Plymouth Hospitals NHS
NHS Trust

# CQC Action Plan Monitoring

March 2017

## Purpose

The purpose of this report is to update the Care Quality Commission (CQC), Clinical Commissioning Group and NHS Improvement with the progress that we are making in delivering the action plan designed to address the Requirement Notices arising from the CQC's inspection of Plymouth Hospitals Trust in July 2016.

The open actions in the action plan have been transferred into this action plan monitoring report which encompasses the outstanding actions (arranged by theme/core service), any arising actions and performance data that will allow us to monitor the impact of the actions that we are taking.

Ongoing monitoring of compliance with the closed actions is derived through the performance indicators included within this report. The report will be presented to, and monitored by, the Safety and Quality Committee.

## Update March 2017

The table below gives an indication of progress with our actions. Further detail of the completed actions can be found in Annex 1.

Actions are marked as completed based on the updates provided by the action leads but are only marked as closed on receipt and review of appropriate evidence.

| Action Status | Number of Actions | Percentage of total |
|---|---|---|
| **Completed and closed on receipt of appropriate evidence** | **18** | **24** |
| **Completed – evidence to be submitted and reviewed** | **16** | **21** |
| **In Progress** | **42** | **55** |
| **Total:** | **76** | **100** |

## Next Update

The next planned update will be on 28 April 2017.

# Urgent and Emergency

**MUST DO: Formalise the recordings of meetings in the emergency department to ensure adequate assurance that the relevant persons are attending and discussions are held to identify learning points. Also ensure actions are recorded and allocated to a person who can progress the actions and progress is monitored.**
**SHOULD DO: Review governance processes within the emergency department to ensure full integration between the medical and nursing teams.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.1 | Commence Super Wednesday every third Wednesday of the month which will review governance framework / actions with a recorded auditable trail. | Matt Warner | 28/02/17 - Complete |

**Update on Actions**

All governance and safety business meetings are agenda'd and minuted and held on the ED Clinical Governance shared drive that is accessible for the whole department – clinical / admin / managerial employees. This has been in place since November 2016 with the output reporting into the Care Group. Action complete January 18 2017.

**MUST DO: Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny. (The data for patients who self-presented was inconsistently recorded. Data provided by the trust showed the initial assessment time from ambulance arrival was consistently within one minute. However, the manner in which the data was entered into the system failed to consider the time the patient was waiting before the nurse in charge took the handover.)**

**Planned action**

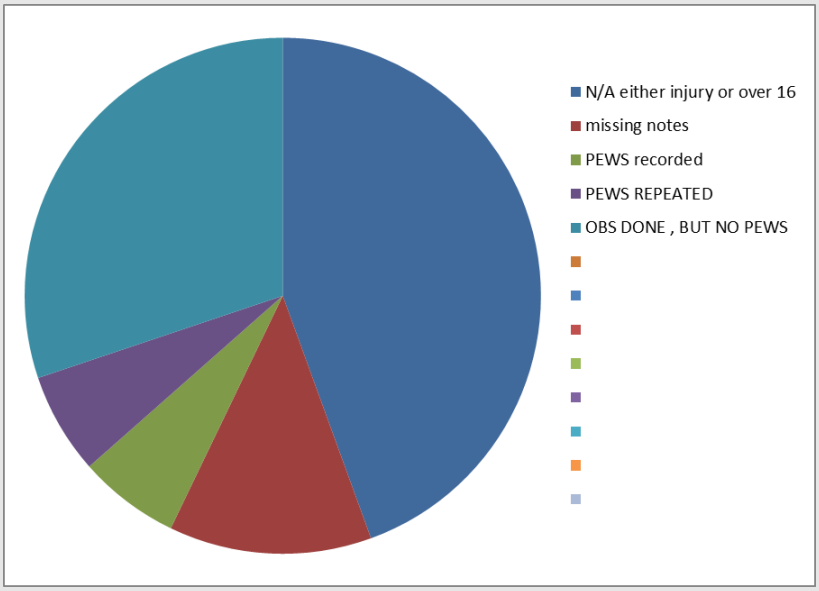
| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.2 | Conduct review of admin process to enable accuracy of time of arrival ensuring that Receptionists are booking in time of arrival. | Tim Parham & Mary Coombs | 01/02/17 - Complete |

**Update on Actions**

Team has completed admin review. This has identified further work to be carried out. A time, motion assessment will be completed with the help of Service Improvement.

**MUST DO: Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed.**

**Current Performance**




**Comment on Current Performance**

59 children attended on 15/01/17. In 28 cases PEWS was not applicable as the presentation was an injury and did not require observations, or the patient was 16 and over. 8 sets of notes were missing so unable to audit them. 4 patients had PEWS documented and all had repeat PEWS scores. 19 Cases had a set of observations recorded, but no PEWS.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.3 | Audit current practice - provide education where required and sharing at team review. | Katherine Norton | 31/01/17 - Complete |

**Update on Actions**

January audit complete and plan to repeat this monthly.

**MUST DO: Continue to work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.**

**Planned action**

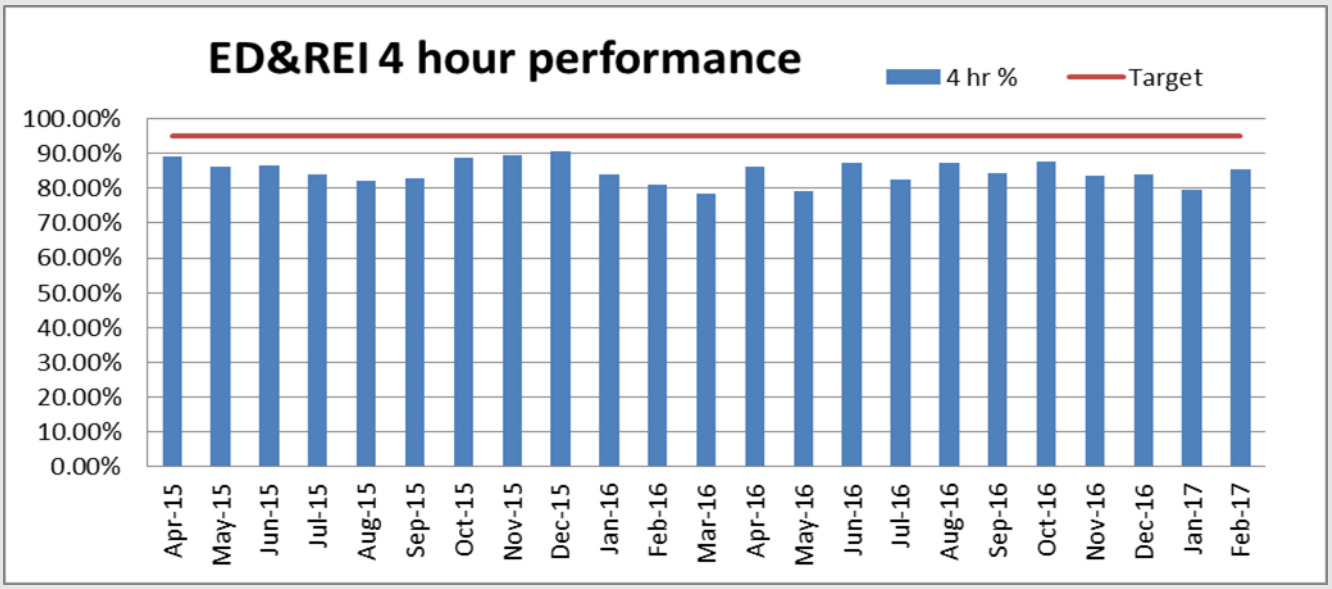
| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.4 | 1.Continue ongoing local review of Mental Health Service.<br>2. Review Pathway.<br>3. Review Contractual issues. | Anne Hicks | 30/06/17 |

**Update on Actions**

Commissioners and acute trusts to meet as part of service review and contractual delivery for 2017/18.

**MUST DO: Continue to ensure the emergency department's four-hour performance improves, with an ultimate aim to achieve the 95% standard.**

## Current Performance




**Putting Patients First Programme Dashboard:**

PPF Programme Dashboard 090317.d

## Comment on Current Performance

The average number of daily ED attendances fell to 249 in February, a small reduction on January and 18 per day lower than the same month last year. The % of those ED attendances triaged in the highest two categories decreased slightly to 42.5% in February, but this is 5.5% higher than the same month last year.

## Planned action

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.5 | 1. Deliver Putting Patients First Programme.<br>2. Improve medical core staffing numbers.<br>3. Submit ED redesign business case for review and approval. | 1. Dave Brown<br>2. Jo Beer<br>3. Anne Hicks | 31/03/18 |

## Update on Actions

The Regional A&E Delivery Board is responsible as a system to support the hospital in delivering the ED target.
We have reinvigorated the internal professional standards for the whole Trust from ED – complete.
We continue to work to agreed ECIP principles and endeavour to deliver an increased availability of beds (improvement governed through the PPF programme) to support flow through the emergency department as part of the ED action plan.
Significant progress has been made in relation to beds occupied by patients with a LOS >6 days. We have additionally shown an improvement in our volumes of Monday Discharges (Mondays have improved for previous quarter (144 to 150 per day) and Saturday discharges (we have seen on average 101 Saturday discharges in the last 3 months (up 7.7% on same period last year and 13.5% on previous quarter).
The DTOC tracking and CD discharge planning SALUS development began rolling out on 13th March 2017 starting with the Devon team.
The number of discharges has reached 110 on successive Saturdays and two weeks with 200+ weekend discharges.
Specifically in relation to the three actions above:

1. Rapid roll out of model ward (PPF) plan to complete all areas by the end of July 2017.
2. Increase in vacancies, increasing risk- to be reviewed.
3. Strategic Outline Case for ED presented to Trust Board by Ann Hicks, Service Line Director for ED, with approval to complete full Outline Business case given.

