reframing the goal around risk and how to achieve this.**

**111 and the out of hours commissioning process are both currently suspended and SWAST have served notice. How will this be managed given the critical nature of the services, particularly given that we will soon be returning to the additional pressure that winter will place on the urgent care system?**

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.10 | With the ongoing reprocurement of NHS111 and the Out of Hours service (though the CCG's Urgent Care procurement), explore the options to use these changes to enhance the impact of both services on the numbers of attendances at A&E and emergency admissions. | Jerry Clough CCG | Complete |
| 1.11 | Understand and articulate the business case for time shifting arrival of patients at A&E / MAU with clarity on different cohorts of patients, options for time shifting (e.g. visiting times, transport) to determine the most cost and operationally effective options for improvement.<br>Understand the full impact and anticipated benefit of any changes. | Sharon Matson (as part of SRG led, urgent care plan) | 31-Oct-15 |
| 1.12 | Hold an urgent care summit with GP Federations, CCG, PHT and PCH to investigate any further options for change. To explore issues including care homes, visiting, accessibility and vulnerable cohorts of patients | Kevin Baber | 30-Nov-15 |
| 1.13 | Investigate the potential of a system wide approach to Medicines Optimisation across primary, community, acute and specialist care. | Phil Hughes | 31-Oct-15 |
| 1.14 | Review urgent care comms plan and ensure SRG agree key approaches. | Sharon Matson / Kevin Baber (as part of SRG led, urgent care plan) | 30-Oct-15 |

## Update on Actions

1.10 The current provider will deliver a service until 30 September 2016. CCG is currently developing a procurement strategy development process following the release of the latest national procurement guidance.

1.11 A review of GP visiting times has been undertaken and found that moving forward the visiting times in the day would provide little benefit. The introduction of Robin Community Assessment Hub will ensure that all clinically appropriate patients who are classified for Healthcare Provider conveyance by SWASFT within 1, 2 or 4 hours to secondary care, will be conveyed to Robin. Work will be undertaken to understand if there are cohorts of patients that could be expedited through the system to improve flow.

1.13 Director of Pharmacy has had meetings with counterparts at PCH and the CCG to take this forward. This needs to be a joint action.

1.14 National approach - NHS England, Public Health England, the Department of Health, the NHS Trust Development Agency and Monitor are joining up their winter campaigns. CCG will utilise information produced by national team. Local solutions to be developed by SRG following review of DOS.

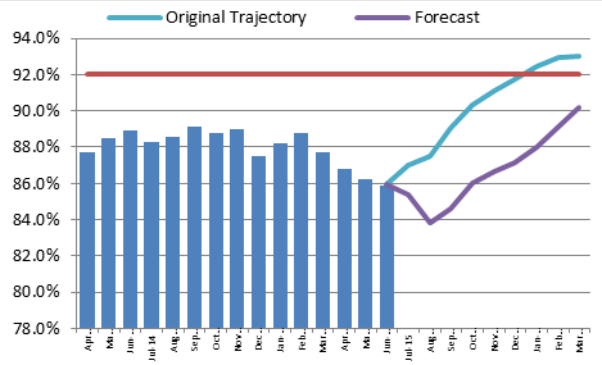
**Planned Care and Follow Up - Improving access, follow up backlog and better management of demand.**

**How could other providers and professionals, embracing technology where possible, work with Plymouth Hospitals Trust to harness the capability of the whole system, all professionals, to ensure that routine, urgent and time critical pathways - like the 2 week wait – are delivered on time all the time?**

## Current Performance

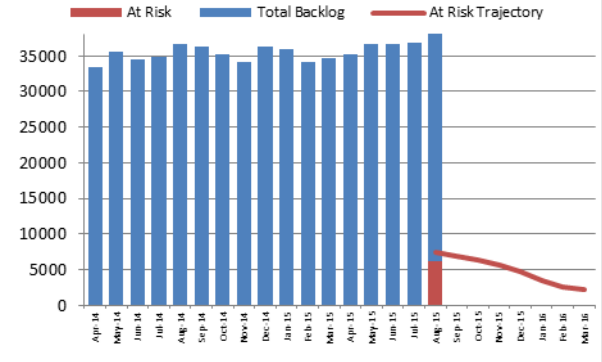
**Referral To Treatment**

**Source: Integrated Performance Report to Trust Board Sept 2015**




**Follow-up Backlogs**

**Source: Integrated Performance Report to Trust Board Sept 2015**




**Our performance against the key RTT metrics for August 2015 is shown in the following table:**

| Description | Target | Actual |
|---|---|---|
| Incomplete pathways | 92% | 84.3% |
| Admitted backlog | 1858 | 2500 |
| Non-admitted backlog | 82 | 162 |
| 52 week waiters | 0 | 3 |

## Comment on Current Performance

Monitoring of the RTT position showed a clear drift from the recovery trajectory during Month 4 which prompted a comprehensive piece of work to risk assess each service line's action plans and recalculate the proposed benefits of all actions. This has been reflected in the forecast now shown on the chart.

The risk to our improvement over the coming months exists in both the CCG's ability to control the above plan levels of demand for our services (current GP to consultant referrals 12% above plan) and our capability to deliver on the improvement plans submitted by each of our services.

At the end of August 2015, there were 37,199 patients past their 'see-by-date'. Of these, 6153 patients are flagged as being at clinical risk; 1251 ahead of the reduction trajectory to reduce this cohort.

Service Lines have completed the risk identification and have now assessed every patient on the follow-up waiting list in line with the clinical risk criteria.This means that patients in high risk groups can now be systematically prioritised for appointments.Service groups have also produced trajectories to reduce the number of patients at risk of harm who have waited past their see-by-date. For 7 service lines, a process of service improvement will be undertaken as part of the agreed CQUIN scheme in order to review and improve how follow-up care is offered in high volume specialties.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.18 | Investigate the use of technology to get access to care and to get information back into primary care for planned care. | Karen Kay | 31-Oct-15 |
| 1.19 | Assuming that electronic communication with primary care is agreed, PHT to scope printing and postage cost savings. | Kevin Baber | Complete and closed |

| | | | |
|---|---|---|---|
| 1.20 | Dedicated workshop on follow-ups to robustly challenge progress on reduction and explore all options for priority and non-priority patients. | Karen Kay/Kevin Baber | 30/12/2015 – Deadline revised as per CQUIN schedule and the need for multiple workshops rather than a single one stop workshop solution. |

**Update on Actions**

1.18 Teledermatology implementation underway. Teleophthalmology opportunities being explored. E-transfer of information is work in progress within PHNT utilising email, Patient Knows Best and Docman.

1.19 Indicative costings have been completed for the Programme Board. These have not been fully audited but are anticipated savings.

1.20 Planned Care Partnership (workshop) agreed principles of "no face to face follow-up unless of proven clinical value" in 2014. Joint PHNT and CCG Programme Board in place monthly since July 2015 with clinical leadership and involvement. Service line workshops planned in accordance with CQUIN schedule (range of specialties over 2015/16). Workshops will have the purpose of developing follow-up protocols between primary and secondary care.

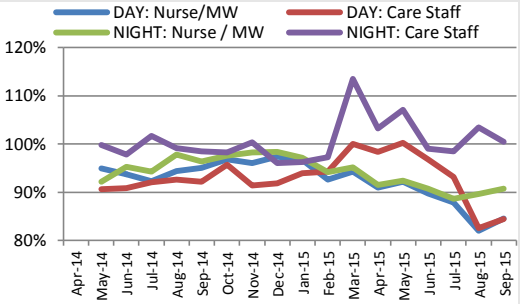
In developing new models of care, PHNT and primary care have identified three areas where clinical consensus has been established for a new model of care – one system, one budget – for introduction from April 2016. They are: dermatology, musculoskeletal, and pain services. Notionally 'pooling' budgets across the new network of providers will create opportunities to redefine objectives of the service and align incentives to stimulate the network to move as one – consistently - all the time. The expectation would be to reduce growth in demand, ensure capacity to meet demand and lower the cost of intervention through the use of new professionals and achieve reductions in prescribing spend.

# Staff numbers

**Derriford Hospital: The Trust must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed to provide adequate levels of nursing and medical staff to ensure the safety of patients at all times. This applies to the emergency department, children's services, outpatients and diagnostics, maternity services and medical services. There were insufficient staff to address the backlog of reporting for diagnostic imaging scans.**

## Current Performance

**Source: Workforce Information**




**Fill rates for September 2015 are detailed in the following table:**

| Description | Fill-Rate |
|---|---|
| Day shift: Nurse / Midwifery | 84.6% |
| Day shift: Care Staff | 84.5% |
| Night shift: Nurse / Midwifery | 90.0% |
| Night shift: Care Staff | 100.5% |

## Comment on Current Performance

The monthly safety staffing return for September was 88.31%. Staffing data is now extracted directly from health roster providing more reliability and assurance on data accuracy. There continues to remain significant operational activity resulting in increased bed capacity requiring additional staffing whilst sustaining an increasing vacancy factor.

Matrons and ward managers are working clinically to support their areas. The night duty care assistants 100.5% reflects specialling and HCAs covering RN vacancies. Work is on-going with using patient acuity and dependency to determine staffing need not just numbers.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.2 | Emergency Department (planned number of ED nurses not always met): Interview for current vacancies 14th August. | Sam Rafferty | Complete |
| 2.3 | Paediatrics (Shortfall in paediatric ward staffing levels): Nursing staff to be in post by September. x2 consultant posts to be in place by November. | Sue Stock | 30-Nov-15 |
| 2.4 | Radiology (not enough medical staff to deal with backlog):<br>1.Recruit to vacancies for consultant staff.<br>2.Commence Private partnership arrangements with external reporting body 1st October for resilience.<br>3.Complete Stress assessment with staff health and wellbeing.<br>Financial Impact: Revenue Above Budget £50,000 | Wendy Colley | Complete |
| 2.5 | Health Care of the Elderly Medical Staff (shortfall of medical staff):<br>1. Complete Recruitment campaigns.<br>2. Review different methods of delivering the service.<br>3. Review strategy following outcome of recruitment exercises.<br>Financial Impact: Revenue Above Budget £360,000 | Paul Hancock | 31-Mar-16 |
| 2.6 | Surgery (shortfall in staffing numbers): Philippine nurses to commence in post.<br>Financial Impact: Revenue Above Budget £320,000 | Sue Johnson | 30-Nov-15 |

| | | | |
|---|---|---|---|
| 2.8 | Consider working collaboratively across the region to source temporary staff - early discussions with the PPSA and 9 other Trusts.<br>Financial Impact: Too early to cost. | Karen Launder | 31/04/16 |
| 2.9 | Medical Staffing Workforce Group to deliver key work streams.<br>Financial Impact: Too early to cost | Director of Corporate Business | Variety of work streams with short-term deadlines - workforce group meets every two weeks |
| 2.11 | Finalise Recruitment and Retention Strategy to support the Trust's workforce requirements.<br>Financial Impact: Too early to cost | Karen Launder | Complete |

## Update on Actions

2.2 Nursing Establishment remains on Care Group risk Register ID 4994. Service Line Director requested an ED Risk Summit where nursing establishment was included in discussions. Head of Nursing has authorised a rolling advert and Matron has increased another 2 RN's above contracted RN's in adult nursing to help out with the Paeds area.

2.3 Paediatric nursing staff now in post. Consultant posts still on track for November.

2.4 There are currently two vacancies in Radiology at Consultant level; interviews for one post taking place on the 2nd November and the other post is out to advert. The department has a short term Locum coming in to cover the additional workload in the run up to Christmas. Private partnership arrangements started 1 October. Stress assessment completed August.

2.5 Recruitment and retention premium now in place to fill vacancies and national campaigns underway. Working with PCH on different ways of working.

2.6 International recruitment of staff successfully completed with Italian nurses now in place. Up to 50 nurses from the Philippines appointed with current start dates Feb 2016 - Visa application has resulted in the delay as the nurses are required to sit English exams.

2.8 PHNT are now part of an established regional Agency Stakeholder Group led by the PPSA. Regional agency Framework rates have been agreed, plans are underway to implement an exit strategy from Thornbury Nursing Services, our most expensive agency and discussions are taking place regarding regional recruitment. Monthly meetings have been arranged to ensure traction is maintained. It is expected that there will be a permanent solution to this problem by 1st April 2016.

2.9 Detailed delivery plan in place, regularly updated and reported to TME and MEC. Doctors Assistants are being piloted on 2 wards and 13 have been approved for recruitment with plan to review possibilities for expansion at the end of the year. Also looking at adoption of Physicians Associates.

2.11 The strategy has now been agreed by the HR&OD committee. The HR team have been tasked with prioritising production of more specific plans for the recruitment and retention of certain staffing grades including nursing and consultants. These more detailed plans will set out specifically the actions being taken to address issues.

# Mental Capacity Act

**Derriford and Mount Gould Hospitals: The Trust must ensure that all staff have sufficient knowledge of and implement the Mental Capacity Act so that patients' mental capacity is confirmed and to identify patients who lack capacity to make decisions, so that patients' best interests were being served. There were variations in staff knowledge and application of the Mental Capacity Act and some had not completed training. The processes and systems in place to identify persons at risk of harm in accordance with the Mental Capacity Act 2005 were not understood in the Chestnut Unit and Ophthalmology or Mount Gould Hospital.**

## Current Performance

**Training Delivered to date:**

| Service Line | Attendees | Date |
|---|---|---|
| Health Care of the Elderly Doctors | 12 | 3rd July 2015 |
| F2 Training Session | 29 | 28th September 2015 |
| Health Care of the Elderly Doctors | 11 | 9th October 2015 |

## Comment on Current Performance

2 sessions delivered to HCE service line. F2 teaching programme changed from vulnerable adults to MCA (2005) and DoLS (2007). This training is to be included in F1 training programme next year. Palliative care, MAU and Renal have training dates booked. Respiratory, Neurology and Gastroenterology have requested training – dates being arranged.

DoLS pathway, risk assessment and capacity/best interest checklist all ready for HRSG and steering groups – following approval will be launched Trust wide.

MCA and DoLS principles now included in Level 2 mandatory training.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.12 | Undertake review of policies and procedures for MCA and DoLS. | Sean Lynch/Jo Brancher | 31-Dec-15 |
| 2.13 | 1.Culture change - Deliver Mental Capacity Awareness Campaign.<br>2.Identify Service Line medical and nursing leads.<br>3.Increase awareness of wide spectrum of issues ranging from impact on Shared Decision Making to DOLS.<br>Financial Impact: Revenue Above Budget £12,000 | Sean Lynch/Jo Brancher | 31-Apr-16 |
| 2.14 | Provide training programmes for each Service Line, including security- mandatory training, workshops, seminars. Training bespoke and relevant to needs and issues facing that Service Line. Follow up discussion to be a part of the programme.<br>Financial Impact: Revenue Above Budget £3,000 | Sean Lynch/Jo Brancher | 31-Jul-16 |
| 2.15 | Develop External (external assessor and QA Organisation) / Internal quality review (service user/carers/clinical staff/administrative staff for MHA and MCA).<br>Financial Impact: Revenue Above Budget £2,000 | Sean Lynch/Jo Brancher | 31-Apr-16 |
| 14.16 | Mount Gould Hospital: See actions 2.12-2.15 which also apply to all other locations | As above | As above |

## Update on Actions

2.12 Review of scope / format of current policies and procedures undertaken. Sean Lynch to review MCA policies in other hospitals. DoLS Pathway, DoLS Risk Assessment Tool, Recording of Mental Capacity and Best Interest Decision Tool drafted and consultation period closed. Documents to be sent to HRSG and then through steering group. Sean Lynch to

write MCA policy, to include DoLS.

2.13 Reminder in Daily Email 14/08/15 and Vital Signs 21/08/15 and 23/10/15. Teaching opportunity bulletin sent to Consultants/Junior doctors direct regarding MCA and DoLS training. Also placed in daily briefing.

2.14 MCA and DoLS covered in level 2 safeguarding adults and children's mandatory training. Bespoke training - 3 sessions now completed, HCE and F2 teaching. Sessions being advertised with 3 sessions booked and 4 other areas having dates arranged. Contact made with F1 teaching programme, booked for 2016-2017.

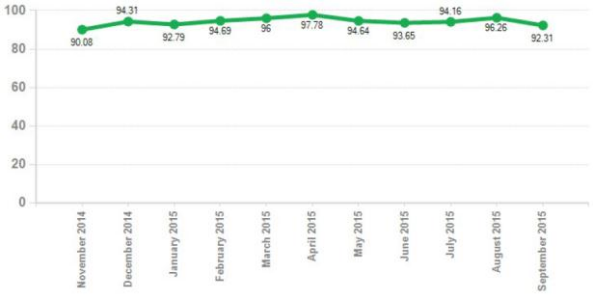
2.15 SL and JB to review sample of notes from DoLS database. Review capacity assessments and documentation around the MCA and DoLS process. Audit template drafted.

# Records management

**Derriford Hospital: The Trust must ensure that patients' records are stored securely at all times to prevent unauthorised access to them. Examples include Fal, Postbridge and ENT clinic.**

## Current Performance

**Satisfactory response to the Environment Audit question 'Are all notes trolleys locked if not in use or attended by an identifiable staff member if in use?' 26/10/15. Source: Meridian.**




**Satisfactory response to the Environment Audit question 'Are there any unattended notes on the ward/department that may be accessed by patients, or other non-authorised persons?' 26/10/15. Source: Meridian.**


## Comment on Current Performance

Performance will continue to be monitored.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.1 | 1. Fit Digilock to the cupboard on Postbridge.<br>2. Identify solution for the Trolley by the nurse's station for Postbridge.<br>3. Identify solution for Fal<br>4. Identify solution for ENT.<br>Financial Impact: Capital £2,000 | Julie Richards | Complete |

## Update on Actions

1. Postbridge digilock fitted.
2. Postbridge notes trolley needs to be converted to a lockable one. A suitable product has been identified and is with the department to order.
3. FAL reception has been assessed and has all the right tools to comply with the safe management of patient records. The department has therefore been asked to re-affirm the procedure of securing notes with the shutter when they leave.
4. ENT reception needs a lockable cupboard. A suitable product has been identified and is with the department to order.

**Derriford Hospital: The Trust should ensure that patients' personal and confidential information on computers and electronic systems is kept securely. We observed a computer which had been left unattended. The screen displayed patients' confidential details which were visible to other patients and visitors to the ward.**

**Current Performance**

Assurance mechanism to be identified – see action point 4.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.2 | 1. Reiterate the importance of locking screens in IG communications and with Matrons via the Heads of Nursing.<br>2. Visit the specific area, discuss screen positioning and remind staff to lock screens.<br>3. Complete implementation of the Agile Desktop Framework system for use by 2000 Clinical staff. This will allow fast user switching and will log users out after 5 mins of inactivity. This will be fully implemented by March 2016.<br>4. Investigate whether this can be added to the Environment audit on Meridian to provide ongoing assurance. | Penny Taylor | 31-Mar-16 |

**Update on Actions**

Screen Savers currently appear after 7 minutes of inactivity.

1. Reminder to staff in Daily Email 13/08/15 and 28/08/15. PT also emailed Heads of Nursing 22/9/15; cascaded on.

2. Specific area not defined by CQC however Clinical Systems walk through the wards on 22/10/15 will include checking for unattended screens and raise awareness.

4. PT has requested that a question is added to a suitable Meridian audit as the Environment audit is being revamped.

# Medicines management

**Derriford Hospital: The Trust must ensure that the checking systems for ensuring medication is fit for use, is consistently followed by staff. Intravenous fluids should be stored securely so that they are not accessible by patients and visitors to wards and departments.**

**Current Performance**

Assurance of compliance and development of metrics will be developed further to the following:

1) Inclusion in ward storage audits from December 15

2) ATO competency assessment results will be published in the pharmacy dashboard from November.

3) Next audit due January 2016.

4) Inclusion in the ward storage audits from December'15

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 4.1 | 1.Review the current process for labelling and managing liquid medicines supplied to clinical areas (NC)<br>2.Reinforce the need for expiry date checking by pharmacy ATOs during ward top ups.(NC)<br>3. Include Expiry date checking of controlled drugs in the daily procedure for reconciling ward stocks.(DW)<br>4.Review the current storage of IV fluids across all Derriford and peripheral sites.(DB)<br>5.Remedial work to be conducted where possible. Where it is not possible to make the areas more secure a robust risk assessment will be undertaken and systems for monitoring / auditing will be developed. (DB) | Simon Mynes | 31-Oct-15 |

**Update on Actions**

1.Process for labelling liquid medicines has been reviewed. Labels now available in all clinical areas. Guidance to ward staff to be published w/c 26th October. Will be included in storage audit from December.

2. Complete. Frequency of ATO ward based competency assessment increased from September. Reviewed through internal pharmacy QMS and results to be reported into pharmacy dashboard.

3.Guidance drafted –to be published w/c 26th October. Audits to commence at next quarterly audit planned for January 2016.

4.and 5. Initial audit of IV storage completed on 07/10/2015. Report to be completed and presented to November meeting of MUAC. The audit results will identify next steps in terms of remedial works and risk assessment.

**Derriford Hospital: The Trust must ensure that medications are managed appropriately in the outpatients departments and trust processes and policies are followed. This includes the safe keeping of the keys to medication stores/cupboards, investigation of stock discrepancies and staff not following the correct procedure for the checking of fridge temperatures.**

**Current Performance**

Audit results will be available for the November meeting of MUAC.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.1 | 1. Communicate the requirements as defined in the medicines policy to all out patient departments.(DW)<br>2. Pharmacy staff to undertake 3/12 audits of all areas (Derriford and peripherals) and results fed back to the service lines / care groups.(NC)<br>3. Define and communicate a standardised process for the monitoring of fridge temperatures.(IB)<br>4. Develop a business case for the introduction and roll out of a wireless temperature monitoring system. (SJM) | Simon Mynes | 31-Oct-15 |

**Update on Actions**

1. Security of medicines is being reinforced as part of the FP10 audit and changeover. All the onsite clinics have been visited and will be followed up with an audit, all the offsite locations holding FP10s bar 3 have been audited.
2. Audits commenced in October 2015.
3. Temperature monitoring guidance being developed and will be published in October.
4. Business case for wireless temp monitoring in development. To be included in capital bids for 16-17.

**Derriford Hospital: The Trust should review the standard operating procedures for Patient Group Directions used in Outpatients to ensure these comply with the legislation and best practice. In ophthalmology we found that patient group directions were not being followed appropriately.**

**Current Performance**

Audit to be undertaken starting in December 15. Results will be available for March 16 MUAC.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.11 | 1. Review and modify the current process for the approval of PGDs.(DW/PG)<br>2. Develop and communicate a standardised SOP for the implementation of PGDs(DW/PG)<br>3. Develop a training tool to support nursing staff in the application of PGDs.(PG)<br>4. Implement audit of compliance (including record keeping in medical notes, use of most current PGD versions, and checking the authorised staff have signed departmental PGD signature lists) as part of the annual medicines management audit programme overseen by MUAC. | Simon Mynes | Complete |

**Update on Actions**

Approval process of PGDs reviewed and modified.

Training package developed and ratified at MUAC 29/09/15.

Audit planned for Dec'15 - results will enable ongoing monitoring of compliance.

**Mount Gould Hospital: The Trust must ensure at Mount Gould Hospital the consistent application of medicines optimisation across the services, in particular: safe storage and management of stocks of FP10 and outpatient prescription forms, safe disposal of surplus or wasted medicines, and safe custody of medicines keys, so that prescription forms and medicines are only accessible to staff with suitable authority.(Also requirement to record room temperature and ensure that staff have undertaken assessment of competence or continued learning in medicines optimisation).**

**Current Performance**

Audit results will be available from the November meeting of MUAC.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.13 | The following actions apply to all off site locations:<br>1. Develop revised guidance on the management of FP10 prescriptions.(DW)<br>2. Introduce and audit pre-populated tracking sheets.(DW)<br>3. Audit the storage of medicines and FP10s - to be undertaken by pharmacy staff every 3/12 (NC)<br>4. Implement daily room temperature monitoring with quarterly auditing as part of new outpatient facilities assurance process which reports into Medicines Utilisation and Assurance Committee (MUAC).<br>5. Check completion of annual update training.<br>6. Develop annual competency assessment. | Simon Mynes | 30-Nov-15 |

**Update on Actions**

Revised SOP for the management of FP10s developed in conjunction with the Heads of Nursing.

Pre-populated tracking sheets developed and being rolled out from 20th July.

Communication to staff via Daily Email 02/09/15 and 04/09/15 and Vital Signs 04/09/15.

Audit visits commenced in Sept. 2015.

Audit of pre-populated sheets ready to commence once they are returned.

Temperature recording to be implemented in November.

Competency assessments developed for the handling of FP10 prescriptions, medicines keys and medicines.

Enhanced security arrangements implemented at Mount Gould – locks changed on cupboards.

Clear defined process for the disposal of waste medicines developed and disseminated to all staff.

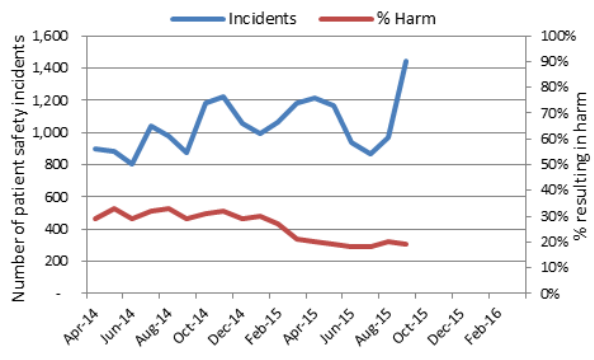
# Quality governance

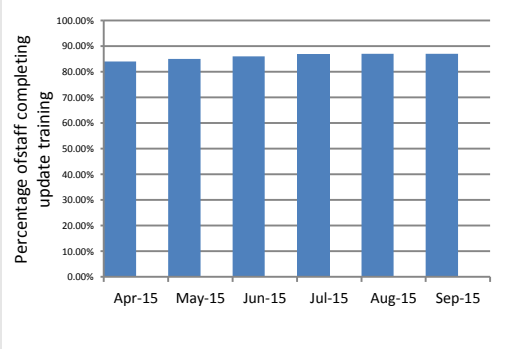
**Derriford Hospital:**

- **The Trust must ensure that all staff are aware of their role in incident reporting and there are systems and process in place to monitor not only individual incidents but trends and themes.(Particular link to Urgent and Emergency - see 7.1)**
- **Ensure that the dissemination of information from investigations following incident reporting should be communicated more thoroughly to support learning across the trust.**

## Current Performance

**Source: Performance Databook**




## Comment on Current Performance

The Trust's incident reporting rate of 14.55 incidents per 100 admissions places Plymouth Hospitals firmly within the national upper quartile and demonstrates a positive reporting culture.

The increase in reporting during September is due to tidying up of incidents which have been sat in the holding areas on Datix. There was a backlog of 408 incidents from 01/04/2015 – 31/08/2015; without these the number of incidents reported would be 1037 and reporting rate 10.44 %

Incident reporting is part of Trust induction and mandatory update training. For September 87% of all staff have completed their update training.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 5.2 | Recirculate communication in Daily Email and Vital Signs as part of a regular programme of communications. | Comms Team | 31-Dec-15 |
| 5.5 | Develop and deliver Governance module of Service Line Director & Service Line Manager training package. This will clearly set out the requirements of the service lines and include a section on incident reporting. | Steve Mumford | 30-Dec-16 |
| 5.6 | Develop Quality Governance Staffnet page that will share learning, trends and themes. | Steve Mumford | 30-Dec-15 |
| 5.7 | Complete roll out of new Service Line governance reports which will be reviewed at quarterly meeting with the Service Line (minimum) to review all Governance outputs including incidents, led by the Clinical Governance Lead. | Clinical Governance Leads. | Complete |
| 5.8 | Create a 'REACT' learning bulletin for each Serious Incident which will be signed off by EDs and circulated to all Matrons and Clinical Governance Leads for wider distribution to relevant staff groups. The sharing of this learning with staff will be tested via the Risk and Incident Team Serious Incident Assurance Visit programme. | Rachel Newport | Complete |

| | | | |
|---|---|---|---|
| 5.9 | Develop Quality Governance web page that will share learning, trends and themes. | Steve Mumford | 30-Dec-15 |
| 5.10 | Complete roll out of new Service Line governance reports which will be reviewed at quarterly meeting with the Service Line (minimum) to review all Governance outputs including incidents, led by the Clinical Governance Lead. | Clinical Governance Leads. | Complete |
| 5.11 | Publish anonymised RCAs on Staffnet page. | Risk & Incident Team in liaison with Comms Team | Ongoing for every SIRI |

**Update on Actions**

5.2 Article in Vital Signs 09.10.15

5.5 The Governance module of the Service Line Director & Service Line Manager training package is in draft form. First session to be delivered November 15.

5.11 Team have been briefed that when RCAs are submitted to the CCG a learning bulletin must be created and an anonymised RCA must be added to Staffnet.

**Mount Gould Hospital: The Trust should review the process for incident reporting to ensure that all staff act in accordance with the risk and incident reporting policy. An electronic incident reporting system (DATIX) was in place which staff confirmed they were trained to use. However, we saw examples where personal responsibility for reporting safety incidents was not taken by staff. A revised incident reporting policy was recently introduced across the trust. Staff we spoke with told us they were not aware of the new policy and could not recall any communication about its introduction. This meant that consistency in reporting and the full extent of safety incidents was not fully assured, placing people at risk of similar incidents occurring in the future.**

## Current Performance

**Incidents reported for Chronic Pain. Source: First Service Line Governance Report.**

| | Jan | Feb | Mar | April | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. SIRI* raised | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| No. SIRI overdue | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| Duty of Candour[1] | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| | | | | | | | | | | | | |
| No. Moderate | 0 | 0 | 0 | 1 | 0 | 1 | 0 | | | | | |
| No. Mod overdue | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| Duty of Candour[1] | 0 | 0 | 0 | NA | 0 | 1 | 0 | | | | | |
| | | | | | | | | | | | | |
| No. Near Miss | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | | | |

## Comment on Current Performance

The Chronic Pain Service Line Governance report has now been produced and discussed with Service Line management leads

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.18 | Develop and deliver Governance module of Service Line Director & Service Line Manager training package. This will clearly set out the requirements of the service lines and include a section on incident reporting. | Steve Mumford | 30-Dec-16 |
| 14.19 | Deliver presentation to MGH staff, content to include overview of Incident Management and Duty of Candour. | Risk & Incident Team with Di Sheppard. | 30-Sep-15 |
| 14.20 | Undertake assessment of all of the offsite services and locations to best determine the most appropriate methods of communicating with teams and provision of training which will include communication on the policy, attendance on some sites and ensuring service lines and care groups understand their responsibility towards staff so that they are aware of their individual responsibility for incident reporting and receiving feedback and learning. | Rachel Newport and Steve Mumford | Assess by 31/10/15 Delivery of plan to be defined based on assessment |

## Update on Actions

14.18 The Governance module of the Service Line Director & Service Line Manager training package is in draft form. First session to be delivered November 15.

14.19 Chronic Pain Services is booked in for DoC/Incident Management training for 15th December 2015; this is their next CME meeting.