**MUST DO: Ensure all equipment in all areas, and specifically the emergency department, is maintained in accordance with the trust's service schedule. Provide a system to adequately monitor and report on this.**

**Current Performance**

Current performance cannot be measured at present due to an ongoing database (preventative maintenance scheduling) fault. A Fault report has been raised with the database supplier and we are awaiting resolution

**Comment on Current Performance**

Not applicable.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.7 | Short term:<br>1.Complete rationalisation of servicing scheduling system on f2 database. On completion servicing schedules will reveal outstanding services on equipment in ED and these will be followed up. Completion will be dependent on quantity.<br>2. Follow up outstanding schedules for other departments.<br>3. Complete Technical Inspection of medical devices in ED.<br>Long term:<br>4.Explore available databases on the market and purchase to enable better management of service schedules and other management information. | Jonathan Applebee | 31/12/17 due to introduction of new database and annual round of service schedules/technical inspection |

**Update on Actions**

1. Rationalisation of service scheduling caused an ongoing database (preventative maintenance scheduling) fault which means that reports from this system are not reliable. Still awaiting resolution from supplier. However we have developed a work-around which has enabled us to complete rationalisation of service scheduling of all High Risk devices.
2. System should now be accumulating more accurate statistics for later reporting. Gaining timely access to High Risk equipment for servicing (e.g. in Critical Care, ED and Theatres) still an ongoing problem, due to high usage. Scheduled servicing in ED is up to date with 3 items due to be serviced this month.
3. Technical Inspection is now complete on levels 12 down to level 5 inclusive except for mop up of some isolated devices. Revisits to mop up taking place.
4. Truro visit and view of database done. Visit to Addenbrookes, Cambridge to see a mature development of possible future system taking place in March.

**SHOULD DO: Strengthen the nursing oversight of the whole emergency department, including majors, minors, resuscitation and the clinical decisions unit for each shift.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 1.8 | 1. Submit workforce plan as part of annual business planning to provide 24/7 band 7 cover.<br>2. Release admin duties from current band 7 stock by trialling a 3 month band 3 to undertake off duty rota on MAPS. | Tim Parham | 01/04/17 |

**Update on Actions**

1. The business plans are pending approval Trust wide with regards to staffing uplift and if approved a recruitment process will subsequently follow for a band 7 in a supernumerary role from 10:00-20:00. This role is aimed at having a view of the whole department and supporting areas where it is at its busiest. This may be working in triage, resus or

assisting to prevent breaches.

2. The appointment of the band 3 is delayed as awaiting multiple health issue reports through Staff Health and Wellbeing

| SHOULD DO: Ensure patients arriving at the emergency department by ambulance are protected from the elements as best as possible. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.13 | Completion of agreed improvement works. | Andrew Davies | 01/04/17 – Complete and closed |
| **Update on Actions** | | | |
| The initial plans have now been reviewed and are not considered to be appropriate. The costs for this were prohibitive and also required planning permission, hence the reason it will now be considered as part of the scheme to develop ED. 30/03/17 Action closed and will be picked up in action ref 1.5 Submit ED redesign business case for review and approval. | | | |

| SHOULD DO: Review the transfer team in the emergency department to ensure that when patients are transferred to a ward a clinically safe handover is completed in all cases. | | | |
|---|---|---|---|
| **Current Performance** | | | |
| Audit data ongoing. | | | |
| **Comment on Current Performance** | | | |
| No transfer related incidents documented. | | | |
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.14 | Completion of SBAR of Doctor prior to transfer. | Mary Coombes and Medic | 28/02/17 - complete |
| **Update on Actions** | | | |
| Spreadsheet commenced to record any transfer related incidents and if occurs will transfer to Datix for action. SBAR form has now been pre-printed on part B admission booklet. | | | |

| SHOULD DO: Review the hospital's procedure for crowding in the emergency department to include the actions required by the wider hospital in order to support safe patient care. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.15 | Head of Operations to complete review of Internal escalation plan. | Lee Johns | 31/03/17 – Complete and closed |
| **Update on Actions** | | | |
| New policy in draft and has been presented to OPDG Tuesday 14th March 2017. Policy produced in conjunction with Care Groups and is being tested live with ongoing developments. The policy is being developed with the CCG to align plans with the community. | | | |

| SHOULD DO: Review plans to increase the space in the emergency department to consider how crowding can be reduced and patient flow improved within current financial constraints. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.16 | Submit Strategic Outline Business case for review and approval. | Anne Hicks | 30/06/17 |
| **Update on Actions** | | | |
| Strategic Outline Case for ED presented to Trust Board by Ann Hicks, Service Line Director for ED, with approval to complete full Outline Business case given. | | | |

| SHOULD DO: Ensure wasted controlled drugs in the emergency department are disposed of in accordance with trust policy. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.18 | Provide education to staff during team review and check knowledge by questioning of staff. | Fiona Veale | 31/01/17 – Complete |
| **Update on Actions** | | | |
| Audit completed which found that the majority of staff are following the trust medication management policy with regard to the disposal of controlled medication. The one member of staff who was not complying with Trust policy was spoken to and informed of the correct procedure as written in the medical management policy. | | | |

| SHOULD DO: Review and upgrade computer systems in the emergency department to allow integration with wider hospital systems.(IT/CT issue). | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.19 | Work with IT to review collaboration of systems. | Dan Henning | 31/03/17 - Complete |
| **Update on Actions** | | | |
| EDIS / SALUS / IPM remain isolated at present. This is an ongoing issue. The only effective solution would be the procurement of an electronic patient record with a cost of c£40m. Surgeon Commander Henning is working with IMandT to ensure systems are as integrated as they can be. He is working on a pioneering link between iCM and EDIS. Also introducing SALUS to CDU and effecting a wider rollout of ADF terminals into the main ED. This will be an ongoing piece of work. | | | |

| SHOULD DO: Ensure staff in the emergency department all have name badges which include the role they are in. Consideration should also be given to providing patients with a leaflet that details the different types of uniforms and what they designate. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 1.21 | 1. Provision of name badges to all staff to be checked at the beginning of team review.<br>2. Medical staff to wear named scrub tops. | Band 7s | 28/02/17 – Complete and closed |
| **Update on Actions** | | | |
| The provision of name badges to all staff has been completed and checks undertaken at team review. All Consultants and Registrars have named scrub tops. The junior doctors have name badges with “Hello my name is ….” given to them just after they arrive. | | | |

# Medical Care

**MUST DO: The provider must ensure that equipment stored on wards and in corridors does not obstruct or impede the access to and through fire exits.**

**Current Performance**

Walk Around Inspections.pdf

**Comment on Current Performance**

None

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.1 | 1. Develop a forward plan and undertake Fire Safety Officer Walk arounds.<br>2. Run an awareness campaign related to the risk of obstructed fire exits.<br>3. Oversee and test through the above to ensure that all wards have appropriate risk assessments in place regarding their equipment storage arrangements. | Julie Richards | 30/09/17 |

**Update on Actions**

1. Fire Safety team already undertake fire safety walkabouts to check compliance with fire safety, talk to fire wardens and staff and reports are sent to ward managers.

2. Regular remainders are issued through Daily Email and Vital Signs. Associate Director of Estates will contact service line leads.

3. Associate Director of Estates will ask Wards and departments to forward their risk assessments to her and keep a copy in their individual fire folders.

**MUST DO: The provider must review the available storage to patients who self-medicate and retain their own medicines on the wards.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.2 | Two pronged approach to be implemented:<br>1. As new lockers are required on a replacement basis the new locker will be the one of choice and purchase.<br>2. Agree an implementation strategy for a staged replacement programme via capital monies. | Bev Allingham | 30/06/17 |

**Update on Actions**

The standard for the new patient lockers has been agreed. We have a plan to replace lockers through a staged capital management programme. More trial patient bedside lockers have now been requested as the models have changed since the last trials that we did. Trial locker being reviewed by ward managers week commencing 13th March, then we can assess them quickly and make a decision; then as new lockers are needed this will be the locker of choice. We will have determined the capital replacement programme in the next few months.

**SHOULD DO: Encourage staff to report mixed-sex breaches.**

**Current Performance**

Eliminating Mixed Sex Accommodation

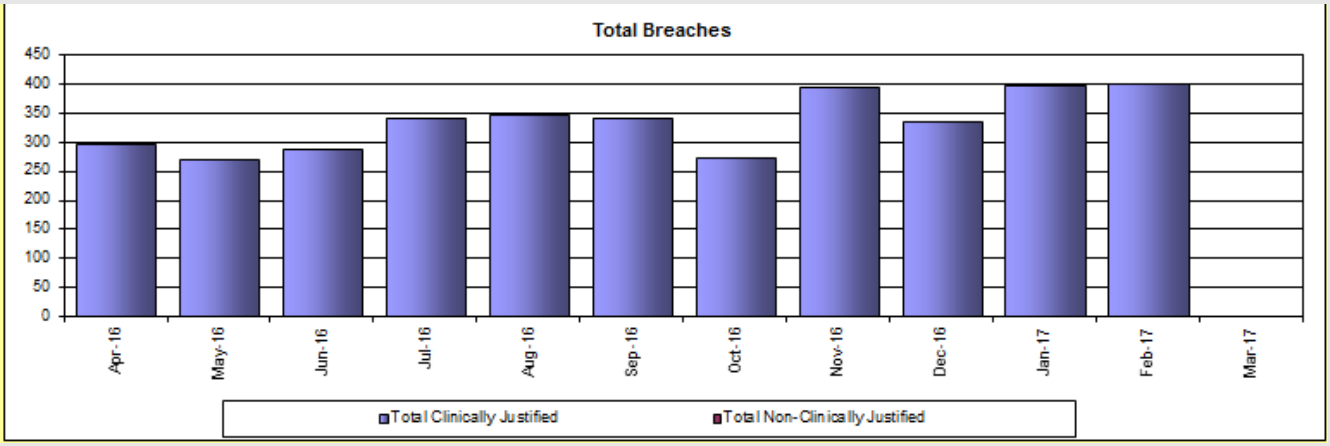



Figure represents the trust position as of Month 11: 2016/17

**Comment on Current Performance**

All breaches were clinically justified for the period April 2016 to February 2017.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.3 | Publish awareness across the trust regarding the need to report mixed sex breaches. | Sam Rafferty | 31/03/17 – Complete and closed. |

**Update on Actions**

Communications via Vital Signs, Daily Email and Care Group communications.

**SHOULD DO: The provider should plan to risk assess the impact of the location of the proposed cardiac catheter laboratory, reflecting on the patient journey and pathway.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.5 | Produce a risk assessment related to the impact of the location of the proposed cardiac catheter laboratory; reflecting on the patient journey and pathway. Where any risk is identified, raise a service line level risk detailing the action to be taken to reduce the risk to its lowest level. | Venk Suresh | 28/02/17 |

**Update on Actions**

The location now is within the Derriford campus at the NW quadrant close to Rowan's. This site will be inspected by CQC and will have dedicated access to emergency ambulance if required. Heads of Terms has been signed by both PHNT and Regents Park (private provider). Project groups are being established to ensure building and operations are developed to standard. The full contract is being led by procurement and is not yet signed. Risk assessment related to the impact of the location reflecting the patient journey and pathway will be inherent in this next phase.

| SHOULD DO: The provider should review the environment regarding the safety of patients admitted to wards and departments living with mental illness and especially with the risk of self-harming. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 2.6 | 1. Conduct a review of inpatient wards for the presence of ligature points.<br>2. Provide fixtures and fittings that meet mental health standards whilst also meeting the PLACE requirements for all patients. | Head of Quality Governance | 31/08/17 |
| **Update on Actions** | | | |
| A working group has been set up to review the new draft ligature policy which also includes a risk assessment process. The working group will review the policy and agree a roll out plan to assess clinical areas. | | | |

**SHOULD DO: The provider should ensure that patient records are consistently completed and are kept up to date.**

**Current Performance**

Data extracted from Meridian: Fundamentals of Care Audits for the period 1st April 2016 to 28th February 2017.

**Figure 1 Has MUST Assessment Been Completed?**

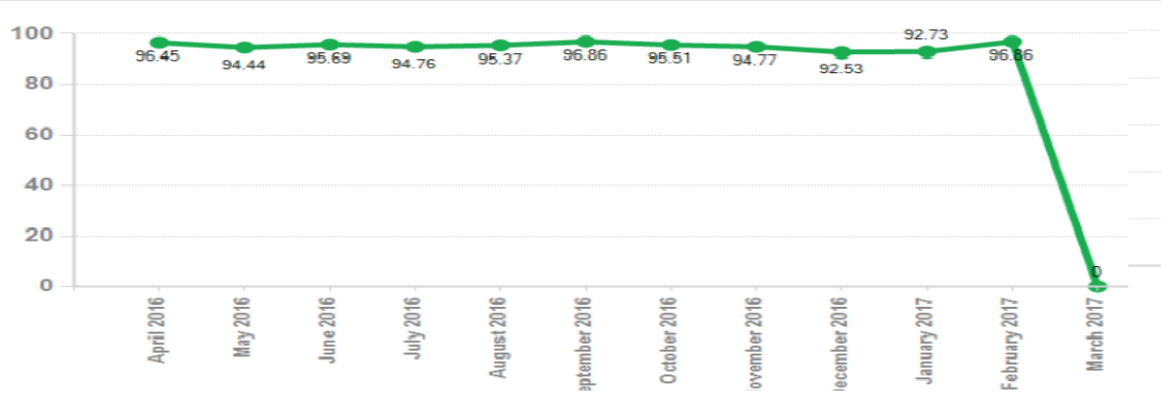



**Figure 2 Has the Waterlow Score been completed on Admission?**

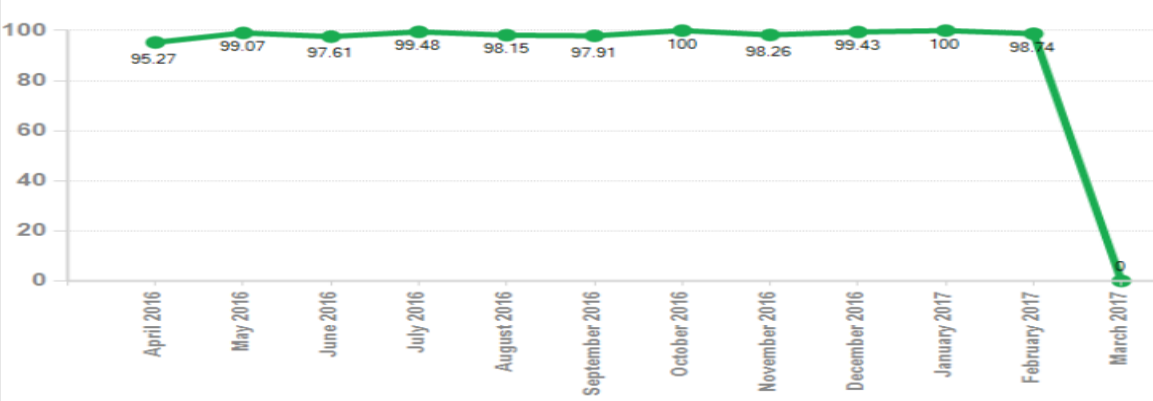



**Figure 3 Has the Manual Handling Risk Assessment been completed and is it up to date?**

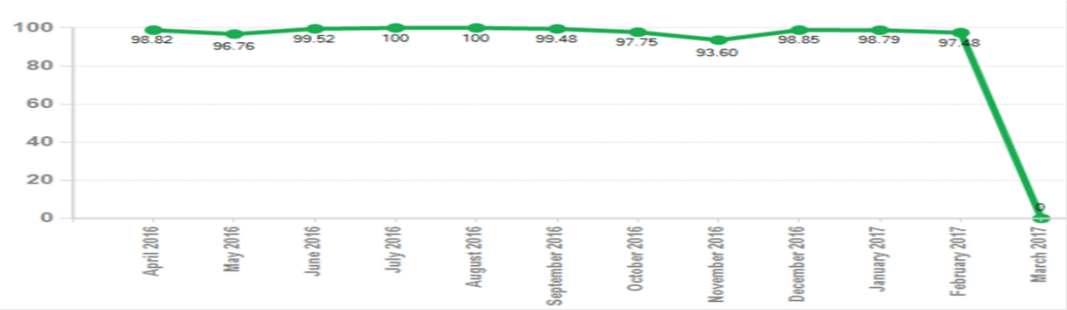
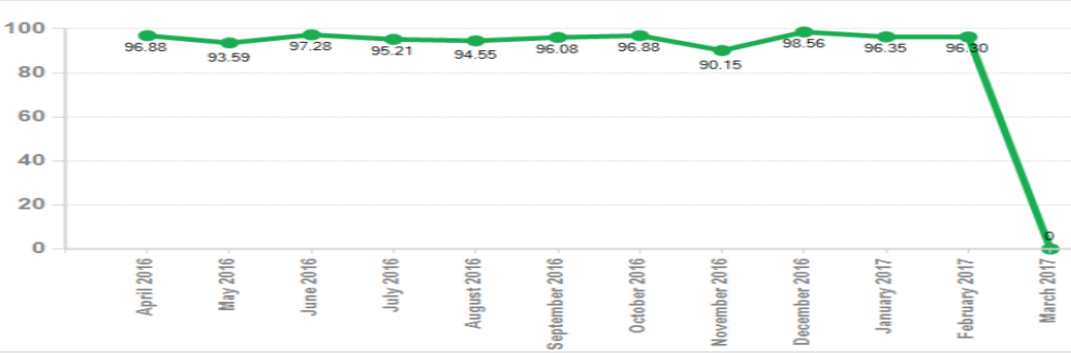



**Figure 4 Has the Falls Care Plan been updated?**




| Comment on Current Performance |
|---|
| Benchmark for the above aspects of nursing practice is 95%.<br>Waterlow risk scoring, manual handling risk assessments and falls care planning are at or above expected benchmark.<br>MUST Screening has been slightly below benchmark since September 2016, but in February 2017 all benchmarks are above 95%. |

| Planned action | | | |
|---|---|---|---|
| **Ref** | **Action** | **Lead** | **Deadline** |
| 2.7 | 1. Complete a pilot of the new risk assessment booklet.<br>2. Roll out assessment booklet.<br>3. Matron led audit of risk assessment and care plan documents at 6 and 12 months intervals. | Sue Johnson / Sam Rafferty | 30/06/17 – Complete and closed |

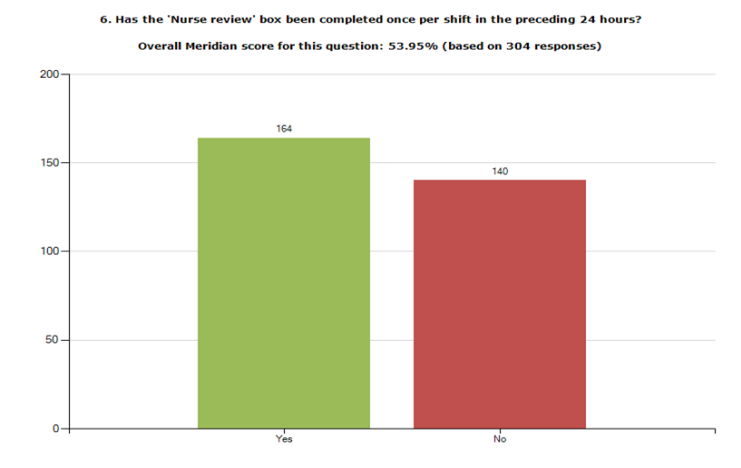
| Update on Actions |
|---|
| 1. Completed a pilot of the new risk assessment booklet.<br>2. Roll out of assessment booklet across the adult inpatient areas completed<br>3.Fundamentals of care audits embedded above show attainment above the 95% standard. The Heads of Nursing plan to review all ward areas with the Nursing Assessment and Assurance Framework (NAAF) audit in Autumn 2017. |

**SHOULD DO: The provider should ensure that where registered nurses were required to countersign the work of health care assistants this was consistently carried out. (Obs charts)**

**Current Performance**

Data extracted from Meridian: Fundamentals of Care Audits for the period 1st April 2016 to 31st December 2016.

Figure 5 Trust wide Adult Inpatient Observations Audit 29/11/2017




**Comment on Current Performance**

53.95% compliance with regards the audit question asking 'Has the Nurse review box been completed once pre shift in the preceding 24 hours?