14.20 Community Paeds at Child Development Centre had Duty of Candour training on 17th September 2015. Assessment of services provided underway to identify where services are solely provided off site

**Mount Gould Hospital: The Trust should Improve the dissemination of learning from safety incidents and complaints. There was no record of further action or the lessons learned in three out of five of the incidents. This meant that there was a risk that similar incidents would not be prevented from happening in the future.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.22 | REACT' learning bulletin for each incident circulated to all Matrons and Clinical Governance Leads for further dissemination. | Rachel Newport | Complete |
| 14.23 | Publish anonymised RCAs on Staffnet. | Risk & Incident Team in liaison with Comms Team | Ongoing for every SIRI |
| 14.24 | Develop Quality Governance web page that will show learning, trends and themes. | Steve Mumford | 30-Dec-15 |

**Update on Actions**

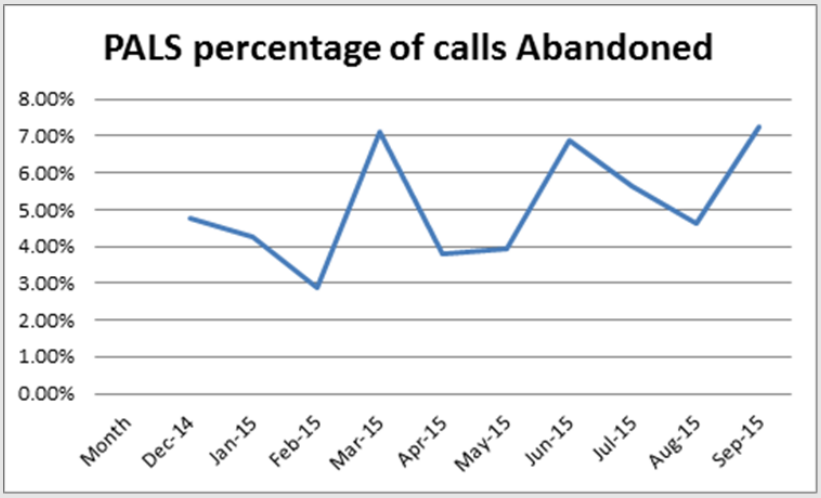
14.23 Team have been briefed that when RCAs are submitted to the CCG a learning bulletin must be created and an anonymised RCA must be added to Staffnet.

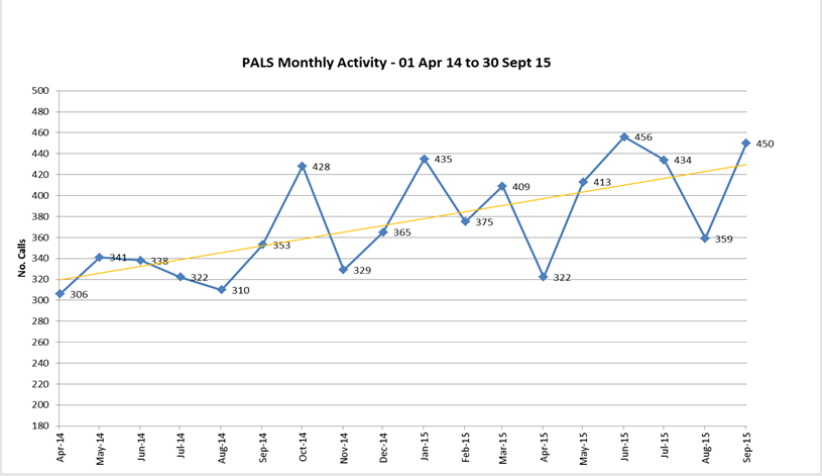
The first Service Line Governance report for Pain was produced in August 2015 and discussed 23/09/15.

**Derriford Hospital: The Trust should ensure that the PALS department is able to respond promptly and efficiently to patients and visitors to the hospital. There was a lack of posters or directions regarding how to access the PALS team.**

## Current Performance

**Source: Telecom system database**




## Comment on Current Performance

The PALS Team were transferred to the Netcall system in December 2014, which had reduced the overall number of calls missed or left unanswered. Netcall enables us to closely monitor the levels of calls abandoned and received. The above chart shows an increase in September which is partly attributed to staffing issues in the department and the number of calls received overall. For September there was an increase in the number of calls and face to face interactions for PALs; the charts above demonstrate that activity and calls abandoned generally correlate. An additional PALS person was appointed 27 October which will improve the situation. Information has been circulated with staff throughout the Trust to ensure that they are aware of PALS and know how to direct patients and members of the public to their services. The office on level 6 has greatly increased awareness of PALS and is reflected in the number of walk in and face to face enquiries.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 5.12 | Update PALs and Complaints information in the Patient Bedside Booklets which are available at every bedside. | Jayne Glynn/Kylie Glynn | 30-Sep-15 |
| 5.13 | Introduce posters relevant to each ward or department detailing how to raise a concern – initially through the clinical team or alternatively signpost to PALS or Complaints. | Jayne Glynn/Kylie Glynn | 30-Sep-15 |
| 5.14 | Increase PALs presence on Level 6 and improve signage throughout hospital at lifts and key points. | Jayne Glynn | 31-Mar-16 |
| 5.15 | 1. Explore cost and implementation of 'info point' stations at each exit providing free taxi call facility and up to 4 additional numbers, one of which would be to PALS.<br>2. Finalise decision about implementation.<br>Financial Impact: Revenue Above Budget £3,000 | Jayne Glynn | 1. Complete<br>2. 31/03/2016 |
| 5.17 | Undertake a review of the quality of the PALS service. | Jayne Glynn | 31-Dec-15 |

**Update on Actions**

5.12 Quotes received from RNS Publication, can only deliver the completed booklets by 31 Dec 15. Draft being reviewed and updated in preparation for publication. Sponsors sought by external company. Second meeting held with RNS publications to agree possible improvements to booklet content on 15 October 2015. Alternative examples received 19 October 2015.

5.13 Noticeboard review for wards will consider what information should be included on existing posters. Currently there are various options across wards and departments.

5.14 Plans submitted for executive approval as part of the retail provision review, will increase PALS footprint on level 6.

5.15 1. Complete: Second meeting held to progress infopoint. Implementation costs established and possible infopoint locations identified. Taxi company are not willing to pick up additional costs at present.

2. Further enquiries being made about taxi contract. Decision to be made about progressing and absorbing the cost for 2 infopoint locations funded by the Trust.

**Derriford Hospital: The Trust should review the provision of translation services in the emergency department to ensure they can be provided in a timely manner. (This particular concern related to access to British Sign language trained interpreters of which there are very few in the region.)**
**Mount Gould Hospital: The Trust should ensure patients have access to information on translation services should these be required.**

**Current Performance**

Poor service provision will be identified via complaints; themes will be identified and any arising action monitored through Patient Experience Committee.

**Comment on Current Performance**

No complaints identified for the period January 2014 to October 2015 (28/10/15).

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.12 | ED<br>1. Investigate with Language Empire the possibility of using Skype<br>2. Review whether flash cards are being used and if they are effective.<br>3. Consider developing cards for sign language for ED.<br>Financial Impact: Revenue Above Budget £5,000 | Jayne Glynn | 31-Mar-16 |
| 14.32 | Mount Gould Hospital<br>1. Information on translation services to be provided to all clinics and locations.<br>2. Language Empire posters to be displayed in departments and areas to ensure patients understand they can request an interpreter – circulation through Patient Services Team.<br>3. Circulate updated information to all staff ensuring they are aware of the fact that translation service requirements should be identified as part of the booking process.<br>4. Update Public website to include details of interpreting services in multiple languages. | Jayne Glynn | 31-Dec-15 |

**Update on Actions**

7.12 ED: Meeting held with Language Empire on 18 Aug 15. Advised of new BSL video translation service. Requested costings and logistics of implementation.
14.32 MGH: The booking process will identify when a patient needs an interpreter. This information is usually contained within the referral letter and then when the patient is booked on the waiting list, comments that they require an interpreter are added on. Reminder of the process to be circulated in Vital Signs 23 October 2015 and through Daily Email, ward clerks and medical secretary emails.
1. and 2. Additional posters have been received from Language Empire regarding the translation services.

**Mount Gould Hospital: The Trust should ensure feedback from patients using Mount Gould Hospital is gathered, reviewed and acted on.**

**Current Performance**

**Friends and Family recommender percentage. Source: Service Line Governance report August 2015**

| | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|
| **Pain Clinic** | 95 | 96 | | | | | |

**Comment on Current Performance**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.35 | Review all off site services to ensure that feedback is gathered wherever possible. | Jayne Glynn | 31-Dec-15 |

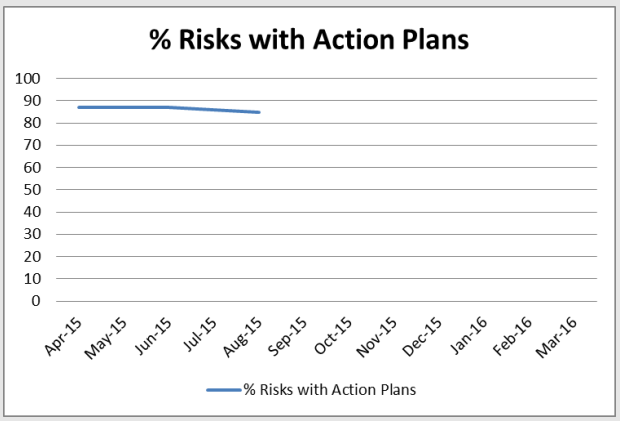
**Update on Actions**

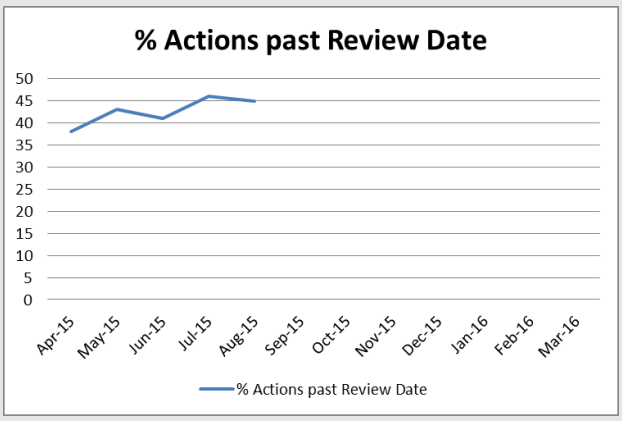
FFT feedback mechanism in place for Mount Gould. Further work underway to identify all community sites and services – this will be an ongoing piece of work. Existing option for all patients to leave feedback through Trust Website.

**Derriford Hospital: The Trust should ensure that staff understand their role in relation to the responsibility, management and oversight of the risk registers throughout all levels of the organisation related to outpatients and diagnostic imaging.(Outpatients)**

## Current Performance

**Source: Datix report**




## Comment on Current Performance

Continue monitoring performance via Quality Managers review of all risks as part of the Service Line governance reports.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 5.18 | 1. Review the Trust's risk management arrangements.<br>2.Develop a plan for implementation of actions arising from the review. | Steve Mumford | 30-Dec-15 |

## Update on Actions

New risk management policy (draft) has been produced and is being reviewed by the Risk Management project group. This will form the basis of retraining across the organisation.

# Equipment

| **Derriford Hospital: The Trust should ensure that there is evidence that up-to-date servicing and maintenance of equipment has taken place. Not all equipment had a sticker identifying the last servicing date or when servicing / maintenance was next due. For example, urinalysis testing machines, blood pressure recording machines, or sluice masters (used for the safe disposable of soiled bedpans).** | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 6.1 | Design new date label to replace current 2 x label system to cover all maintenance / servicing / testing / inspecting for medical devices under MEMS remit. Deployment of new design label achievable through normal annual servicing round. | Jonathan Applebee | 31-Jul-16 |
| 6.3 | Review contract performance management processes for non-clinical equipment. | Julie Richards | 30-Mar-16 |
| **Update on Actions** | | | |
| 6.1: New labels produced and being deployed as at 13-Aug-15. Reminder Daily email 28/08/15. 11/09/15: On schedule. We previously labelled sluice masters and stopped because the labels proved hard to keep clean and it was decided that to label them was unhygienic. All critical equipment is on the Estates Management System and the records are up to date. | | | |

# Urgent and emergency care

**Derriford Hospital: The Trust must ensure that all staff are aware of their role in incident reporting and there are systems and process in place to monitor not only individual incidents but trends and themes.**

**The Trust should review the governance systems to improve the function, monitoring and learning from incidents, complaints and risks.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.1 | 1. Complete Safety Culture questionnaire - When we have enough responders the results will be fedback to the Lead and to the service line, will be discussed in safety and research forums and action taken accordingly. The survey will then be repeated at a later date (A Rickard).<br>2. Consider how to improve feedback to staff and discuss this with the ED Safety Team 23/09/15 and at the Safety days scheduled for September and October 2015. | Andy Kelly | 31-Dec-15 |
| 7.14 | Review of effectiveness of governance system to be undertaken by ED Safety Team (meeting 23/09/15) to see how we can improve things further, including how to improve sharing learning with other departments. | Andy Kelly | 31-Dec-15 |

**Update on Actions**

7.1: Systems already in place e.g. safety days, handover, screensavers, adhoc comms and Comm Cell.

1. Verbal feedback on Safety Culture Questionnaire received. In order to use this information and evolve the department's safety culture, multiple opportunities for staff to receive feedback and to further highlight areas of concern regarding our underlying safety culture are being planned. This will allow improved engagement regarding safety culture and positive work on the valuable feedback that 60% of our staff gave when we conducted the Safety Culture questionnaire. We also need to clarify various responses which were received in the free text sessions and plan to do this by speaking with small groups to understand certain areas of response in the survey, such as those reflecting our strong burnout climate and some perceived problems with leadership and teamwork. This will not only allow solutions to come from within our own multiprofessional cohort but, in the process of listening and engaging in meaningful discussion around our safety culture, we hope to provide effective feedback.

Senior doctors and nurses will be addressed at the monthly governance and education meeting (GEMS) on Wednesday 21st October and the plan is to start focussed feedback sessions in small groups on the same day. After these initial feedback sessions have happened, we will need to work on some further ongoing methods to ensure the culture of effective feedback and engagement is embedded within the department and also between the department and senior leaders in the Trust.

2. Have discussed with staff on first safety day. Have now separated safety and "social" newsletters. Also looking at communications to the team on news from the rest of the Trust. Discussed at meetings and on the four half safety days in September/October to seek the thoughts and feedback of staff. The team have started a new safety newsletter with the first one issued week commencing 12/10/15. Ongoing work to share feedback via safety alerts and daily handover.

7.14: We have introduced an extensive clinical governance overhaul which we are still embedding and developing. Mechanisms for learning and sharing currently include email, newsletters, screensavers, clinical governance meetings, handover, adhoc communication, safety notices, clinical guidelines, and safety days. The culture of the department was discussed at the safety days. Staff feel that the department has a transparent culture but don't feel that they get feedback about incidents.

| Derriford Hospital: The Trust must ensure that staff are administering medicines in line with the NMC standards for medicines management. (Issue identified with Propofol infusion) | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.2 | 1. Issue a reminder to all staff and include in the department newsletter.<br>2. Undertake monthly observations of propofol infusions Sept-Dec 2015. | Tim Parham<br><br>Fiona Veale, Resus Lead | Completed and closed |
| **Update on Actions** | | | |
| All staff are required to undertake online mandatory training on IV drug administration.<br>1. Complete - Email issued to all ED nurses 30/07/15 and staff 04/09/15. Guidance on the labelling of syringes issued by PG in Pharmacy. Switch to pre-made propofol syringes implemented from 9 Oct 15.<br>2. Action no longer required given switch to pre-made propofol syringes. | | | |

| Derriford Hospital: The Trust must ensure that patients receive appropriate and ongoing risk assessments such as mental health risk assessments and complexity scoring, to determine the appropriate place for them to be cared for and monitored. | | | |
|---|---|---|---|
| **Current Performance** | | | |
| Ongoing assurance will be provided via repeat audits. | | | |
| **Comment on Current Performance** | | | |
| N/A at this time. | | | |
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.3 | 1. Complete implementation phase for ED Mental Health proforma.<br>2. Gather user feedback and feed into the final version of the document.<br>3. Undertake a formal evaluation of this document (Research Fellow in ED). This will look at how the proforma is used, will amend the proforma as required and will result in the approved final version. | Anne Hicks | 31-Oct-15 |
| **Update on Actions** | | | |
| Implementation phase complete. | | | |

**Derriford Hospital: The Trust must ensure that patients in the emergency department that are awaiting x-rays in the corridor and the reception area away from staff vision are suitably monitored.**

**Current Performance**

Successful implementation will be monitored via the call bell audit.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.4 | 1. Issue a reminder to staff that patients must be suitably monitored.<br>2. Investigate the possibility of installing wall mounted call bells in this area or purchasing wireless fobs which would feedback to the main call bell panel in ED.<br>Financial Impact: Capital £20,000 | Tim Parham | 31-Oct-15 |

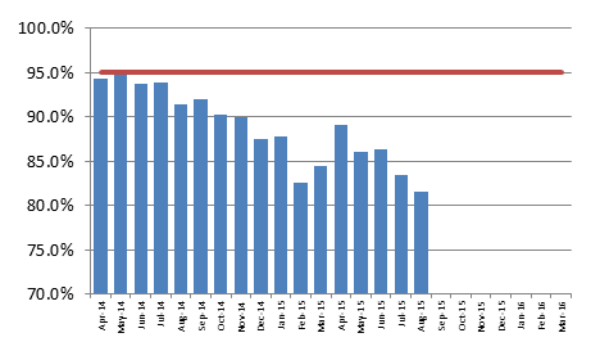
**Update on Actions**

Patients in the corridor can be monitored via CCTV by the radiographers and also by staff in the staff room. Any patient that required close monitoring would always be accompanied.
1.Emailed reminder to ED nurses 30/07/15 and CDU staff 04/09/15.
2. Installation is complete and will be commissioned 04/11/15.