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.8 | 1. Undertake a matron led campaign to raise awareness among registered nurses of the importance of countersigning healthcare assistants' written entries on observation charts.<br>2. Conduct an audit of observation charts and draw recommendations from it with associated action plan. | Sue Johnson / Sam Rafferty | 30/06/17 |

**Update on Actions**

Heads of Nursing have arranged for a Matron from each care group to undertake an awareness campaign. Awareness campaign to be run to highlight the importance of countersigning all documentation, as well as obs charts, completed by HCAs, student nurses and preceptees. This will run as follows:

• To include countersigning of documentation in ward safety brief each day.

• List countersigning of documentation as an agenda item at the Ward Sisters meetings – demonstrating the 'gold standard' required.

• Communicate through Vital Signs and daily emails.

• Ensure HCA tutors emphasise the need for HCA to get their documentation signed by a RN. This should be highlighted at every stage of their training.

• Countersigning of documentation to be included on the mentorship courses and the preceptee programme.

• Screen Savers as a prompt to ward staff.

2. Adult observation audit undertaken on 29th November 2016. Results feed into a trust wide Quality Improvement Project – Deteriorating Patient. The next stage of this project is being considered and monitored via the Quality Improvement Committee. The observation audit will be repeated across the Trust on an annual basis. Once E' observations are implemented this will be easier to check and audit. In the meantime the actions highlighted above around an awareness campaign are in progress.

**SHOULD DO: The provider should ensure that all chemicals are secured and not accessible to patients and visitors to wards and departments. Clinical waste including sharps bins should be sealed and dated correctly and removed from the wards promptly.**

**Current Performance**

Data extracted from Meridian: Environmental Audits for the period 1st April 2016 to 28th February 2017

| Question Text | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Benchmark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4. Does the ward appear generally tidy | 98 | 96 | 97 | 96 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 95 |
| 47 Are areas tidy with equipment stored appropriately | 95 | 93 | 97 | 89 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 95 |

**Comment on Current Performance**

Benchmark 95%: Overall the adult inpatient areas are exceeding or achieving the 95% target for compliance on 2 key questions in the environmental audits. Matrons undertake peer audits by inspecting each other's areas.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 2.9 | 1. Conduct a review of COSHH storage facilities in both inpatient areas and departments.<br>2. Review the Matrons' Audit programme in terms of ensuring the sluice area is monitored for sharps bins being sealed and dated correctly and removed from the wards promptly.<br>3. Collaborate with SERCO for an independent quality check of sluice areas as part of SERCO cleanliness audits in terms of ensuring the sluice area is monitored for sharps bins being sealed and dated correctly and removed from the wards promptly. | Sue Johnson / Sam Rafferty | 30/06/17 |

**Update on Actions**

1. The Quality Manager is seeking assurance from all Ward Managers that they have the appropriate COSHH storage facilities. This will be completed by 31st March 2017.

2. Request sent to Patient Safety Manager 30/01/2017 for advisory note to be added to Meridian. This will prompt the matrons to specifically score and comment on safe working practices within the sluice environment. Proposed that this is inherent in Question 4: Does the ward appear generally Tidy? Since January the Meridian Environmental Audit has been completed 13 times showing 100% compliance to the question "Are sharps bins not overfilled and are dated and temporary closure utilised." The link on Meridian around the sluice environment is not yet available; the Patient Safety Manager has been asked to provide confirmation of when this is likely to be live.

3. Feedback from PHNT SERCO link is that monitoring removal of full sharps containers from the sluice would not fit with the National Audit that has been developed for the Trust. Supervisors could be asked to add comments against the "Overall Tidiness" element under Sluice. The responsibility which sits behind each element would put this down to nursing responsibility. The audit completion reports will list all the comments but the completion of reports comes out individually after each audit has been submitted. To get an overall picture would require sifting through all the audit remedial action reports; which is not an efficient means of obtaining performance data on compliance. A decision needs to be made as to whether a previous plan to review the matrons audit should be reinvigorated or seek to close this line of enquiry and aim to keep with having the advisory note as detailed in sub action 2 above.

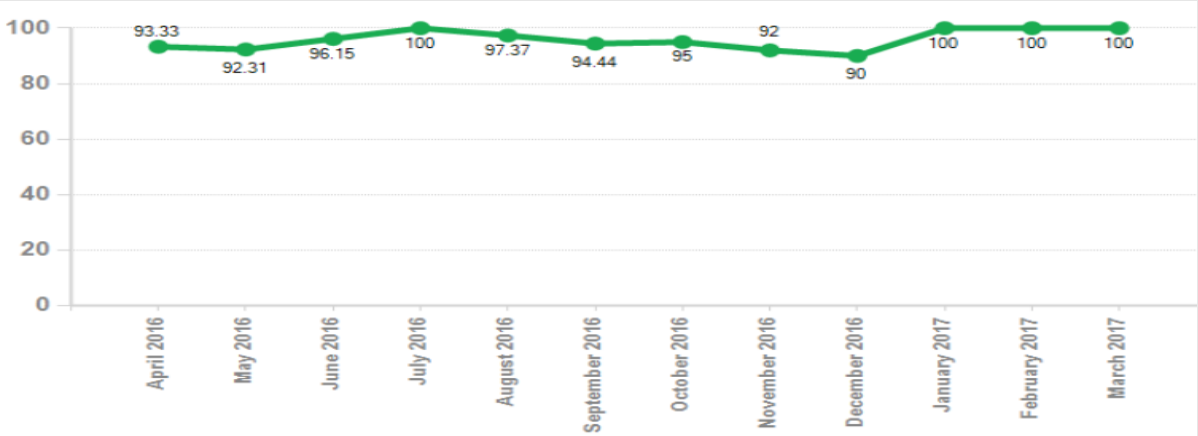
| SHOULD DO: The provider should review the layout of wards which had six beds to a bay as in some areas this impeded access to hand washing facilities and clinical waste bins thus potentially compromising the control and prevention of infection. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 2.10 | 1. Undertake a review of the medical bed base requirements on each ward.<br>2. Risk assess the operational impact of reducing each bay to 5 beds against key performance indicators related to improved quality standards. | Joanne Beer | 31/12/17 |
| **Update on Actions** | | | |
| 1. Review of bed base requirements in progress.<br>2. Draft risk assessment written. To be presented to OPDG for approval. | | | |

| SHOULD DO: The provider should review the signage for the ambulatory care unit as it was not clear from the main hospital corridors. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 2.11 | Undertake a review of way finding signage for the Ambulatory Care Unit from the main hospital corridors. Review to consider cost implications versus timing of the planned move of the Ambulatory Care Unit which will subsequently require further amendments to signage. | Stuart Windsor | 30/04/17 |
| **Update on Actions** | | | |
| Service Improvement Lead for Acute Care Co-ordination advised that the aim is for the Acute Care Unit to move into Orthopaedic Outpatients by April 17. There are some delays at the moment regarding confirmation of dates for relocation. The Facilities Programme Manager will work with the SI lead to ensure signage is changed to signpost the ACU in line with the timeline once dates are known. The paper outlining the plans should be presented to the OPDG in April. | | | |

**SHOULD DO: The provider should ensure that medicine trolleys are not left unattended when unlocked and that medicines are secured at all times.**

**Current Performance**

Data extracted from Meridian: safe storage of medicines: 1st April 2016 to 16th March 2017



| Comment on Current Performance |
|---|
| Overall the Trust is meeting the required benchmark for the safe storage of medicines. |

| Planned action | | | |
|---|---|---|---|
| **Ref** | **Action** | **Lead** | **Deadline** |
| 2.12 | 1. Review the medicines' management policy pertaining to safe storage of medicines.<br>2. Review the medicines storage audit to ensure drug trolley security is monitored.<br>3. Conduct a matron led review of each ward's routine for stocking and cleaning drug trollies; and for undertaking drug rounds.<br>4. Undertake a matron led review of all wards to:<br>- check the adequacy of supply of trolleys,<br>- the condition of medicines trolleys to ensure they are fit for safe storage of medicines during drug rounds: e.g. all locking mechanisms are in good working order;<br>- that keys are in the possession of the staff member undertaking the drug round. | Sue Johnson / Sam Rafferty | 30/06/17 |

| Update on Actions |
|---|
| 1. Policy reviewed – Medicines Management Policy and Standard Procedures V9 June 2016 reviewed. Section 6; 6.3 page 26; Responsibility for Medication Cupboard/Trolley Keys. Action Completed. |
| 2. Q13 of the safe storage of medicines asks the following: Are all drug trolleys: TETHERED to the wall and LOCKED if not in use OR ATTENDED by a Registered Nurse if in use? Action Completed. |
| 3. Matrons will be asked to review their clinical areas; date to be confirmed. Their findings will be collated and shared. The Quality Manager has prepared an Excel Spreadsheet to collate findings of the matrons review of their areas; approval secured from Heads of Nursing to roll this out to matrons to populate. |
| 4. The Quality Manager is awaiting response from the Ward Managers to confirm the adequacy of the trolleys and whether there are any problems with locking mechanisms or tethering to the wall. |

# Surgery

**SHOULD DO: Review why surgery has received the most complaints.**

**Current Performance**

Complaints by Care Group and Opened (Month and year) report extracted from Datix on 16th January 2017.

| | Jul 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Full Year Total |
|---|---|---|---|---|---|---|---|
| Quality Governance | 0 | 0 | 0 | 1 | 0 | 0 | 4 |
| Clinical Support Services | 3 | 3 | 3 | 0 | 1 | 3 | 19 |
| Corporate Functions | 1 | 1 | 0 | 0 | 1 | 0 | 6 |
| Estates | 0 | 0 | 1 | 0 | 1 | 0 | 3 |
| Facilities | 1 | 1 | 0 | 0 | 0 | 0 | 8 |
| Medicine | 27 | 24 | 18 | 19 | 13 | 22 | 240 |
| Surgery | 17 | 31 | 31 | 22 | 21 | 15 | 278 |
| Trustwide | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Women's and Children's | 4 | 6 | 7 | 4 | 6 | 6 | 67 |
| Total | 53 | 66 | 60 | 46 | 43 | 46 | 626 |

**Comment on Current Performance**

During 2016 Surgery have received 278 complaints in comparison to Medicine's 240 complaints. 44% of the Trust's complaints are for the Surgical Care Group. 93 of the complaints within surgery relate to Access and Waiting in comparison to 38 for the Medical Care Group.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.1 | 1. Continue monitoring via the Surgical Care Group with the Patient Experience reports, looking for themes and local action.<br>2. Monitor Internal complaints though PALS. | Ian Wren | 30/04/17 – Complete and closed |

**Update on Actions**

The reasons for complaints within Surgery are discussed at the Care Group Governance Meeting with the Patient Experience Manager presenting a report which comments on the high number of patients raising concerns through PALs and through formal complaints about access and waiting times. Reviewing of complaints and PALs themes forms part of the forward work plan for the Care Group Governance Meeting and is part of the assurance framework when service lines present to the Care Group.