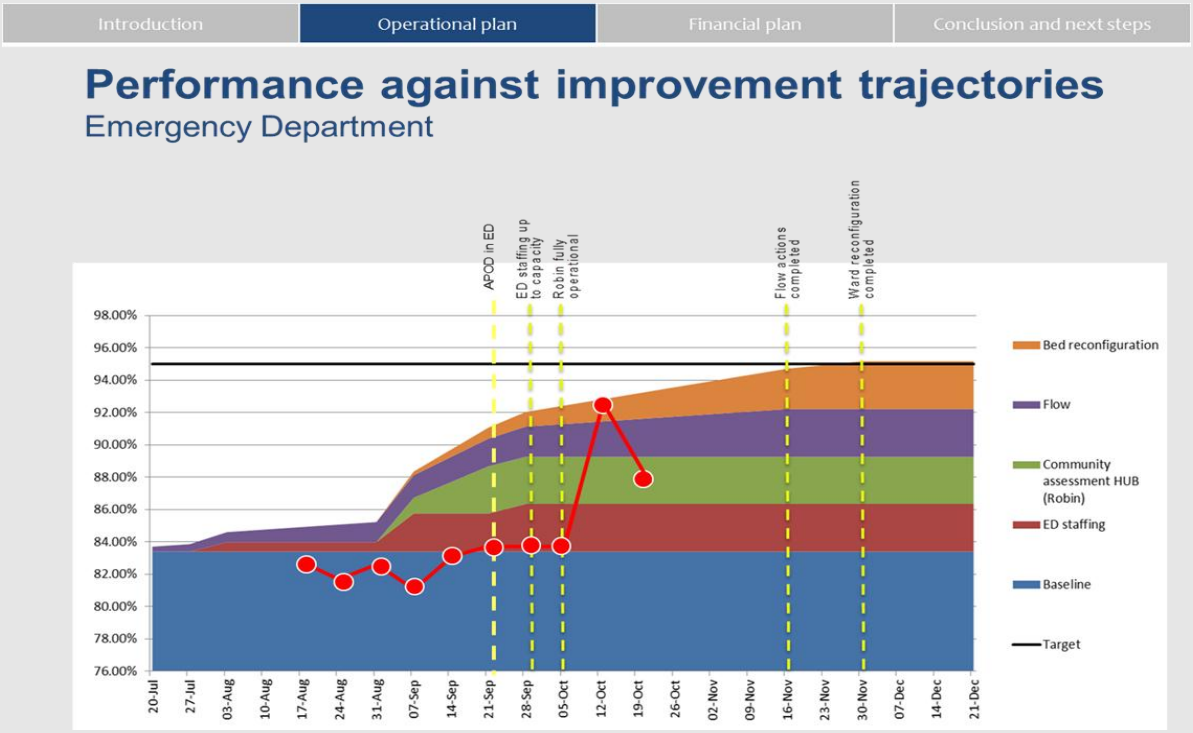
**Derriford Hospital: The Trust must ensure that patients are protected from risk through improvement of systems and performance in relation to the time patients spend in the emergency department.**

## Current Performance

**The Trust failed the A&E 4hr wait standard in August 2015 at 81.5% (source: Integrated Performance Report Trust Board September 2015):**




**Performance Against Improvement Trajectories. Source: Recovery Plan Update to Trust Board October 2015.**




## Comment on Current Performance

Following an increase in ED attendances from Feb-15 through to May-15, the daily average volume of people attending ED has plateaued at 251 per day in August.

The numbers of patients triaged in the highest two categories is 6% higher than the same time last year and as a result performance against the 4 hour standard remains challenging.

An internal and cross-community ECIST plan to recover ED performance by the end of Q3 is being implemented.

The Performance Against Improvement Trajectories graphic demonstrates that each intervention will incrementally impact on our ability to deliver the 4 hour target.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 7.6.1 | Implement Service Improvement Project focussed on ED Flow designed to improve compliance with the 4 hour standard. Test several solutions - further actions to follow the results of the tests.<br>Financial Impact: Too early to cost | Richard Best | Ongoing improvement programme |
| 7.6.2 | 1.Increase staffing overnight when highest breaches occur.<br>2. Implement Acute Physician of the Day (APOD) in ED and electronic handover.<br>3. Implement ECIST recommendations for 'safer ward bundle' & flow. | David Brown | Ongoing improvement programme |
| 7.7 | Implement Service Improvement Project for MAU Flow focussed on optimising handover to wards, rapid consultant review and the appropriate use of the Ambulatory Care Unit. Test several solutions - further actions to follow the results of the tests.<br>Financial Impact: Too early to cost | Richard Best | Ongoing improvement programme |

**Update on Actions**

7.6 1 Initial tests reveal opportunity for 40min reduction with changes to assessment and Xray flows. Further tests ongoing, This approach is to be standardised from November along with reception resource. Repeat tests have re-enforced benefit.
7.6.2 (1) - 3rd SHO in place overnight, 4th SHO starting 26th October. 5th doctor (F1) to start 1st December.
7.6.2 (2) - APOD in ED and electronic handover both active.
7.6.2 (3) - SAFER bundle work is ongoing. This is an iterative improvement cycle.
7.7 Three areas being pursued: MAU consultant and Team working in ED on afternoons 21/9 - significant impact.; increase flow to ambulatory care – impact has been minimal, tests to reduce time moving to ward from MAU – this has been stuck and is being re-launched in the next week to work on improvement.

**Derriford Hospital: The Trust must ensure that the reception and waiting area in the emergency department complies with the Disability Discrimination Act.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.8 | Estates team to work with ED to come up with a compliant and workable solution for the minors reception desk. Financial Impact: Capital £10,000 | Julie Richards | 30-Oct-15 |

**Update on Actions**

Finance is agreed. We are finalising the works to be done and should be able to complete the works subject to access being agreed over the next few weeks, by end November.

**Derriford Hospital: The Trust should review privacy arrangements for patients arriving in the emergency department, either through reception or via ambulance, awaiting investigations such as x rays and while in the 'corridor' area.**

**Current Performance**

Monitoring arrangements to be determined based on the outcome of the review.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.11 | Undertake a review of privacy arrangements. Consider the use of privacy screens. | Tim Parham | Review complete |

**Update on Actions**

The department trialled a new system for assessing patients by keeping three cubicles free but this was not successful. Currently assessing possibilities for use of alternate space which would free up a Minors solution.

**Derriford Hospital: The Trust should review bereavement and viewing facilities within the department.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.13 | Undertake a review of bereavement and viewing facilities. | Tim Parham | Complete |

**Update on Actions**

Physical layout and space is an issue. Currently use cubicles 11, 14 and 15. Have adopted the use of a butterfly symbol to put on the door to increase staff awareness. The butterflies will be laminated and put into majors cupboard opposite room 11. If a patient is at the end of their life or has indeed passed away place the butterfly on the door.

| Derriford Hospital: The Trust should review nursing leadership within the CDU. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.15 | Band 7 manager of Short Stay ward to run CDU and Short Stay. Annual leave etc would be covered by a Band 7 in ED. | Tim Parham | Complete and closed |
| **Update on Actions** | | | |
| Band 7 has started in post 12/10/15. | | | |

| Derriford Hospital: The Trust should review the provision of a play specialist for the paediatric emergency department area. While there were some toys available and a television was on, these were designed for younger aged children. Though the department had free Wi-Fi available, this was not advertised to young people attending. | | | |
|---|---|---|---|
| **Current Performance** | | | |
| Monitoring to be determined once a solution is identified. | | | |
| **Comment on Current Performance** | | | |
| N/A at this time. | | | |
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.16 | 1. Work with the Childrens and Young People Service Line to seek input into the ED paeds area in terms of advice re environment and resources and training for ED staff so that they can use the basic techniques 24/7.<br>2. Explore opportunities for joint funding a post, or buying time from the CYP SL.<br>3. Advertise WIFI to patients e.g. via a poster.<br>Financial Impact: To be determined | Ian Higginson | 31-Mar-16 |
| **Update on Actions** | | | |
| 1. In talks with Matron Dykes.<br><br>3. Wifi posters put up 13/08/15 | | | |

# Medical care

**Derriford Hospital: The Trust must ensure that care and treatment is provided in a safe way for patients by ensuring premises are safe to use for their intended purpose, that is cleaning materials and sharps materials are stored securely in areas that are not accessible to patients or visitors. The sluices contained cleaning materials that were accessible and needles were left on unsecured phlebotomy trolleys in ward corridors.**

**Current Performance**

Assurance of compliance to be obtained via Matrons' Checklist – see action 2.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.1 | 1. Review the existing COSHH policy.<br>2. Review compliance by adding this to the Matrons' checklist. Patient Safety Team to add to Meridian for the Matrons' checklist.<br>3. Review in 3 months.<br>4. Matrons to review the location of phlebotomy trollies when not in use and ensure these are not stored in an area that is unobserved or unsecure. | Sam Rafferty | 30-Nov-15 |

**Update on Actions**

Quality Manager attended Matrons' meeting on 8th October 2015. Matrons were asked to ensure that the Health and Safety risk assessment checklists are completed for their areas and any unresolvable issues are raised on their respective risk registers. Monitoring should then be via Service Line Quality Governance Reporting meetings where the risk register is reviewed. These meeting are minuted.

**Derriford Hospital: The Trust should ensure the safe storage of medical gases at all times.**
**Medical Care: A number of medical gas cylinders were stored in an area without any medical gas signage. This may pose a risk to patients, visitors and staff.**

**Current Performance**

Audits are to commence in December. First report will be presented at January meeting of MUAC as part of the storage audit report.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.2 | 1. Implement the required signage.<br>2. Include medical gas storage in quarterly ward medicines storage audit.<br>Financial Impact: Capital £3,500 | 1. Bryan Kidger<br>2. Simon Mynes | 1. 30/09/2015<br>2. 31/12/2015 |

**Update on Actions**

The required signage was delivered on site 22/09/15 and is currently being fitted by Estates. Training for pharmacist staff was delivered on 19th October. Training for ATOs to be delivered. Audits to commence in December as planned

**Derriford Hospital: The Trust should ensure that service specific mortality and morbidity meeting minutes are recorded in sufficient detail to enable any trends or issues to be identified, in order to take action or learning from the minutes.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.3 | Request that Service Lines feedback to the Care Group management team regarding how they document their M&M meetings currently. If a good example exists, an existing proforma will be shared as best practice. If not, a new proforma will be designed. | Phil Hughes | 31/03/16 |

**Update on Actions**

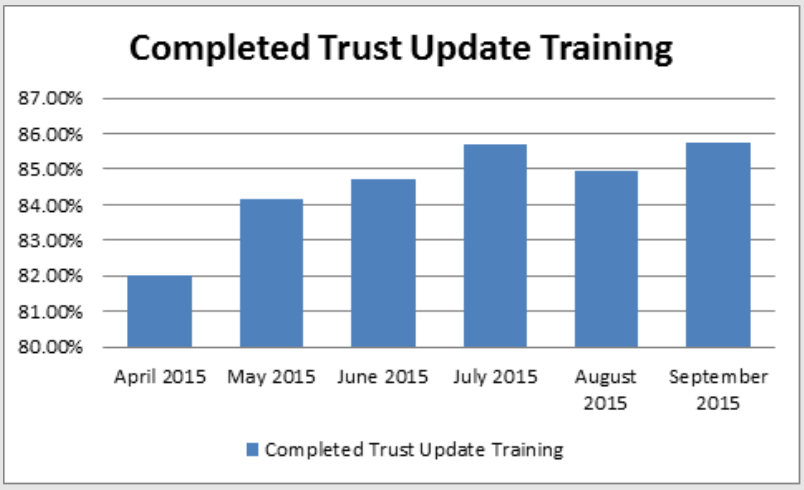
Rather than just focussing on the Medicine Care Group, the Trust as a whole via the Mortality Review Panel is looking at Mortality Reviews and the process within service lines for minuting their meetings. Phil Hughes, Medical Director will now lead this action as Chair of the Mortality Review Panel. An audit of what we are currently doing will be undertaken and then areas of standardisation will be agreed. The Quality Manager for Medicine has, as of 7th October 2015, provided evidence for 6 of 11 Service Lines. Further update to be provided in November.

Service Lines will be asked to present evidence of their M&M meetings to the Mortality Review Panel at least yearly. Phil Hughes is writing to service lines to detail what the expectations are related to the format and function of M&M meetings.

**Derriford Hospital: The Trust should ensure staff consistently complete infection control training and that patients with communicable infections requiring isolation are cared for in isolation.**

**Current Performance**

**Source: Workforce Information data for clinical staff.**




**Comment on Current Performance**

Infection Control is inherent in Trust Update training. Within the Medical care group this is scrutinised at quarterly Service Line Governance Meetings, with a report showing the breakdown by staff groups.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.4 | Review the Mandatory training plan for the nurses. | Sam Rafferty | Complete and will be ongoing. |

**Update on Actions**

This was raised at the Matrons meeting on 8th October. Difficulties with releasing staff to undertake training should be escalated to Head of Nursing. Infection Control is inherent in compliance with Trust Update training. Within the Medical Care Group this is scrutinised at quarterly Service Line Governance Meetings, with a report showing the breakdown by staff groups. For Nursing Staff this is also covered in the matrons' 2 to 1 with Heads of Nursing and performance reviews with Ward/department managers.

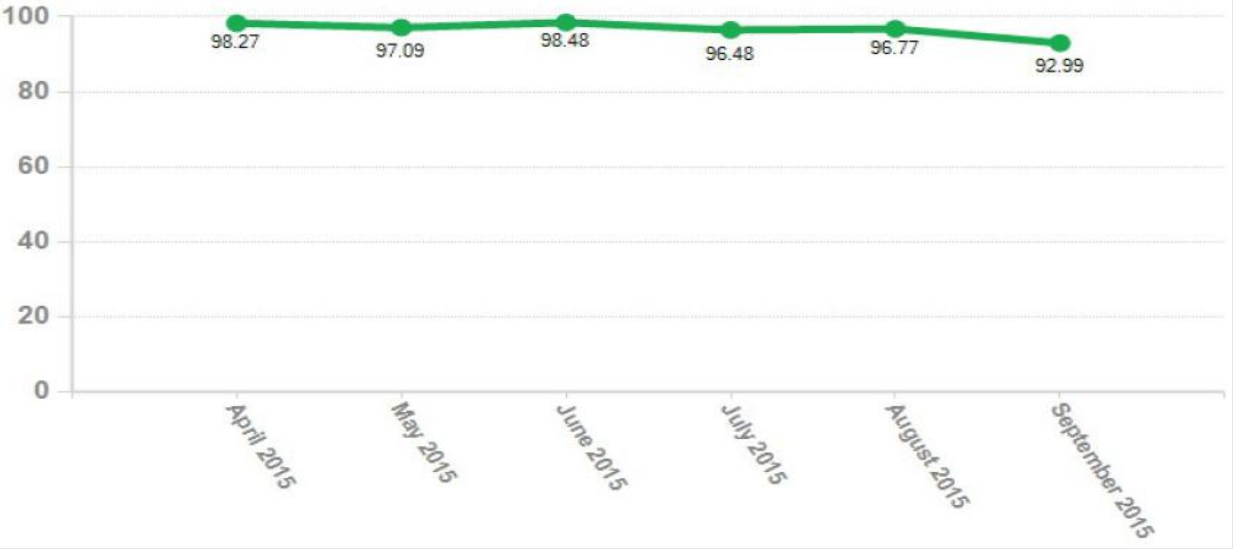
**Derriford Hospital: The Trust should ensure risk assessments and care documentation for individual patients are consistently and appropriately completed by staff. For example VTE risk assessments were not consistently completed in full or actioned promptly.**

## Current Performance

Risk assessments are inherent in the Fundamentals of Care audits.