Work detailed in actions 3.2 and 3.3 aim to reduce the number of patients within the long wait categories of more than 40 and 52 weeks and bring the standards in line with the RTT of 18 weeks. Equally for outpatients, there continues to be follow-up backlogs mainly within Ophthalmology, Trauma, Orthopaedics and Rheumatology Service Lines. These risks are clearly stated on the Care Group's risk register (ID 5081, 5080, 5565, 5197).

**SHOULD DO: Continue with the action plan to reduce their referral to treatment times in all surgical specialities. Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.**

**Current Performance**

| Patients waiting >40 weeks for Treatment | | | |
|---|---|---|---|
| Specialty | 22/02/2017 | 06/03/2017 | 09/03/2017 |
| Neurosurgery | 109 | 98 | 97 |
| Plastic Surgery | 27 | 23 | 27 |
| ENT | 9 | 2 | 2 |
| General Surgery | 7 | 6 | 7 |
| Urology | 5 | 5 | 3 |
| Upper GI Surgery | 5 | 5 | 5 |
| Colorectal Surgery | 5 | 10 | 3 |
| Orthopaedics | 4 | 4 | 4 |
| Vascular Surgery | 1 | 2 | 0 |
| Cardiac Surgery | 1 | 0 | 0 |
| Hepatobiliary & Pancreatic Surgery | 1 | 1 | 1 |
| Pain Management | 1 | 0 | 0 |
| Maxillo-Facial | 0 | 1 | 0 |
| Dermatology | 0 | 0 | 1 |
| Grand Total | 175 | 157 | 150 |

**Comment on Current Performance**

Referral to Treatment (RTT) has slightly improved, we are working with the national elective care programme and there are monthly meetings to review progress chaired by the Chief Nurse and Operating Officer. One or two areas are not on course to achieve the planned trajectory to 92%. The number of patients waiting more than 40 weeks has fallen below 200 (290 at the start of this year). Current performance shows a reduction from 175 on the 22nd February 2017 to 157 on the 6th March 2017 and 150 on the 9th March 2017.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.2 | 1.Deliver individual action plans.<br>2. Monitor delivery of plans via monthly Individual meetings, weekly RTT meetings and bi-monthly OPDG meetings. | Ian Wren | 31/07/17 |

**Update on Actions**

Work continues with the commissioners particularly around Neurosurgery. An option appraisal is being completed for additional resources, including additional theatre and bed capacity and additional surgeons.

Additional theatre capacity is on line with Plym 3, Tavistock and a plan in place for Freedom 6 for March 2017, which is offsetting the risk from losing outsourced capacity. The Elective Care Intensive Support Team are developing more robust recovery plans, breaking improvements down into manageable trajectories. The Theatre Improvement Programme is focussing on all capacity.

The Neurosurgery business case has now been approved. This includes:

• provision of additional theatre capacity (1/2 theatre) following recruitment;

• an increase in the bed base for neurosurgery; and

• development of an extended recovery primarily for neurosurgery patients.

Also resilience around avoiding cancellation including offering patients choice about staying in recovery overnight or

waiting for a bed on the ward.

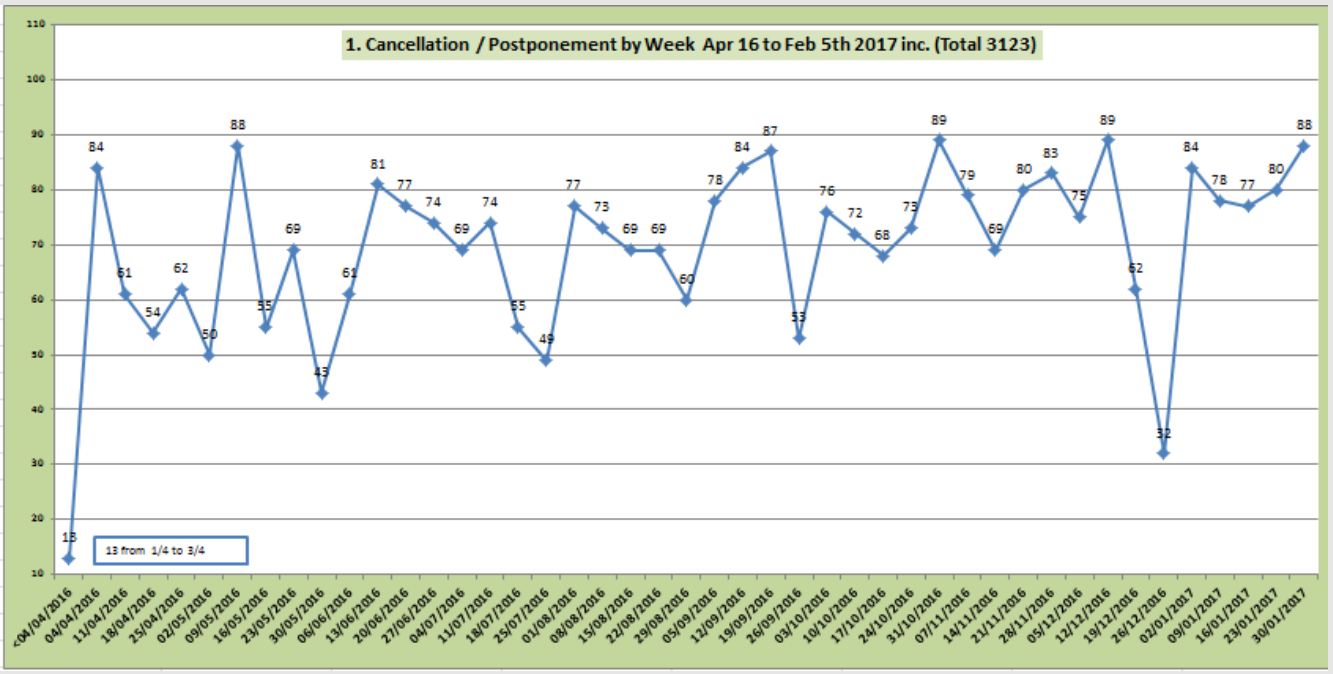
RTT trajectory plans are in place for 2016/17 and 2017/18 for each speciality. This is reviewed weekly in the Care Group and monthly with the Chief Operating Officer.

**SHOULD DO: Continue to look at ways of reducing the number of cancelled operations and the numbers not re-booked within the 28-day time scale. Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.**

**Current Performance**

See previous section referring to 52+ week waiters.

Please see below for the current Theatre Improvement Plan. Cancellation Graphs Feb 16 v8




**Comment on Current Performance**

More detailed information is now available per specialty, by day-case and inpatient and by reason for cancellation. The data supplied for external monitoring includes the data for the Planned Investigation Unit, and other non-surgical procedure cancellations.

The cancellations due to bed pressures have significantly reduced and improvements are now being implemented to the patient reminder service.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.3 | 1. Define Service Line Improvement Project.<br>2. Establish mechanisms to monitor delivery of project via monthly report and working group.<br>3. Service lines to develop individual actions by Jan 2017. | Ian Wren | 31/01/17 – Complete and closed |

**Update on Actions**

Theatre Improvement Programme Actions relating to cancellations

| Project | Action | Completion date |
|---|---|---|
| Cancellations | Disseminate updated cancellations by surgeon, review findings, establish trends & action plans for high cancellation specialties | Feb-17 |
| Cancellations | Disseminate completed specialty packs. Work with SLM, SLD to review, establish action plans and start implementing potential changes to reduce cancellations. | Feb-17 |
| Cancellations | Review NHS benchmarking data and report suitable performance information (IPM and current data) | Feb-17 |
| Cancellations | Establish targets and KPI's for overall cancellations and each specialty and agree at next prog board | Feb-17 |
| Cancellations | Review data numbers against through-put, discharges, breaches and correlate information. | Feb-17 |
| Cancellations | Review Reminder service and establish current state (JF) | Complete |
| Cancellations | Gain agreement on performance team dashboard format using manually collated data (Cancellations, Delays, Late Starts, Late Finishes etc.) | Complete |

- Disseminate updated cancellations by surgeon: weekly data now available. Weekly cancelled ops meeting with service lines to be arranged.
- Daily lunchtime meetings: happen daily at 1.30pm, these commenced in January.
- Review NHS benchmarking: Matron Cindy McConnachie is attending a meeting in London about this during March.
- Establish finalisation of theatre lists: Lists should be finalised by 1pm.
- Reminder service: Reviewed, additional staff member in post from February, therefore reminder service will roll out to all specialities who are currently not reminding patients. Weekly data now available following reminder calls which are undertaken 48 hours prior to date of surgery.
- Natsipps: We are setting up a project steering group to oversee implementation of NatSIPPS.
- Theatre communications : with effect from 13th Feb trialling new structure – Theatre Operations Manager in post working more closely with Site team with fixed daily meetings – planning 3 hours ahead for beds to improve sending times and start times.
- Recovery flow and processes: data being collected regarding times of patients within recovery.
- Recovery – expand ward level 1 capacity: additional level 1 bay going into Stonehouse ward from April 2017.
- Recovery PACU: trialling level 1 area in theatres w/c 20th Feb will prove trial of concept for PACU.

Surgical Breach meeting with Head of Operations reviewing the previous day's cancellations is established.