**Source: Meridian report (27/10/15) April to September 2015 for the Medicine Care Group for the following questions:**

11. Has the Waterlow score been completed on admission?
12. Within the last 24 hours, has the ongoing Waterlow score been recorded?
13. Has the pressure ulcer score (EPUAP) been recorded on admission?
14. Within the last 24 hours, has the ongoing skin assessment (EPUAP) score been recorded?
15. Has the Manual Handling Risk Assessment been completed on admission and is it up to date?
19. Has MUST assessment been completed?




## Comment on Current Performance

See update on actions.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.5 | Finalise consolidation of a number of assurance processes to form a Nursing Assessment and Assurance Framework (NAAF) that will make intelligence gathering and action from audits more effective. | Sam Rafferty | Complete and ongoing monitoring through Fundamentals of Care |

## Update on Actions

This continues to be embedded in Matron's 2 to 1 meetings with the Heads of Nursing. Replacement for Pressure Ulcer risk assessment is currently being subjected to a pilot. Targeted work with key wards going forward via Matrons and Practice Educators with oversight at Matrons' 2 to 1 meetings. Regular quarterly agenda item at Matrons meetings to review themes and trends related to fundamentals of care.

With regards to VTE risk assessments there needs to be further dialogue between the Care Group Director and the VTE lead to determine what the improvement plan should look like for the Care Group. The Quality Manager has asked the Care Group Director and Care Group General Manager to discuss at the Service Line Directors' Meeting.

**Derriford Hospital: The Trust should ensure that all staff are knowledgeable about the sepsis identification and management system in operation within the trust.**

**Current Performance**

Audit results not yet available.

**Comment on Current Performance**

Not Applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.6 | Action reframed:<br>1. Implement requirements of national sepsis alert re access to screening form to be available in all areas.<br>2. Implement programme of education.<br>3. Deliver ongoing 8 Step programme of work. | Paul McArdle/Tim Nutbeam | 1. 31-Oct-15 – Complete<br>2. Complete<br>3. Ongoing improvement programme |

**Update on Actions**

A sepsis programme has been introduced in ED and MAU. A formulated sepsis assessment tool has been implemented in areas where patients are admitted i.e. MAU, SAU, ED and Paediatrics. Regular safety briefings are held on MAU.

Sepsis is included in Induction / Statutory update training. A nurse has been appointed with the responsibility of leading sepsis education and a programme of education is in place. Sepsis simulation is in place on MAU, a Researcher has been appointed to undertake simulation work and a student has been attached to MAU to undertake regular audit.

Interim audit results for the Sepsis CQUIN are now available. It is recognised that the sensitivity of the audit could be improved to identify patients who might benefit most from this. This is currently being discussed with the CCG.

A forward plan is being developed to address issues identified by the national CQUIN. A SEPSIS group reviews progress.

An antibiotic app has been developed by Rob Tilley. In addition, software is being developed to pilot in ED which will help spot sepsis early. The next hurdle for this is interface management with IT.

**Derriford Hospital: The Trust should ensure that the system for advising staff of the medical cover for medical outliers is disseminated efficiently and to all staff. A number of staff were not all aware of the email detailing cover arrangements. The medical outlier consultants had individual bleep numbers and on the staff handover sheets we saw these numbers were included but did not specify which consultant was caring for which patient. The electronic bed management system identified the consultant cover for the medical outliers. However, not all staff we spoke with were aware of this or how to access this information.**

**Current Performance**

We will seek assurance of the effectiveness of this process by asking staff to test their awareness.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.7 | Medical staffing plan for the next week is confirmed at the weekend staffing meeting each Friday. Share this information with all senior nurses via group email and include as part of the ward handover information the following week.<br><br>Ward reconfiguration project intended to limit the amount of Medical outliers required. | David Brown | Complete<br><br>31/12/15 |

**Update on Actions**

Medical cover arrangements for the outlying wards have been stabilised with the same consultant team having responsibility for the wards for the week duration. Dedicated junior doctors are also allocated rather than doubling up with medical wards teams. Three outlier teams have been established who look after patients for one week at a time.

Survey of ward teams to confirm their understanding of medical cover to be completed by end November.

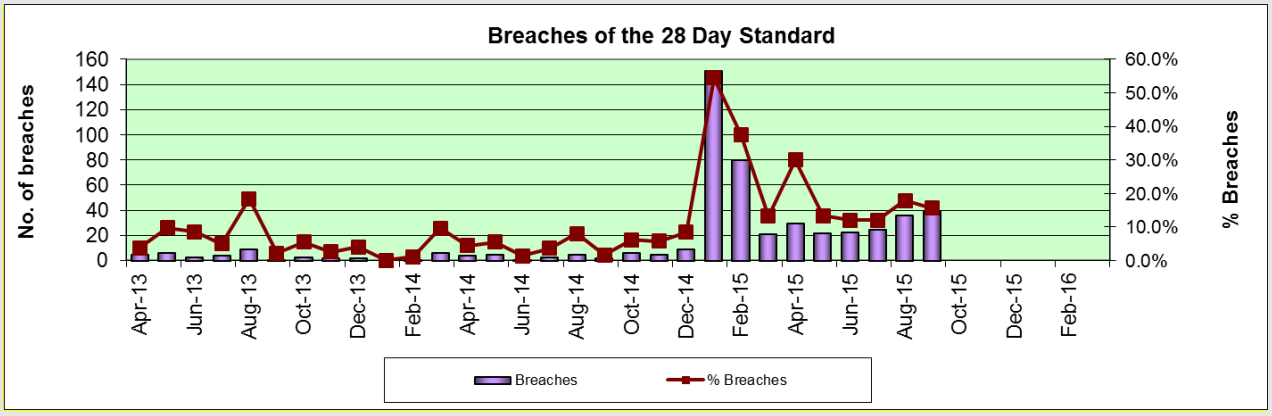
First two phases of bed reconfiguration are complete. Third phase expected to be complete by Dec 15.

# Surgery

**Derriford Hospital: The Trust must ensure there are systems in place so that the impact of system escalation does not delay patients who are cancelled at short notice and that they are re booked for their surgery within the 28 day requirement.**

## Current Performance

**Source: Performance Information Data Book 26/10/15**




## Comment on Current Performance

There were 36 breaches of the 28-day rebooking standard in August 2015. The operational pressure is making it extremely difficult to rebook these cancelled patients within the 28-day window.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 9.1 | 1.Undertake weekly list reviews (as per scheduling policy).<br>2. Consider bed bureau for elective bookings.<br>3. Improve scheduling of Level 1 patients, (implementation of outlook booking system to ensure greater visibility).<br>4. Maintain weekly monitoring of theatre utilisation, including relets and weekly RTT meetings chaired by Chief Operating Officer.<br>5. Review performance data and highlight concerns for individual patients to Service Line Managers. | Ian Wren | Complete |

## Update on Actions

1. An Assurance Framework is being developed with the support of the Service Improvement Team to develop metrics which can be used to check compliance with weekly list reviews. The metric should be available within the next two weeks.

2. Lynher and Neurosurgery are starting bed bureau as proof of concept.

3. Scheduling policy approved by Surgical Care Group Governance meeting.

4. Weekly RTT meetings are in place. More metrics are being identified to monitor performance.

**Derriford Hospital: The Trust must ensure that systems for booking theatre slots are robust and coordinated across the trust so that theatre time is utilised to provide a timely and consistent service. The system used for booking operations failed to identify when mistakes were made resulting in patients being cancelled. This placed patients at risk of harm due to delays in their treatment.**

**Current Performance**

Arrangements for assurance and monitoring to be defined – see action point 4.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 9.2 | 1. Implement TIMS.<br>2. Undertake List reviews.<br>3. Redesign and application of scheduling policy.<br>4. Surgery Care Group Manager to identify mechanism and resources required to support implementation and monitoring of compliance and ensure that this links with ongoing Board oversight.<br>Financial Impact: Revenue above budget £40,000 | Ian Wren | TIMS 2016<br>Other actions complete. |

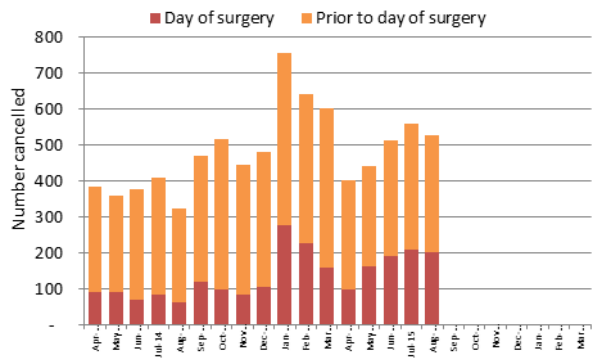
**Update on Actions**

1. The Trust is disappointed with the progress with design and implementation of TIM's. If the concerns are not addressed within the next 4-5 weeks then the contract will be terminated. This action is therefore not on track to deliver.
2. Metrics will be available within the next couple of weeks to ensure that list reviews are being completed.
3. Scheduling policy approved by Surgical Care Group Governance meeting.
4. A full set of metrics is being developed with the Service Improvement Team. Once the full set of metrics is available, these will be presented to Safety and Quality Committee.

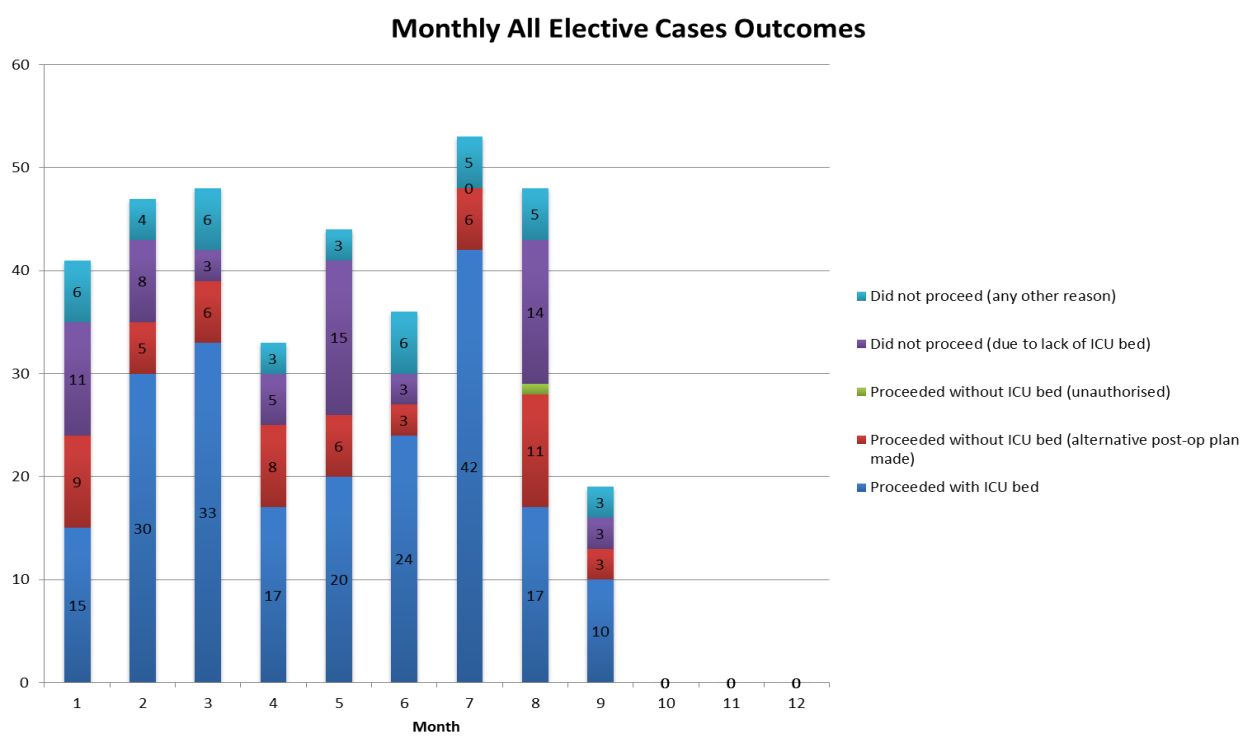
## Derriford Hospital: The Trust must ensure that it improves the experience of patients by addressing the high numbers of elective operations that have been cancelled.

### Current Performance

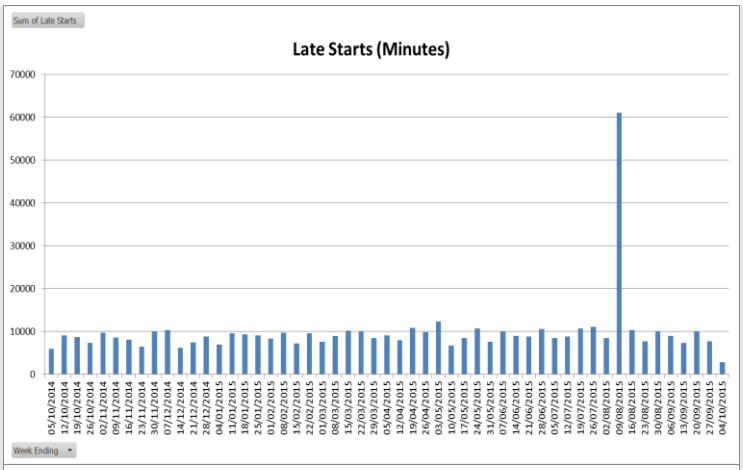
**Cancelled Operations. Source: Integrated Performance Report to Trust Board September 2015.**

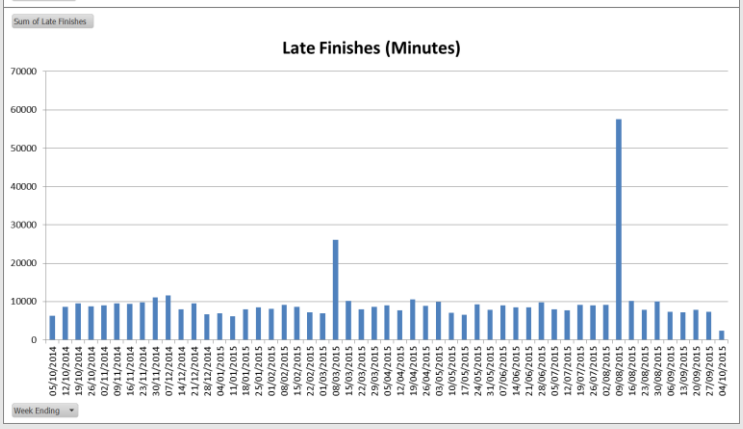



**Reduction in ICU cancellations and therefore cancelled operations. ICU cancellations are monitored continuously in a cancellation log. Source: Critical Care, data for calendar year.**




**Theatre Utilisation Elective sessions Jan-Aug 2015. Source: Performance Information**




| Period | Utilisation |
|---|---|
| Total Utilisation For Period Selected | 67.62% |

Aiming for 85%.

## Comment on Current Performance

201 operations were cancelled on the day of admission in August 2015 representing 4.3% of elective admissions. A further 325 operations were cancelled in advance of the day of operation during the month. Bed availability continues to be the most prevalent reason for cancellation.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 9.4 | Review bed configuration to ensure Surgical Care Group have c.300 beds available for emergency and RTT activity.<br>Financial Impact: Revenue above budget £1,152,000 | Ian Wren | 31-Dec-15 |
| 9.5 | Review theatre timetable and redistribute sessions to hard pressed specialties (those with higher cancellation rates) | Ian Wren | Complete |
| 9.6 | Improve overall scheduling of theatre cases and develop a care group process to review - level scheduling | Karl Trimble | Complete |
| 9.7 | Scope Service Improvement Project focussed on theatre start times, cancellations, scheduling and ringfencing surgical beds.<br>Financial Impact: Too early to cost | Kevin Baber | Complete |

## Update on Actions

9.4 Phase 1ward moves commenced 19/09/15 with SAU and Hound switch. Phase 2 Norfolk to Meavy was completed by 14/10/15. PIU Norfolk commenced its first full week on level 7 week commencing 19/10/15 and Merrivale is now partially open on level 10 and will be used to care for medical patients and the frail elderly. Phase 3 options appraisal complete with one final review by senior managers planned before proceeding.

9.5 Review complete.

9.6 Scheduling policy has been reviewed. Bed bureau proof of concept and development of metrics with Service Improvement Team.

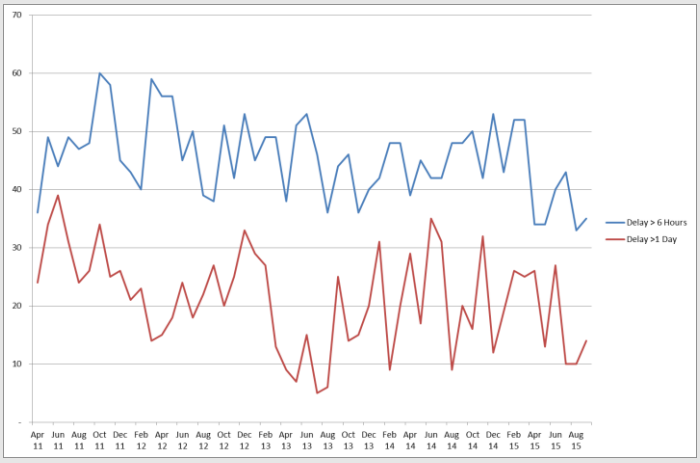
9.7 Emphasis changed to theatre stop time; a Stop Policy has been developed. Currently looking to implement the NCEPOD classifications for surgery which determines what constitutes urgent surgery.

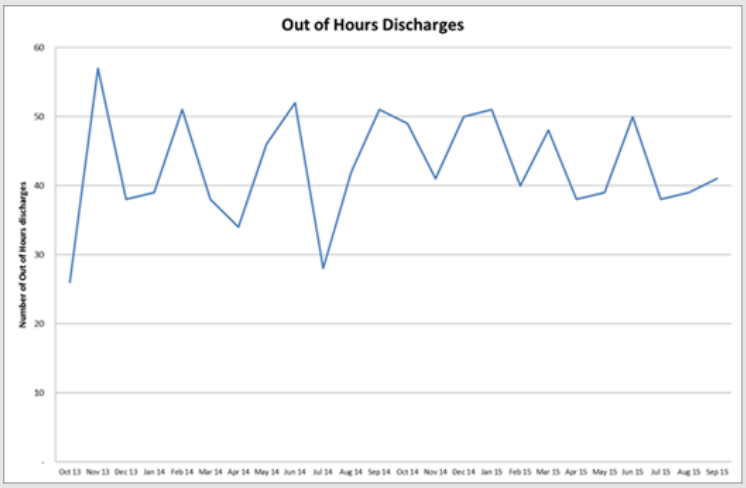
# Critical care

**Derriford Hospital: The Trust must ensure that the critical care service improves the experience of patients by addressing the significantly high levels of discharge from the unit that are either delayed for more than four hours or happen at night.**

## Current Performance

**Source:ICNARC**




## Comment on Current Performance

As of 22 July 2015 this is working very effectively and continuing to improve. Ongoing review of process. Measurement of delayed discharges, times recorded. CQUINN target for <10% >24h delays. New hospital target for <6h discharge. Step change noted in July; performance monitoring continues.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 10.1 | Revise Discharge process. Established principle of moving all dischargeable ICU patients within 6 hours and between 0700-2200. | Sam Waddy, Ed Cox, Kevin Baber, HONs | Complete and closed |

## Update on Actions

N/A

**Derriford Hospital: The Trust should prioritise pressure area care within critical care to reduce the incidence of pressure ulcers. The target levels for patient harm from falls or pressure ulcers being considered as 'acceptable' at levels above zero should also be reviewed and reflected on. Data on venous thromboembolism (VTE) or urinary tract infection (UTIs) should also be captured in dashboard reports and incident data.**

## Current Performance

| QUALITY IMPROVEMENT | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month Target | Tolerance | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| SAFE CARE | | | | | | | | | | | | | | |
| Grade 2,3,4 Hospital Acquired Pressure Ulcers | 8 | | 5 | 3 | 1 | 2 | 2 | 6 | | | | | | |

## Comment on Current Performance

The original action plan was based around practice in Penrose ward as this has historically been an area of high incidence of unit-acquired pressure ulcers. The most recent data extracted from Datix does not show a sustained reduction in the rate of unit-acquired pressure damage, nor does it show a significant increase. However, Matron has reviewed the September incidents and many are related to medical devices (NG tubes, ET tubes, foot pumps) and span both Penrose and Pencarrow Wards. To help reduce these incidents further the Matron for Critical Care invited the Lead Nurse for Tissue Viability (ME) to attend the ICU Band 7 meeting on 20 October 2015. Out of this meeting, new actions have been generated:

- Trial of new pressure relieving material to reduce pressure damage from ET tapes.
- Reinforcement of the correct way to 'hammock' an NG tube to reduce risk of pressure damage from the tube.
- We will be holding a 'Pressure Ulcer Awareness' week in November to coincide with STOP the Pressure Ulcer day.
- Development of a new Mnemonic 'ULCER' to heighten awareness of device related pressure damage and how to reduce this.
- Continued use of the mini-RCA tool for all unit-acquired pressure damage to establish whether the damage was avoidable or unavoidable.
- Review the use of Hibiscrub as a routine decolonising agent due to risk of skin drying and subsequent moisture damage.
- Refresh of Penrose action plan as many actions now complete

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 10.3 | 1.Develop new nursing metrics dashboard (corporate).<br>2. Discuss all pressure ulcer incidents at weekly incident meeting.<br>3. Implement new Rapid Review tool reviewing all ICU-acquired pressure ulcers to assess whether they were avoidable.<br>4. SW to check last 2 year's VTE events with VTE CNS.<br>5. Add VTE prophylaxis assessment to Innovian. | Ed Cox | Complete |

## Update on Actions

1.Nursing Assessment and Assurance Framework in place and reported to NMOC quarterly.

2 and 3. Established action plan for pressure injury on ICU. All pressure ulcer incident reports are discussed at the weekly incident meeting. The Band 7s are using a rapid review tool to review all grade 2 pressure ulcers and an RCA is completed for any grade 3 or 4s.

4. Last 12 months VTE data shows 8 events. No avoidable events.

All VTE events involving ICU patients will now be included on the ICU dashboard.

5. Innovian has a VTE prophylaxis assessment daily.

99% of ICU patients are catheterised therefore urinalysis is always positive due to colonisation. Deciding if a UTI is present is a complex clinical analysis similar to VAP, there is not a definitive test.

**Derriford Hospital:**

- **The Trust should review the level of physiotherapy provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine for therapeutic treatments.**
- **The Trust should review the level of pharmacy support provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine.**
- **The Trust should review the provision of mental health support given to patients and their families who are or have been patients in the critical care unit.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 10.5 | 1.Meet with contract team to establish deficiencies in commissioning. (completed)<br>2.Establish list of requirements in preparation for 2016 commissioning.<br>3.Meet with Support services lead and establish model for expansion of physio provision in ICU.<br>Financial Impact: Revenue above budget £87,400 | Sam Waddy | 31/04/2016 |
| 10.6 | 1.Meet with contract team to establish deficiencies in commissioning. (completed)<br>2.Establish list of requirements in preparation for 2016 commissioning.<br>3.Meet with Support services lead and establish model for expansion of pharmacy provision in ICU<br>Financial Impact: Revenue above budget £43,800 | Sam Waddy | 31/04/2016 |
| 10.10 | 1. Progress the business case with clinical psychology team to improve psychology provision for ICU.<br>2. Submit the business case to the contracts team to be discussed in this year's round of contract issues both in relation to intensive care and psychology.<br>Financial Impact: Revenue above budget £31,400 | Sam Waddy/ Rupert Noad | 31/04/2016 |

**Update on Actions**

Met with commissioning team. Contracting Issues document submitted to PHT Finance department for inclusion in the 2016/17 contract negotiation.

**Derriford Hospital: The Trust should review the professional development of the nursing team within critical care and ensure over 50% have a post-registration award in critical care nursing, as recommended for safe care by the Faculty of Intensive Care Medicine. Appraisal rates should be improved to trust levels and continuous professional development should be funded and included in this review, to ensure staff skills and rates of retention are continually improving.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 10.7 | Develop robust Training Needs Analysis to ensure that over 50% of the nursing team achieve post registration award in critical care nursing.<br>Financial Impact: Revenue above budget £57,100 | Intensive Care education team lead Peter Branfield | August 2017 |

**Update on Actions**

ICU Course is now re-established in the locality and run by the education team at Derriford and nurses are now attending this course to achieve a post graduate qualification. All new starters will have planned progression towards qualification. Currently 35% with the course ongoing. This will take significant time to reach 50% target due to the length of the course.

**Derriford Hospital: Decisions around consent, mental capacity assessments and the use of any deprivation of liberty or restraint should be improved in the critical care medical notes.**

**Current Performance**

Audit data when it is available.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 10.9 | 1. Update Daily checklist to ensure capacity assessments are documented more clearly.<br>2. Add to the audit diet to provide a check on compliance. | Sam Waddy | Complete and closed |

**Update on Actions**

Tool is in place in ICU notes and the team is working on utilisation. Too early to audit yet, but have added to audit diet.

# Maternity & gynaecology

**Derriford Hospital: The Trust must ensure that the environment and equipment on the delivery suite is fit for purpose and is able to be effectively cleaned and decontaminated to prevent the risk of cross infection. Sinks were badly stained and none of the sinks had elbow operated taps. Infection control risks were not on the maternity risk register.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.2 | Matron to work with Estates to cost and plan the recommended refurbishment.<br>Financial Impact: Capital £112,000 | Nicola Phillips | 30-Nov-15 |

**Update on Actions**

Refurbishment has been costed and planned and placed on the Risk Register as there is no funding to proceed.

Replacement sinks have been approved in principle, however Matron has not yet been able to obtain a definite date for their installation.

**Derriford Hospital: The Trust must ensure that there are sufficient resources to ensure the cleaning of blood and body fluid spillages does not pose a risk that clinical staff are unable to meet the clinical needs of patients in preference to cleaning.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.3 | 1. Review rostered time for cleaning and impact on provision of patient care.<br>2. If the review concludes that dedicated cleaning provision is required, undertake options appraisal for the possible solutions. | Nicola Phillips | 30-Nov-15 |

**Update on Actions**

We currently have an HCA funded establishment to ensure that there is sufficient staff on duty to ensure the environment is maintained to the required standards of cleanliness.

The Matron for Delivery suite has had a discussion with the Hotel Services Lead and a contract meeting was held on 21st September to review the requirements needed. HCA staff are continuing to provide cleaning support to the delivery suite and surrounding areas whilst the new contract is discussed. A work checklist is on the delivery suite to ensure that all staff are aware which items have been cleaned. Costings were received from SERCO in order to plan for additional services – this quote came back but was based on the ad hoc rates and exceeded £70 000 pa; a new quote has been requested. It is likely that this is not going to be achieved during this contract and we will need to continue to use clinical staff to provide the level of cleaning required.

**Derriford Hospital: The Trust must ensure that the ratio of supervisor of midwives to midwives is at the recommended level of 1:15 . The high ratio was not on the maternity risk register at the time of our inspection.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.4 | 1. SoM's to complete training.<br>2. New Risk Manager to commence in post (due to start August 2015 and is a SoM). | Janette Thomas | 31-Oct-15 |

**Update on Actions**

Three SoM's currently in training. Two due to finish in October 2015. Two further places commissioned for 2015- 2016 cohort. Full Time SoM commenced in post (July 2015) and taking an increased caseload.

The ratio of supervisor of midwives to midwives is included on the Risk Register. The successful qualification of two existing members of staff, and the appointment of two new staff (already qualified Supervisors of Midwives) will mean that the date of Dec 1st 2015 to achieve the 1:15 ratio is achievable. This will however be dependent on the LSAMO appointing the two new members of staff as SoM's by that date. Two additional Midwives will commence the course this month (Oct 2015) for ongoing succession planning.

**Derriford Hospital: The Trust must ensure that staff working in gynaecology are supported to have annual appraisals.**

**Current Performance**

**Source: Performance dashboard 26/10/15.**

| CORE STANDARDS | Current Month Target | Tolerance | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| APPRAISALS | | | | | | | | | | | | | | |
| Appraisals completed by due date | 95% | 85% | 44.4% | 45.9% | 45.7% | 54.5% | 54.6% | 57.1% | | | | | | |

**Comment on Current Performance**

See update on actions below.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.5 | Devise Appraisal forward planning programme. | Cath Williams | 31-Mar-16 |

**Update on Actions**

From Gynae point of view there are 50 nurses on the appraisal list:

- 34 in date
- 4 have been completed but not recorded correctly
- 7 have dates for appraisal over the next 4 weeks
- 1 on maternity leave, 1 on long term sick leave, 2 have left the Trust, 1 AWOL – going through HR process.

The plan for the ward is for the 2 x band 6s to undertake their appraisal training (1 has already completed this) and a rolling programme is being put together between them and the band 7 to ensure that appraisals are completed 1-2 months prior to an individual's incremental date.

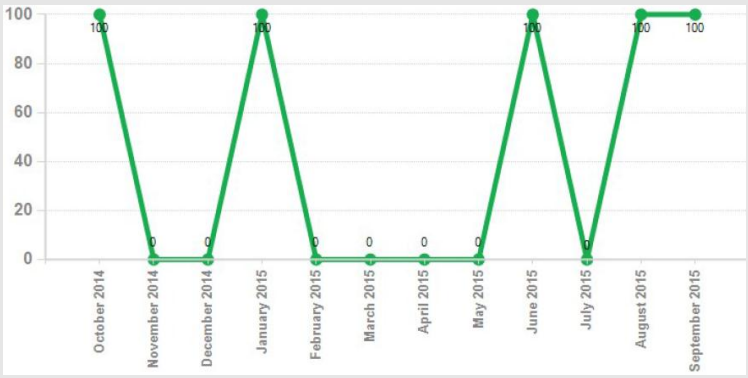
Both outpatients and Ocean are such small teams that the band 7s are able to ensure that everyone has an appraisal each year in line with their incremental date; they have not been a problem.

The problem appears to be with admin and this has been escalated.

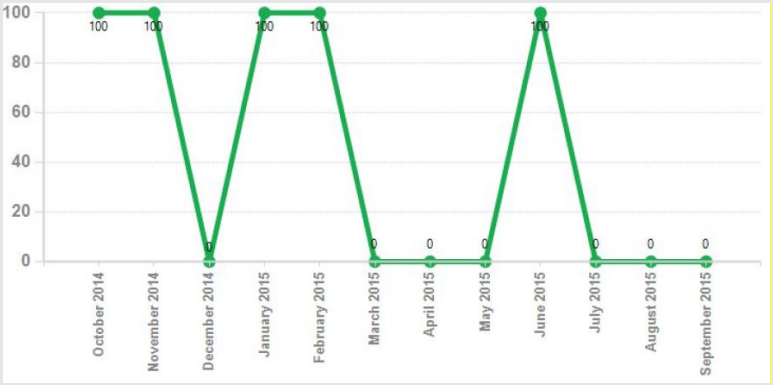
**Derriford Hospital: The Trust should ensure all patient records on the delivery suite are stored securely and have accessible monthly midwife to birth ratio figures in order to be able to confidently audit and monitor safe staffing levels.**

## Current Performance

**Satisfactory response to the Environment Audit question for CDS 'Are all notes trolleys locked if not in use or attended by an identifiable staff member if in use?' 07/10/15. Source: Meridian.**




**Satisfactory response to the Environment Audit question for CDS 'Are there any unattended notes on the ward/department (CDS) that may be accessed by patients, or other non-authorised persons?' 07/10/15. Source: Meridian.**




## Comment on Current Performance

None.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.6 | 1. Undertake a sweep of the ward to check that there are no other records held insecurely.<br>2. Commission a review of records storage to review the storage of notes awaiting coding.<br>Financial Impact: Capital £1,000 | Nicola Phillips | 31/10/2015 |

## Update on Actions

Records that are used for current episodes of care are stored in a locked central store on labour ward or are in the delivery rooms. The records identified during the inspection were old records used for teaching. The Notes trolley is now stored in a cupboard with a padlock. Notes waiting for coding are all in blue boxes in the main CDS office; only staff with swipe access can enter the delivery suite. However these notes are now going to be moved to the Risk Office which is locked when unattended. Monthly review included on Matrons check list which can be seen on Meridian.