There are three themes with regards to cancelled operations:

• Operational issues and bed availability.

• Staffing.

• Medical and patient related cancellations (e.g. unfit for surgery on the day).

The initial focus was to resolve the operational and bed availability concerns and now this has shifted to on the day cancellations. The pre-alert programme has been strengthened whereby we are contacting patients prior to surgery to ensure that they know the date for their surgery and to confirm that there are no issues that would prevent them from having surgery on the day.

Performance targets are now set for each service line into the financial and performance improvement plan, with a target of 50% reduction in cancellations. Lunch time meetings in place between Theatre Management Team, Care Group Management and Operations lead reviewing the previous day's performance and initiating forward view of the next day's work.

**SHOULD DO: Ensure that theatre lists are finalised at 3pm the day before the operations are due to take place.**

**Current Performance**

In the daily 2pm meeting, theatre team leaders review the operating lists for the following day, including a review of whether the list is finalised, if the right staff are available (e.g. surgeon, anaesthetist, theatre staff), kit, information around the patient, order of the list, infection control issues etc.

Data from this, including finalised list data, is collated on a spreadsheet. Any feedback is given to service lines via email. Information from the spreadsheet will be collated into a run chart. Quarterly audit will be conducted.

**Comment on Current Performance**

Data on the number of lists finalised will be accessed from the run chart as described above.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.5 | 1. Conduct quarterly audit to assess compliance.<br>2. Present findings to the Service Lines to cascade down by Jan 17. | Ian Wren | 31/01/17 |

**Update on Actions**

Internal audit review completed, report has been received and recommendations are being implemented.

Theatre scheduling policy is adequate however it needs strengthening to accommodate NATssips. There is currently variation on completing of theatre lists and local action plans need to be completed to address these issues.

Service Improvement are assisting with pulling together a run chart, the summary of which will be added to this document.

The plan is now to ensure that theatre lists are finalised by 1pm and not 3pm which will allow more time to resolve any issues. The 842 policy on scheduling has now been agreed and is expected to launch in March. At 8 weeks a surgeon should be allocated to a list, at 4 weeks patients should be booked onto a list and at 2 weeks the list should be finalised, having checked equipment issues etc. If the management team do not have assurance against these key measures then the list will be removed from local control.

Quarterly audits will commence in March.

**SHOULD DO: Make sure chemicals and substances that are hazardous to health are secured and not accessible to patients and visitors in the Fal unit sluice area.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 3.6 | Install locked cupboard. Key to be held with Band 6. (Fal Unit) | Jenny Pitt | 31/12/16 – Complete and closed |

**Update on Actions**

The only hazardous substance in the Fal sluice is actichlor tablets which have been removed and stored appropriately in the Postbridge sluice yellow metal (COSHH) cupboard. A notice has been put up in Fal sluice informing staff of the new storage location and instructing that they are not to store actichlor tablets in an unlocked cupboard. Quality Manager for Surgery has undertaken three spot checks of Fal and confirmed that there has been no actichlor or any other COSHH item found.

| SHOULD DO: Make sure that all staff ideas are listened to and reasons given if they cannot be actioned.(Interventional Radiology) | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 3.9 | 1. Implement Daily Team brief with Band 7 across all departments and theatres.<br>2.Encourage staff to raise questions via Ask Ann. | Kerri Richardson | 30/04/17 - Complete |
| **Update on Actions** | | | |
| Daily team brief implemented at 08:30 which includes consultants, matron, nursing band 7, radiographer band 7 and other staff from the department. The team brief gives the opportunity to discuss issues from the previous day.<br>There is also a Staff meeting held on CME mornings which is led by either the nursing band 7 or radiographer band 7, but due to shift patterns not all staff are able to attend.<br>The actions have been completed and this is now routine which will be monitored by the matron for the area. | | | |

# Critical Care

| SHOULD DO: Complete progress to allow the cardiac critical care service to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 4.2 | Investigate funding options to progress contribution to ICNARC. | Malcolm Dalrymple-Hay | Dependent on funding approval - hopefully 2017/18 financial year |
| **Update on Actions** | | | |
| This service development has been raised with local commissioners on a number of occasions but has not been agreed/funded. Formally raised in Business Planning for 17/18 in the expectation that this will be funded; feedback awaited. | | | |

# Maternity & Gynaecology

**SHOULD DO: Should complete all outstanding refurbishments required on the delivery suite. This includes the remaining nine birth rooms, and the bathrooms and toilets which were shared between patients.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 5.2 | 1. Complete Room 5 refurbishment by end Dec 16.<br>2. Complete Room 14 refurbishment by end Jan 17.<br>3. Discuss room 6 and triage refurbishment in new financial year. | Sue Wilkins | 31/12/17 |

**Update on Actions**

**Areas already complete / refurbished:**

- Delivery rooms 1, 2, 5, 12, 14 and 15
- The main bathroom (Op Snowdrop)
- Patient day room
- Snowdrop viewing room (8)
- Snowdrop room (9)
- Replaced communal corridor flooring across 80%
- Fixed wall protection along the communal corridors

**Next and in priority order:**

| | |
|---|---|
| Shower room 4/072 | Refurbishment will include a large shower cubicle (In progress this month) |
| Dirty utility | Replacement of all cabinetry and sink / taps / drainer and small tidy up |
| Clean utility | Replacement of all cabinetry and sink / taps / drainer and small tidy up |
| Bathroom (Op room 14) | Major refurbishment |
| Triage 4 | Refurbishment / quotes being sourced |
| Triage 1, 2 & 3 | Refurbishment / quotes being sourced |
| Delivery room 7 | Birthing pool / quotes being sourced |
| Delivery room 11 | This room had a tidy up, but needs a total refurbishment |

**Other areas awaiting updates:**

| | |
|---|---|
| Delivery 3 | Fair condition |
| Delivery room 10 | Fair condition – may be included as part of the Snowdrop Appeal |
| Bathroom (By Triage) | Needs refurbishing / Undecided as to the use of this room. |

**En suite toilet – all areas have been tidied, including painting radiators (Nov/ Dec 2016):**

| | |
|---|---|
| Between room 1 & 2 | Fair condition |
| Between 5 & 6 | Fair condition |
| Between 7 & 8 | Fair condition |
| Between 9 & 10 | Fair condition |
| Between 11 & 12 | Has had a new toilet, sink and IPS / but hasn't had a total refurb / Fair condition |
| Between 14 & 15 | Fair condition |

| SHOULD DO: Should provide more equipment to promote normalising birth and movement during labour and to aid pain relief. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 5.4 | 1 Agree procurement order for new dopplers - Complete.<br>2. Appoint normality midwife.<br>3. Discuss provision of equipment purchasing in 17/18 budget setting. | Sue Wilkins | 31/12/17 |
| **Update on Actions** | | | |
| Doppler purchased.<br>Normality midwife advert was put out twice last year but there were no appointable applicants. The intention is to re advertise in Spring 17. EPR number applied for with intention of advertising at the end of March.<br>Monthly meeting with finance team to discuss overall budget including equipment purchasing. | | | |

# Children and Young People

**SHOULD DO: Consider staffing allocation to allow for management and supervision from senior staff in all paediatric areas.**

**Current Performance**

**Community**
Regular 3-4 monthly clinical supervision is in place and records kept for all Community children's nurses.
Individual and group supervision monthly for therapists – records kept.
Monthly supervision for Psychologists records kept.
Ad hoc supervision for continence team – regular sessions to be established.
Monthly safeguarding supervision provided for all staff by the safeguarding team.
Ad hoc safeguarding supervision available and records kept in notes available from designated safeguarding supervisors.
Individual senior staff receive supervision from peers external to the service line.

**Acute**
There is a Senior Band 7 or above available every weekday, office hours to provide support and supervision. Ward Managers work a predominately 4 day week, cross covering each other as necessary whilst covering the senior role for the floor. Ward Managers try to roster their band 6 to work on days when they are off.

**Comment on Current Performance**

Not applicable.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 6.1 | 1. Review allocation of supervisory time of ward manager role.<br>2. Ensure supervision is available for all staff across the community service line. | Anita Dykes / Sue Syers | 30/04/17 - Complete |

**Update on Actions**

**Community**: Monthly meetings now set for continence team; records to be kept. Closed action 9/2/17 SMT agree that minutes of supervision are available.

**Acute**: Supervisory role of Ward Managers reviewed. 24/7 support from paediatric senior nurse in place if Ward Manager not available due to days off, annual leave etc. Matron available weekdays and Ward Managers also cross cover. Agreed at Post CQC inspection meeting 16/3/17 to close action.

**SHOULD DO: Ensure height and weight measurements of children are readily available for staff prescribing medications.**

**Current Performance**

Audit data not yet available.

**Comment on Current Performance**

Not applicable.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 6.2 | Remind staff in all paediatric areas to record the height and weight of children via newsletter and email and audit compliance. | Anita Dykes / Heather Jarvis | 30/03/17 - Complete |

**Update on Actions**

**Community:** Email to staff sent to remind them that children should be weighed at each appointment and if prescribing.

SMT have agreed that this will be added to the yearly records audit for monitoring. Next due April / May. Closed 10/02/17.

**Acute:** Staff reminded via email reminder. Height and Weight Question being added to Paediatric Fundamentals of Care Audit. Fundamentals of Care change request submitted so compliance can be audited.