Monthly Midwife to Birth ratio is integral to the dashboard and has been calculated for this purpose.

**Derriford Hospital: The Trust should ensure the process for learning from incidents is embedded in practice at ward level.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.7 | Develop a further governance board for all clinical areas with such learning integral to the agenda. | Trudie Roberts | 30-Nov-15 |

**Update on Actions**

All learning is circulated via Maternity newsletters and email. Included within the action plan and audit trail arising from each incident report is a check to make sure that staff are aware of the incident and actions.

Consideration is being given to putting on a study day: learning from incidents. This may be included within the Mandatory Training block as many current sessions are devised reflective of this agenda.

**Derriford Hospital: The Trust should provide a staffed perinatal mental health service. The trust had developed a pathway but there were no personnel in place such as specialist mental health midwives or psychologists or plans to develop these services. As a result, clinicians were only able to signpost women to external mental health services. These issues were not on the maternity risk register at the time of our inspection.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.8 | 1. Care Group Manager to maintain ongoing consultation with CCG to highlight service disparity. The context of CQC concern will be articulated in these discussions.<br>2. Issue to be added to the risk register.<br>Financial Impact: Too early to cost | Ian Wren | 31/04/2016 |

**Update on Actions**

It is understood that there will be a national fund to support the provision of this service but guidance on how bids may be placed to secure some of the funding is unlikely to be released until the end of the financial year. Discussed with commissioners week commencing 19/10/15.

**Derriford Hospital: The Trust should have a baby abduction policy, and review the policy and procedure for discharge of patients from the maternity unit.**

**Current Performance**

Assurance mechanism to be determined once policy has been developed.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 11.13 | Develop Policy. | Pauline Claridge | 31-Oct-15 |

**Update on Actions**

Policy currently out with guideline group for review. Ratification scheduled for November 16th.

# Children and young people

**Derriford Hospital: The Trust must ensure the safety of adolescents with mental health issues when using any of the paediatric services at all times. Some of the staff on Wildgoose Ward told the CQC that they did not feel confident in looking after the number of children and young people admitted with mental health problems. During a recent safeguarding incident the internal security team although present were not able to assist in restraining a young person who was trying to leave the unit.**

**Current Performance**

This will be monitored via the Datix process and regular meeting with CAMHS staff. The number of incidents reported on Datix where children are at significant risk to themselves or others is small. They are however extremely difficult to manage and challenging for staff.

**Comment on Current Performance**

1 serious incident in June 2015. No CAMHS incidents since June 2015

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 12.2 | 1. Provide additional training for security services.<br>2. Meet with Director of Facilities and undertake a risk assessment for Wildgoose Ward.<br>3. Create a de-escalation area.<br>4. Deliver additional training re Mental Health Act to nursing staff in September/October 15.<br>Financial Impact: Capital £1,000 | Anita Dykes | 31/10/15 (training)<br>31/01/16 (de-escalation area). |

**Update on Actions**

Meeting has taken place with Director of Facilities, a risk assessment has been completed for Wildgoose Ward and the need for a de-escalation area has been identified.

L1, 2 and 3 de-escalation and conflict resolution training is being provided for ward staff (3 year programme). Additional training re Mental Health Act has been provided for medical staff.

The programme has now been reduced to 2 years (Sept 15). Working with CAMHS to develop joint strategies for management of teenagers with challenging behaviours.

De-escalation area has been identified. Working with a charity organisation called “Give a Child a chance” to re-furbish the room.

**Derriford Hospital: The Trust must ensure that all children using the acute or community paediatric services have a care plan in place that is updated at regular intervals or when changes occur to the child or young person.**

**Current Performance**

Audit data will be available from November for community (a 3 monthly audit will occur as part of supervision with annual full notes audit.)

Audit data will be available from March 2016 for the Acute service who will complete an audit 3 months after implementation and will audit annually thereafter.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 12.3 | 1. Revise and implement Community care plan.<br>2. Undertake document review for Acute service.<br>3. Implement Audit programme. | Sue Syers and Anita Dykes | Community – Complete<br>31 December 15 (Acute) |

**Update on Actions**

Acute service have undertaken a document review and will adopt the Bristol Care Plan format. Care plans for the acute service have gone for typesetting and drafts will be available in November for pilot.

Community Care plan has been revised and implemented. Audit of community paediatric care plans will take place in November 15.

**Derriford Hospital: The Trust should ensure the milk kitchen is kept locked so it is not indiscriminately accessible to patients or visitors on Woodcock Ward (used by the High Dependency Unit (HDU) and Child Assessment Unit (CAU)).**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 12.5 | 1. Undertake review of milk kitchen.<br>2. Lock the kitchen in the interim.<br>3. Plan and undertake refurbishment.<br>Financial Impact: Capital £5,000 | Anita Dykes | Review complete September 2015<br><br>Lock fridges and freezer complete September 2015<br><br>Awaiting quote for refurbishment, unlikely to take place due to the capital freeze. |

**Update on Actions**

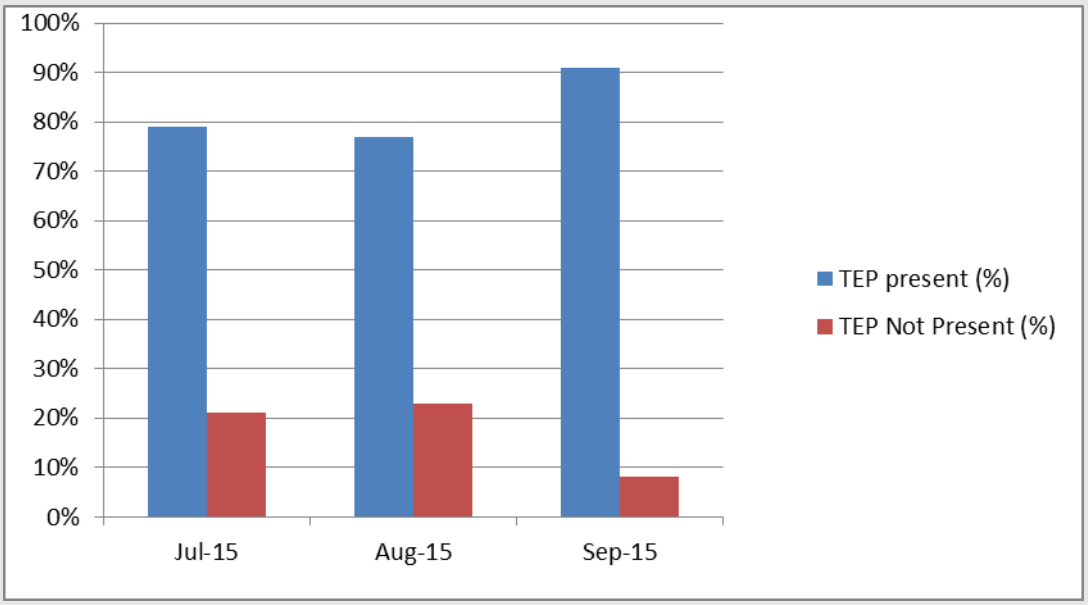
Fridge and freezer now have clasp locks as the room needs to be available to parents for bottle cleaning and making up of feeds. Sink has been replaced. The quote for re-furbishment has gone to estates for costing, however all capital projects have been withdrawn and we are unlikely to get funding from elsewhere.

# End of life care

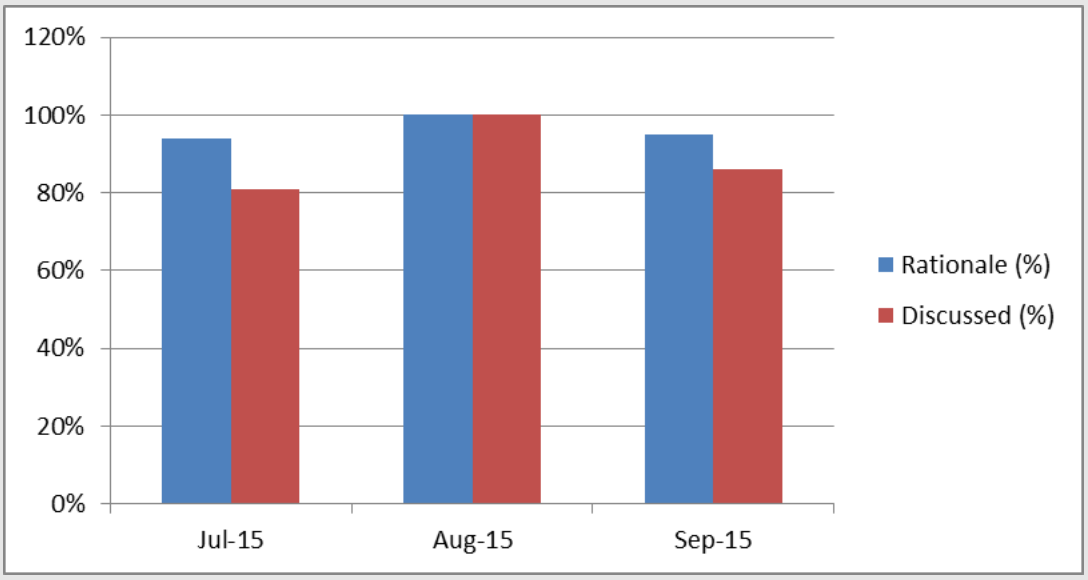
**Derriford Hospital: The Trust must ensure that Treatment Escalation Plans (TEPS) are fully completed to ensure patients' choices and preferences and ceilings of care are identified.**

## Current Performance

**Resus Team Emergency Calls Retrospective TEP Audit July-September 2015**




**Patients who were not for resuscitation (NFR) but had rationale and discussion documented on their TEP:**




## Comment on Current Performance

The TEP Emergency Calls Retrospective Audit (July-September 2015) highlights that the Treatment Escalation Plan (TEP) and Resuscitation Decision Form is present and completed in the medical notes of 77-91% of those patients who have had a call for the emergency team to attend. 94-100% of patients had the rationale documented for the decision 'not to resuscitate' and had ceilings of care determined for their future management. 81-100% of patients/relatives had been involved in the resuscitation decision process.

From August 2015 the audit now assesses for patients who lack capacity whether the mental capacity assessment component of the TEP has been completed. From August 2015, 5 patients who lacked capacity did not have the mental capacity component of the TEP form completed. Where appropriate the Nurse Lead will discuss incomplete TEP forms

directly with medical staff. Action taken to address trust wide is set out below (13.1).

| Planned action | | | |
|---|---|---|---|
| **Ref** | **Action** | **Lead** | **Deadline** |
| 13.1 | 1. Integrate into resus training programmes and junior doctors induction.<br>2. Implement TEP Audit onto Meridian for individual service lines to be responsible for their TEP completion compliance to identify areas and monitor improvement. Arrange meeting between Phil Hughes, Jamie Fulton and Jackie Williams to agree implementation and process and discuss including within service line performance dashboard. | Jackie Williams | 31-Jan-16 |

**Update on Actions**

1. Updated Resus Officers with areas for TEP improvement and integrated into Resus Training immediately. Changed current Emergency Call Audit Form to capture areas identified by CQC. Added key points of learning to new doctors induction training (Aug)

2. Meeting with Medical Director who has approved the roll out of the Meridian TEP audit; 10 x sets of random notes audited from each clinical area (by a junior doctor) with outcome of audit fed into Service Lines / Care Groups. Presentation to be given to HMSC (date to be agreed). Meridian Audit Tool has been reviewed by stakeholders.

**Derriford Hospital: The Trust should ensure that patients' dignity and respect are considered in the arrangements for discreet use of lifts when transporting the deceased.**

**Current Performance**

We will undertake a review to check that the actions have addressed the concerns raised. Spot check with porters to be undertaken by end December 2015.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 13.3 | Investigate the installation of split lifts to improve privacy and dignity with a view to requirement for additional lifts within the long term overall strategic plan.<br>Financial Impact: Several million | Julie Richards | 31-Dec-16 |
| 13.4 | 1.Service existing trolley to reduce 'rattling' sound.<br>2.Review existing mortuary trolley to explore possible improvements. | Jayne Glynn | 1. Complete<br>2. 31/03/16 |
| 13.5 | Ensure porters are aware of and have access to the override swipe card (to prevent the doors opening to the public on each floor when they need to use public lifts) accessible in the porter's office as some porters were not aware of this or the code needed. | Louise Pelley | 31-Oct-15 |

**Update on Actions**

13.3: Current major refurbishment of all lifts.

13.4: Service of mortuary trolley completed 20/07/15. Review of existing mortuary trolley underway.

13.5: During the time of the CQC inspection the lifts were undergoing refurbishment. After the refurbishment of the lifts the porters have now been given access back to the Theatre lift via a swipe card enabling the porters to move patients with dignity and respect. The porters will also be given access to the code on the main lifts.

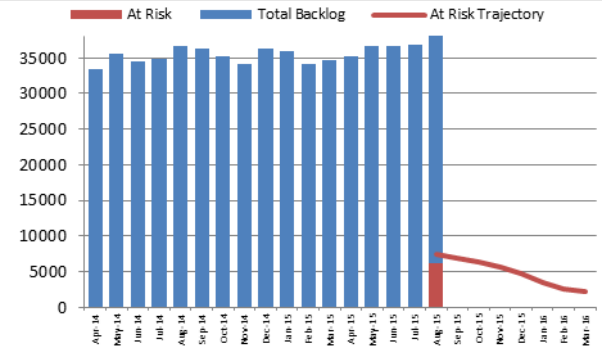
# Outpatients and diagnostic imaging

| Derriford Hospital: The Trust must ensure that It improves the premises for patients who are using Interventional Radiology, to make sure there is a suitable environment for patients to recover post procedure. | | | |
|---|---|---|---|
| **Current Performance** | | | |
| To be monitored through PLACE. | | | |
| **Comment on Current Performance** | | | |
| N/A at this time. | | | |
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 14.3 | 1. In the short to medium term patients must not be delayed in returning to their end destination for non-clinical reasons and the senior in charge of the area will escalate any delays to the deputy service line manager.<br>2. Progress the OBC for the Lightwell development which will deliver the long term solution with regards to suitable infrastructure.<br>Financial Impact: Revenue above budget £60,000. Capital £8,500,000 | Wendy Colley / Mark Walker | short term immediately, medium term option to be identified, long term OBC to Board summer 2016 for approval to proceed to TDA |
| **Update on Actions** | | | |
| The Full Business Case for the new facility will not be ready until at least next summer. The build will be long and complicated so Imaging will not have a new facility for at least 18 months. Post procedure rooms are part of Phase 2 of the development so are several years away. A more immediate solution must therefore be identified. MW to meet with Estates team to identify options. | | | |

**Derriford Hospital: Systems and process are in place to manage the backlog of follow-up appointments and the backlog of imaging reporting, to mitigate the risks to patients of delayed diagnosis and treatment. Action plans to manage the backlog need to be focused and realistic in achieving what is required.**

## Current Performance

**Follow-up Backlogs. Source: Integrated Performance Report to Trust Board Sept 2015**




## Comment on Current Performance

At the end of August 2015, there were 37,199 patients past their 'see-by-date'.
Of these, 6153 patients are flagged as being at clinical risk ; 1251 ahead of the reduction trajectory to reduce this cohort.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.5 | 1.Identify solutions and trajectory to eliminate the at risk backlog in Ophthalmology.<br>2. Deliver trajectories to clear the at risk backlog in all specialties.<br>3. Address the lower risk back logs through rapid service improvement projects over the next 6 months in high volume services.<br><br>Imaging - duplicate of next action (14.6) | Phill Mantay | 31/03/16 |

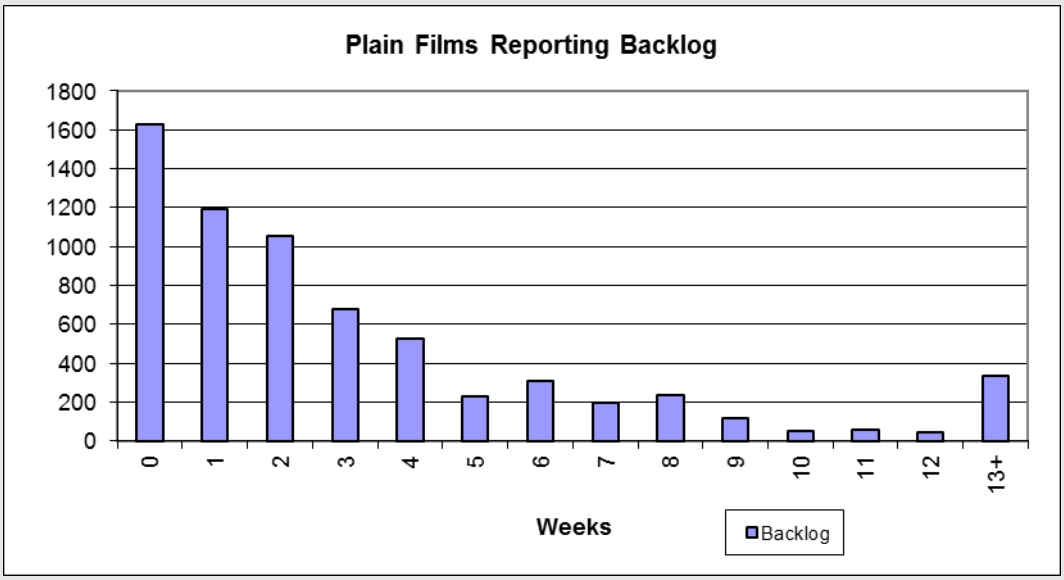
## Update on Actions

Service Lines have completed the risk identification and have now assessed every patient on the follow-up waiting list in line with the clinical risk criteria. This means that patients in high risk groups can now be systematically prioritised for appointments. Service groups have also produced trajectories to reduce the number of patients at risk of harm who have waited past their see-by-date. For seven service lines, a process of service improvement will be undertaken as part of the agreed CQUIN scheme in order to review and improve how follow-up care is offered in high volume specialties.

**Derriford Hospital: Systems and process are in place to manage the backlog of follow-up appointments and the backlog of imaging reporting, to mitigate the risks to patients of delayed diagnosis and treatment. Action plans to manage the backlog need to be focused and realistic in achieving what is required.**

## Current Performance

**Plain films reporting backlog. Source: Imaging Dashboard at 26/10/ 15**




## Comment on Current Performance

Imaging sending 700 per week to Medica for plain film reporting with a 72hr turnaround has now been initialised. This capacity is to be used for GP film reporting to ensure fixed and sustainable capacity and enable the Consultant Radiologists at PHNT to focus on the Planned and Urgent category in all modalities.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.6 | 1. Outsource GP plain films to an external reporting house until backlog is eliminated at 700 per week as of 06/07/15.<br>2. Work in partnership with procurement to seek external reporting houses that are capable of providing reporting capacity for all modalities if required - in progress with Steve Carter. Fee for service in situ for PHNT consultant reporters particularly for CT and plain film.<br>3.Continue to seek to fill consultant vacancies and manage long term sickness absence | Wendy Colley / Mark Walker | Backlog to be delivered by 31/08/15<br>Work with Procurement 01/10/15 |

## Update on Actions

1.Outsourcing is continuing and backlog has reduced. Current trajectory indicates that the backlog will be eliminated at the end of the year. A previous trajectory of improvement assumed an earlier agreement from Medica and therefore the backlog is slightly behind plan but improvement for the next two months until full recovery of the backlog is anticipated. Imaging is currently exploring options of outsourcing with another provider to reduce the backlog even sooner and using Medica in tandem for a short period of time to achieve this.

2.A meeting has been held with potential providers for an external partnership on 10/09/15 and is ongoing with a potential implementation date by late November. Formal external reporting contract is close to sign off.

3 New Cardiac/General Consultant to start in November 2015, Breast Consultant in October 15 and an advert for a neuro Consultant is out with an interview date arranged for November 2015.

**Derriford and Mount Gould Hospitals: The Trust must ensure that they review the managerial and governance arrangements in outpatients, so that risks systems and processes to minimise likelihood of risk in relation to access to services and a standard booking process for appointments across all departments are fully implemented.**

**Current Performance**

To be defined.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.7 & 14.15 MG | 1. Review the current management arrangements around the outpatient administration function. | Kevin Baber | Complete |
| | 2. Ensure the continued roll-out of the OMC structure to ensure best practice booking. | Samantha Sheridan | 30/10/15 |
| | 3. Work with Service Lines to ensure there is an adequate framework to enable best practice booking - pilots and test of changes. | Samantha Sheridan | Complete |

**Update on Actions**

Roll out of the OMC has commenced and will continue until all relevant Service Lines are engaged.

The work with the Service Lines will form part of the 8-step game changers for the Trust.

1. Review of management structure complete. Recommendations will now be implemented.

2. The roll out of the OMC model has been delayed to allow for a period of "bedding-in" for those areas that have gone live. Currently determining pace and priorities for continued roll out which is planned to be concluded by Dec. 2015.

3. A series of standards and expectations have been agreed by the Clinical Administration Programme Board which establishes a framework of roles and responsibilities to enable best practice booking. A set of expectations for Service Lines has been developed and signed off by the Exec Team. This includes for example making sure that rotas are completed.

**Derriford Hospital: The Trust should ensure that staff (inc reception staff) in outpatients have an adequate understanding of safeguarding to ensure that incidents are identified appropriately.**

**Current Performance**

Staff understanding will be tested via questionnaire/survey.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.8 | 1. Make bespoke workshops available to all staff.<br>2.Implement focussed workshops for Reception staff in outpatients. | Jo Brancher | 29-Feb-16 |

**Update on Actions**

All staff have L1 safeguarding training as part of mandatory training. Bespoke training has been offered but there has been little uptake to date. This will now be promoted through Matrons.

**Derriford Hospital: The Trust should ensure that there is adequate and suitable seating available for patients waiting for an outpatient appointment and that these seating areas are not obstructed.**

**Current Performance**

To be monitored through PLACE.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.9 | Review Ophthalmology, Fracture clinic and Oncology outpatient areas to identify the issues and appropriate solutions. Solutions may include additional seating but may also focus on booking practice to manage peaks in arrivals into the department. Further timelines will be identified when solutions are agreed.<br>Financial Impact: Capital £50,000 | Bev Cox | 31/08/2015 - In line with the action stated, timeline now revised to 31/03/16 to reflect arising actions. |

**Update on Actions**

Ophthalmology: Bariatric chair has been sourced; with clinic changes this has created more space in the Department.

Fracture Clinic:Receptionist to email Service Line Manager updates during the day wc 21/09/15 to report when it gets to standing room only. We will probably need to do this for a few weeks to get a clear picture of the problem.

Oncology: We have outgrown the current footprint and these issues are on the Risk Register. In recognition of this, a Strategic Outline Case was submitted to relocate Chemo DCU to Burrator L8 and expand Onc OP into the current Chemo footprint on L2 in Aug 2014. This was put on hold due to the Trust's need to first address the medical bed base. We have subsequently agreed to establish a project board and steering group to progress this from November 2015. Meanwhile, we have maximised use of the space currently available and continue to provide overflow seating in the Mustard Tree during peak times.

**Derriford Hospital: The Trust should review the processes for the referral to diagnostic imaging scans, particularly in computed tomography to reduce the risks of patients receiving multiple scans.**

**Current Performance**

Monitor via Incidents on Datix from December 2015.

**Comment on Current Performance**

N/A at this time.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.10 | Commence the electronic vetting service and roll out electronic requesting to all services. This will eliminate paper requesting and with a mandatory pause and check built into the electronic system, this risk will no longer be evident | Abdul Gafoor -SLCD | 31-Nov-15 |

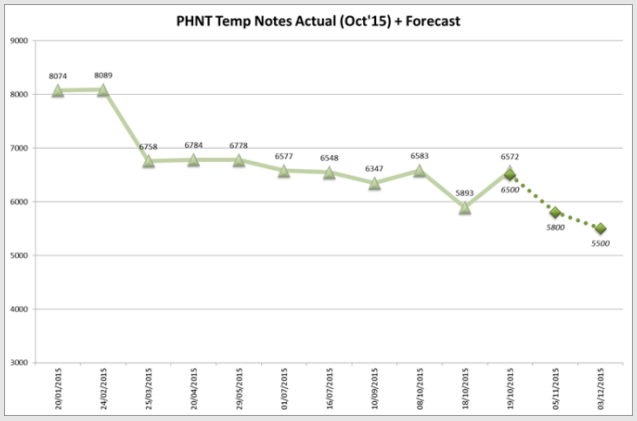
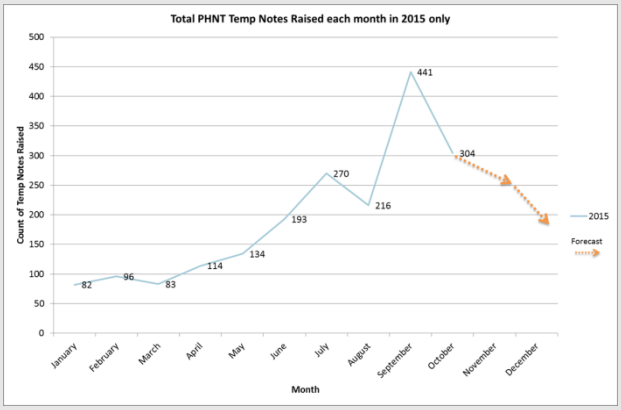
**Update on Actions**

Electronic vetting is now 92% complete and movement towards Electronic Ordering is now underway.

Update 07/10/15: Hope to go live Oct/Nov but there is a possibility of delay until January to finalise the project plan. To ensure that the right clinical governance decisions are being made.

**Mount Gould Hospital: The Trust should assess the impact of using temporary notes for clinics, to ensure systems do not compromise patient safety. We were told that on occasions the full set of people's medical records were not available, and that temporary notes would be made up for patients. There was inconsistency in the approach doctors took in their decision to see patients with temporary notes. There was incomplete audit data to enable us to assess the impact of this.**

## Current Performance

| Temporary Notes 2015: Totals by Month plus forecast | Temporary Notes Raised by month plus forecast |
|---|---|
| Source: Temp Notes total CRL Drive | Source: PI Report P1521 |
|  |  |





## Comment on Current Performance

See update on actions below.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.27 | 1. Continue to monitor the creation of Temporary Case Notes report on a monthly basis.<br>2. Target departments that create a high number of Temporary Case Notes to identify reasons for this and ensure that training is completed if a valid reason is not provided.<br>3. Undertake a Temporary Notes amnesty across the Trust to be complete by 31/07/16.<br>4. Review Main Notes to check if the Temps have already been amalgamated and not deleted from iPM.<br>5. Monitor the Tracing Report.<br>6. Review temporary notes incidents raised on Datix.<br>7. Continue with all of the above until the implementation of eNotes. | Anne Bussell | Ongoing awaiting the implementation of eNotes |

## Update on Actions

New reporting provided by the Performance Team has helped the eNotes Business Change Team (BCT) to identify areas/individuals raising high numbers of temporary folders. This has revealed an increase in the number of Temporary notes raised in September. This was due to the number of late addition clinics and the inability of the Clinic Prepping teams to source the main case note in time for the clinic. There were also staffing issues within the team. The BCT are now working with the Central Prepping Team to improve processes and the graph above shows a reduction in raised temporary notes in October. They are also working on identifying the backlog of temporary folders which may or may not have already been merged with the main notes. This work will significantly reduce the overall number of temporary folders.

**Mount Gould Hospital: The Trust should ensure GP letters are typed and sent within the required time scale, so that information is available to relevant practitioners when required. Staff told us there had been problems with delays of typing and sending doctors' letters to GPs. On average this had been four days later than the agreed target. One patient we spoke with had experienced a delay in their initial consultation as the letter had arrived after the date of the first appointment.**

## Current Performance

### Typing Delays. Source: Databook 26/10/15

| Trust Total | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Max | | | | | 247 | 30 | | | | | | |
| Mean | 4 | 3 | 4 | 5.0 | 4.51 | 4.21 | | | | | | |
| > 2 Days | | | | | 2,324 | 2,043 | | | | | | |
| Total | | | | | 4,599 | 3,843 | | | | | | |
| % Breaches | | | | | 51 | 53 | | | | | | |

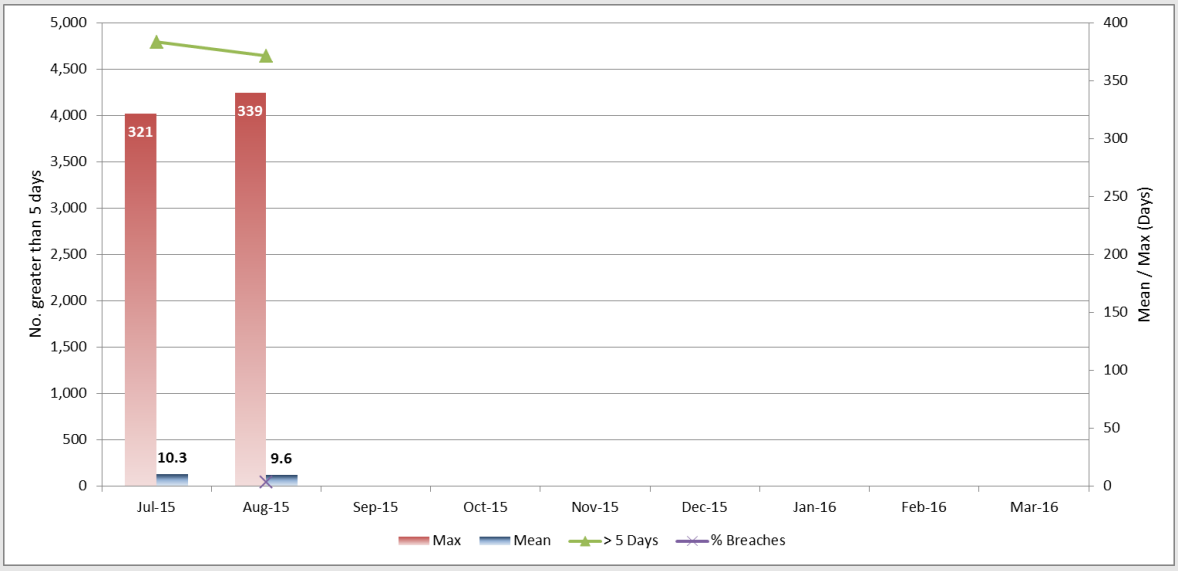
### Signing Delays. Source: Databook 26/10/15

| Trust Total | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Max | | | | | 334 | 308 | | | | | | |
| Mean | 10 | 5 | 14 | 12.0 | 10 | 7.77 | | | | | | |
| > 2 Days | | | | | 2,242 | 2,826 | | | | | | |
| Total | | | | | 3,757 | 4,542 | | | | | | |
| % Breaches | | | | | 60 | 62 | | | | | | |

### Overall Delays. Source: Databook 26/10/15

| Trust Total | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|
| Max | 321 | 339 | 326 | | | | | | |
| Mean | 10.3 | 9.6 | 8.89 | | | | | | |
| > 5 Days | 4,792 | 4,642 | 4,497 | | | | | | |
| Total | | 10,111 | 9,838 | | | | | | |
| % Breaches | | 46 | 46 | | | | | | |

### Overall Delays. Source: Databook 26/10/15




## Comment on Current Performance

A lot of work has been put into making the reporting mechanisms more sophisticated and as a result of this we are now more able to report directly from the digital dictation system. There is a current workstream around ensuring that the data quality controls are sufficiently rigorous to ensure accuracy of reporting. Once these data quality errors have been worked out of the system then the organisation should see a significant improvement in the performance of its service lines. Despite there being some data quality errors, it is clear that the majority of service lines are improving their position with a majority achieving either the standard or are very close to it.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 14.30 | Continue weekly review of typing and signing as part of the overall RTT weekly review process. | Sam Sheridan | Ongoing weekly review |

**Update on Actions**

Despite the improvements made to date work continues with more challenged specialties and the following actions are currently being scoped out with the relevant areas:

- Redistribution of backlogs where there is not a pooled typing arrangement.
- Review of buddying systems for clinical and secretarial staff.
- Ensuring an appropriate level of admin time prior to annual leave for clinicians.
- Attempting to establish a system of pooled approvals rather than it being dependent on individual availability.