**SHOULD DO: Ensure only current medicine guidance is available in all paediatric areas. (BNF)**

**Planned action**

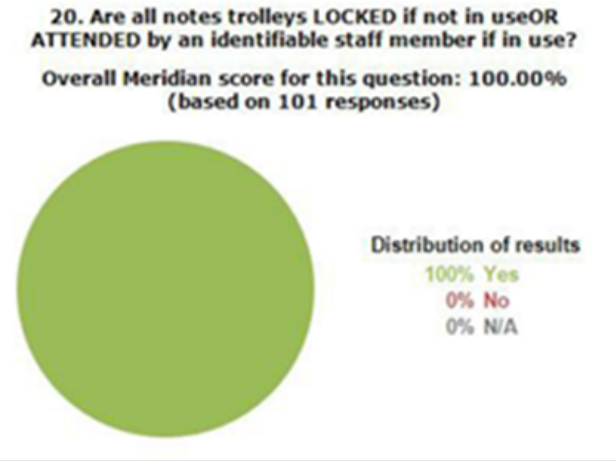
| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 6.3 | Ensure all out of date BNF-C are removed from circulation. | Anita Dykes | 28/02/17 - Complete |

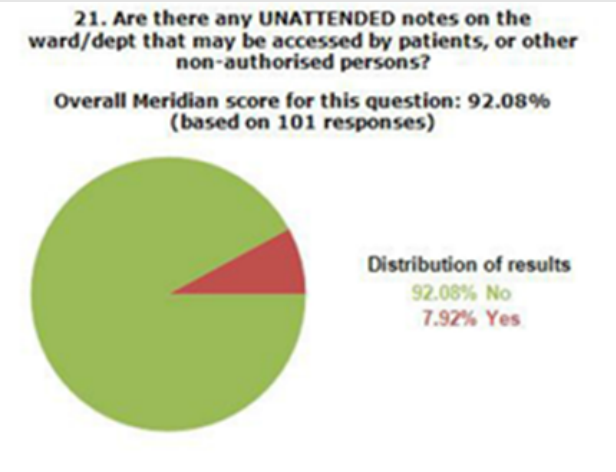
**Update on Actions**

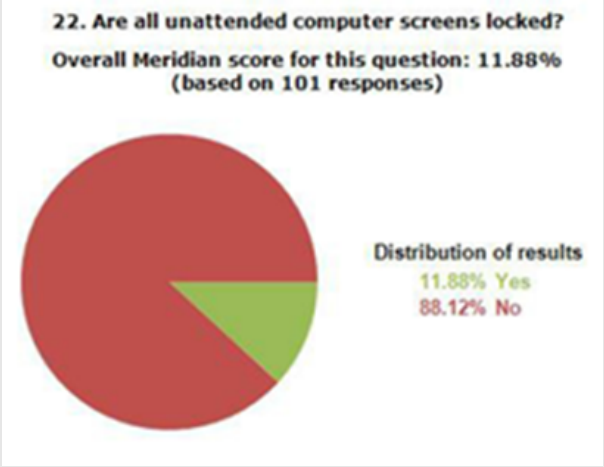
All removed from CDC. All removed from Level 12 and Plym by Paediatric Pharmacist.

**SHOULD DO: Ensure patient details in children's and young people's services are kept confidential and that only authorised personnel are able to access details of care. (Patient details were displayed on an electronic board where visitors could view it which could compromise a child's privacy.)**

**Current Performance**




Monitored via Matrons Audit on Meridian for Acute Paediatrics. Charts display results for the period 01/08/16-27/03/17.

**Comment on Current Performance**

None.

**Planned action**

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

| | | | |
|---|---|---|---|
| 6.4 | 1. Review the placement of electronic screen to ensure privacy.<br>2. Ensure patient notes are not left in clinic rooms unattended / accessible to members of the public.<br>3. Ensure patient identifiable information is not visible. | Anita Dykes | 30/06/17 |

**Update on Actions**

**Community:** Staff reminded to close computer screens when not in use and ensure clinic doors are kept closed if notes are in them unattended. This will be monitored via 3- 6 monthly spot checks - first walk around confidentiality audit is due imminently.

**Acute:** Placement of screens reviewed by Matron. Woodcock's nurse screen could potentially lead to information being visible to other patients or parents so this will be moved. New works request to be submitted by 30/3/17. To be highlighted to staff in the next newsletter. Audit continues.

**SHOULD DO: Make sure the equipment log is up to date with all servicing of equipment.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 6.5 | 1. Create a ward log of equipment.<br>2. Identified lead to manage the equipment.<br>3. All equipment added to one database to be maintained. | Anita Dykes / Sue Syers | 28/02/17 – Complete |

**Update on Actions**

**Community:** All equipment checked and now up to date and on one database. Ongoing checking process in place and monitored by specific staff. 9/2/17 – closed – database will be monitored by Service line governance group.

**Acute:** Link nurses identified for paediatric wards and equipment. Log obtained from MEMs, cross checking in place.

Actions complete.

**SHOULD DO: The oxygen cylinder for use in emergencies, kept at the Child Development Centre, should be portable and safe for staff to move.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 6.6 | Investigation and purchase of suitable trolley for the equipment | Sue Syers | 31/01/17 |

**Update on Actions**

Some issues with identifying a suitable trolley. We cannot use a normal resuscitation trolley unless we have it stocked in line with the rest of the Trust which would not be required. The current equipment is portable and is stored in a carry bag. Specific trolley identified and has now been authorised for purchase but it is a non-standard item and is awaiting approval to be added to the system as a new product request. Once approved it can be ordered. There is a trolley for use if needed in the interim.

**SHOULD DO: Consider how to raise an alert to potential safeguarding issues if parents or their children do not book appointments that have been professionally advised.**

**Current Performance**

Policy is in place and algorithm is available to staff to ensure understanding of process. The safeguarding team monitor reported incidents when children are not brought or not opted into services and communicate with multi-agency partners as needed. Systems and processes are in place. Audit data not yet available.

| Comment on Current Performance |
|---|
| All incidents where policy is not followed should be reported. Staff do report repeated failure to be brought to appointments to the safeguarding team so that they can liaise with community health colleagues as needed. |

| Planned action | | | |
|---|---|---|---|
| **Ref** | **Action** | **Lead** | **Deadline** |
| 6.7 | This is incorporated in the DNA/Was not brought policy currently in use. Conduct audit of compliance with policy. | Alison O'Neill | 31/05/17 |

| Update on Actions |
|---|
| DATIX is monitored regularly and no incidents have been noted.<br>Staff do report regularly to the safeguarding team children who do not attend and do not opt into offered services.<br>Due to staffing issues the audit of policy has not commenced as yet. An audit of children who are not brought or whose parents do not opt into offered services is planned. |

| SHOULD DO: The Trust should consider how they manage and mitigate the risk to lone workers. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 6.8 | 1. Agree purchase of monitored lone worker devices.<br>2. Purchase and implement use of devices. | Andrew Davies (purchase) / Brigitte Price | 28/02/17 |

| Update on Actions |
|---|
| **Community:** The Trust has now purchased these devices and we are in the process of allocation. Data for staff currently being provided for Skyguard to upload onto their systems. Training planned for April.<br>**Acute**: Not relevant. |

| SHOULD DO: The trust should consider in-house provision of physical intervention trainers to ensure appropriate staff in the children and young people's service are fully trained. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 6.9 | Develop a business proposal for internal training team. | Matron Brancher (Safeguarding) & Sophie King Clinical Educator CYP | May 2017 to go to Care Group leadership team with proposal for internal trainers |

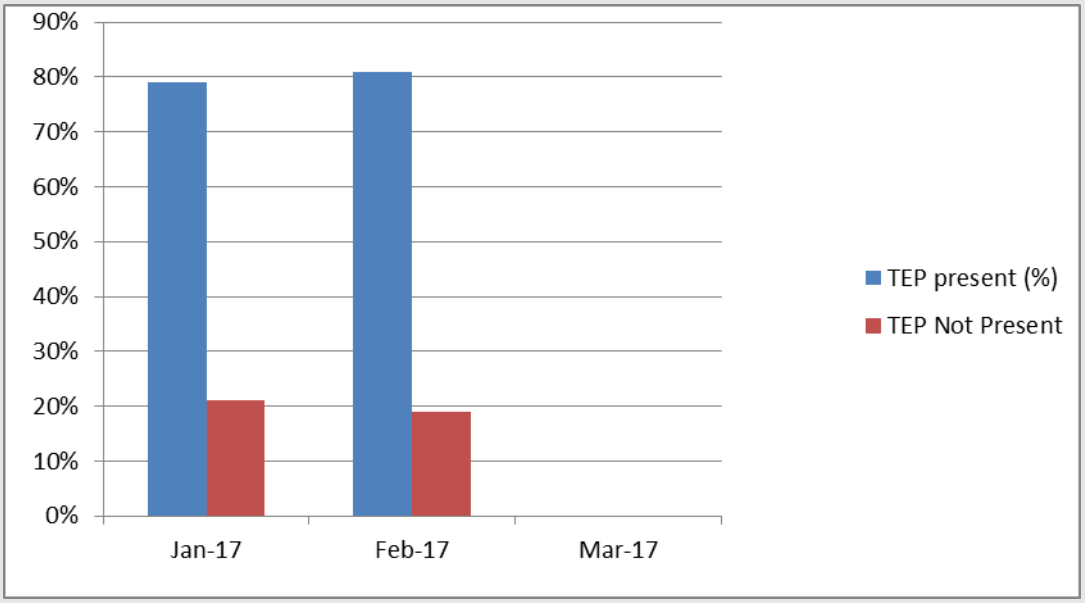
| Update on Actions |
|---|
| As an interim measure CYP has outsourced external training provision for 2017 regarding Physical Interventions training; this also includes Maternity staff and staff working with children in other areas of the Trust e.g. E.D., Paediatric Radiographers etc. Training for all maternity and paediatric staff in PI takes place in Block Week Training. Physical Intervention training continues. The Clinical Educator has been supported to undertake GSA regulated PI training to support the wards and Trust in further developing PI training in house and reduce reliance on outside trainers. Business Plan has been developed and submitted and is awaiting approval. |

# End of Life Care

**MUST DO: Ensure audit programmes associated with end of life care are carried out in line with the plan and that actions and improvements are reviewed.**

**Current Performance**

Retrospective audit of all emergency calls continues and quarterly reports are presented to both the End of Life and Resuscitation Committees. January – February 2017 report highlighted that TEP presence in medical notes = 79-81% of those patients who had a call for the emergency team to attend. For those patients deemed 'not for resuscitation' 100% of patients had the rationale documented for the decision and 86-93% of patients/relatives had been involved in the resuscitation decision process and discussion.




The revised Meridian TEP audit was piloted on x 20 patients in December 2016 on Healthcare of the Elderly wards and results are much clearer and demonstrate very good compliance with TEP completion.

Our organisation's (CQC) TEP Action Plan is to concentrate on exemplar areas within the organisation to ensure there is excellent TEP completion compliance prior to rolling out the audit across the organisation. Healthcare of the Elderly and Brent wards have been chosen as the exemplar areas.

**Comment on Current Performance**

See above.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 7.1 | 1. Meridian tool to be revised and rolled out across the Trust.<br>2. Results to be uploaded to service line dashboard.<br>3. Agree plan for reporting improvements and results. | J Williams | 30/04/17 |

**Update on Actions**

Healthcare of the Elderly and Brent wards will implement the Meridian TEP audit April 2017. Results will be displayed on service line dashboards.

| SHOULD DO: Ensure that local audits for the 'Last days of Life Care Plan' are put in place to provide evidence or any changes needed in practice. | | | |
|---|---|---|---|
| **Current Performance** | | | |
| Last Days of Life Local Audit completed December 2016. Compared with local audit 2015 and National Audit 2016. 14 sets of notes reviewed from the first patients to have died in May 2016. All 14 pts were non-cancer. 42% of patients >3 co-morbidities. | | | |
| **Comment on Current Performance** | | | |
| Local Audit completed. When compared to the National Audit March 2016 there seems to be an overall general improvement in care for patients dying within the acute trust | | | |
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.2 | To complete local Audit Dec 16. Results (produced annually) to be presented to and monitored by EOL Committee. | A Munton | 31/01/17 – Complete |
| **Update on Actions** | | | |
| Audit complete. Plan to be presented to EOL Committee April 17 and integrate with overall EOL plan. | | | |

| SHOULD DO: Ensure the ongoing completion of plans in place to develop rooms for privacy for patients at the end of life and suitable environments for private discussion and the delivery of bad news. | | | |
|---|---|---|---|
| **Current Performance** | | | |
| Matrons completed baseline and work in progress to provide suitable BBN rooms | | | |
| **Comment on Current Performance** | | | |
| Matrons / Sisters to contact Planning regarding sisters offices to be redecorated. | | | |
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.3 | Work with Estates, HON and Matrons to identify suitable private rooms for BBN and guiding principles for BBN if room not available. | Matrons, Estates and HON | 31/08/17 |
| **Update on Actions** | | | |
| The majority of Matrons have completed baseline assessment. Requires further work to make current facilities more suitable for patients and carers. Raised within Nursing and Midwifery Operational Committee. | | | |

| SHOULD DO: Ensure improvements identified by the end of life 'quality improvement in the environment' project have timescales for completion which will enable patients and families to have a better experience. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.4 | Plan agreed. Room redecoration to commence Feb 17 (two rooms over two weeks) with completion expected within 6-8 months; this will be under review to assess for impact on capacity. | K Lyth | 31/10/17 |
| **Update on Actions** | | | |
| Funding agreed. Plan to commence 2 rooms at one time from Feb 17. Work commenced, work intermittently stopped due | | | |

to operational pressures. Now resumed and escalation process implemented.

| SHOULD DO: Continue to explore options to increase space for multi-faith prayer and facilities for ablutions prior to prayer. | | | |
|---|---|---|---|
| **Planned action** | | | |
| **Ref** | **Action** | **Lead** | **Deadline** |
| 7.5 | Arrange multi faith meeting to discuss possible options. Review opportunities to redesign space available within Chapel and surrounding offices/rooms to accommodate requirements for Friday prayers and ablutions. Work with estates to implement plan. | P Snell | 30/04/17 |
| **Update on Actions** | | | |
| Identified a temporary way forward prior to implementing a permanent solution. The proposal is to purchase some free standing screens to create a prayer area for Jumah prayers on Fridays only (the prayer room will continue to be used during the rest of the week.) This can be achieved within the next month, once the type is decided.<br>Further temporary proposal to adapt the existing toilet and ablution facility, to incorporate 2 or 3 sinks in the existing room, and possibly to remove the toilet facility in line with CQC requirement. The leader of the Muslim congregation suggested the facility is adequate for weekday usage and that on Fridays many of those worshipping carry out their ablutions elsewhere before arriving whilst others can continue to use the existing facility. Actions in progress. | | | |

# Outpatients and Diagnostic Imaging

| MUST DO (Derriford): The provider must make sure that medical records are stored securely overnight in the oncology outpatients department. |
|---|
| **Current Performance** |
| To be assessed via quarterly case note audits once records have been relocated. |
| **Comment on Current Performance** |
| Not applicable at this time. |
| **Planned action** |

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.1 | Relocate Oncology Medical Records into expanded Oncology OP in March 2017 with all records to be stored in there overnight and with swipe access to new facility. | Denise Roddy | 31/03/17 |

| Update on Actions |
|---|
| Relocation project currently being reviewed. |

| SHOULD DO (Derriford): The provider should translate the vision and values of the organisation and service lines into clear, credible, and well defined objectives for outpatients which are regularly reviewed and remain relevant and achievable. |
|---|
| **Planned action** |

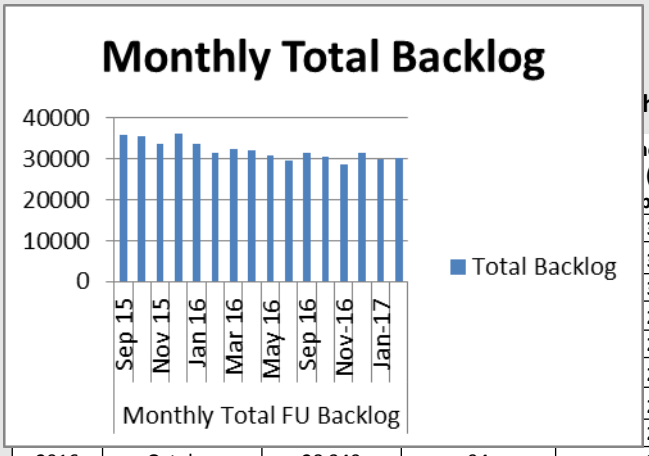
| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.2 | 1. Local objectives will be set through the annual business planning process.<br>2. Outpatient Forum to consider the objectives generically for outpatients as an agenda item. | Sue Johnson | 30/06/17 |

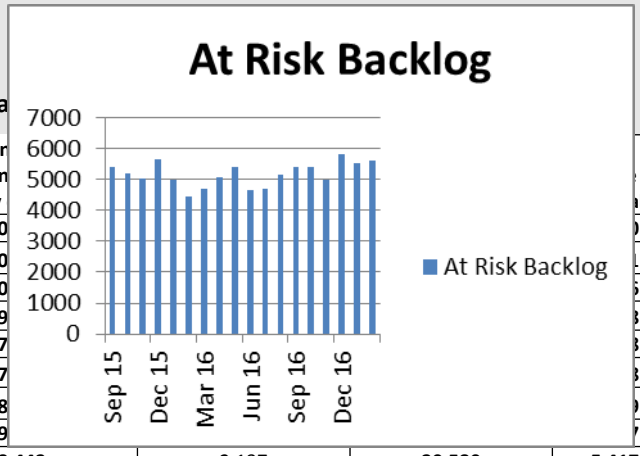
| Update on Actions |
|---|
| This was considered at the Outpatient Forum on 22 February 2017 and it was felt that this was only really a concern for main outpatients which supports a broad range of service lines rather than outpatient clinics that sit within their service lines e.g. fracture clinic. |

**MUST DO (Mount Gould): Take action to reduce the numbers of patients waiting past their to be seen date on follow-up and pending waiting lists.**

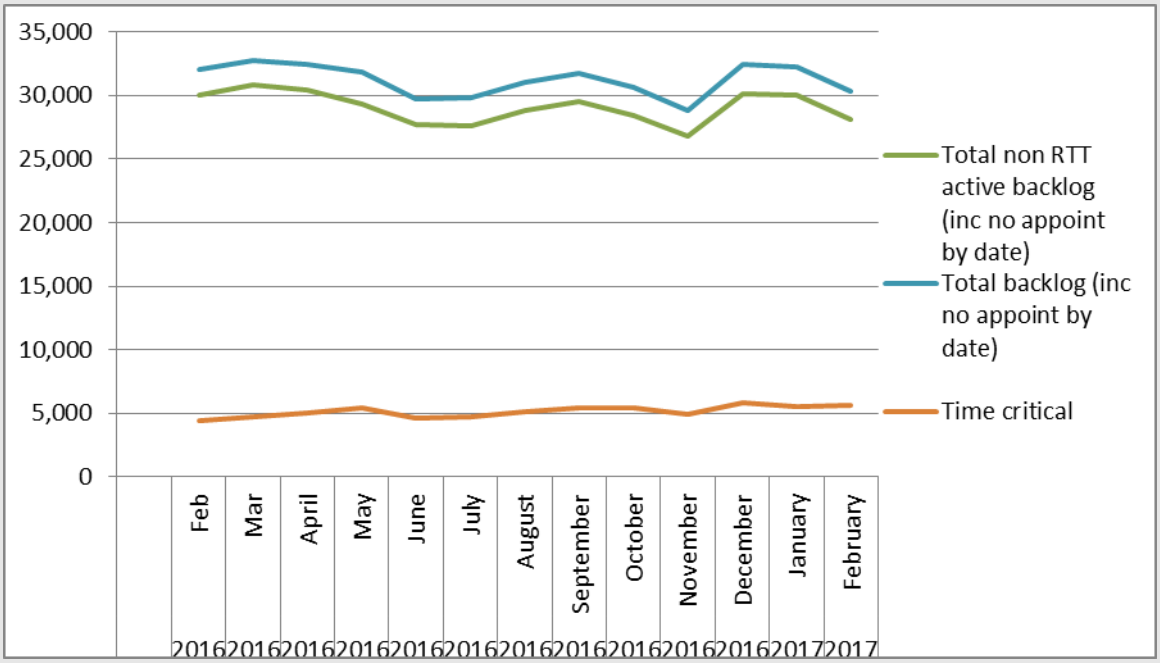
**SHOULD DO (Derriford): The provider should continue to make improvements on the follow up backlog waiting list to meet people's needs.**

**Current Performance**



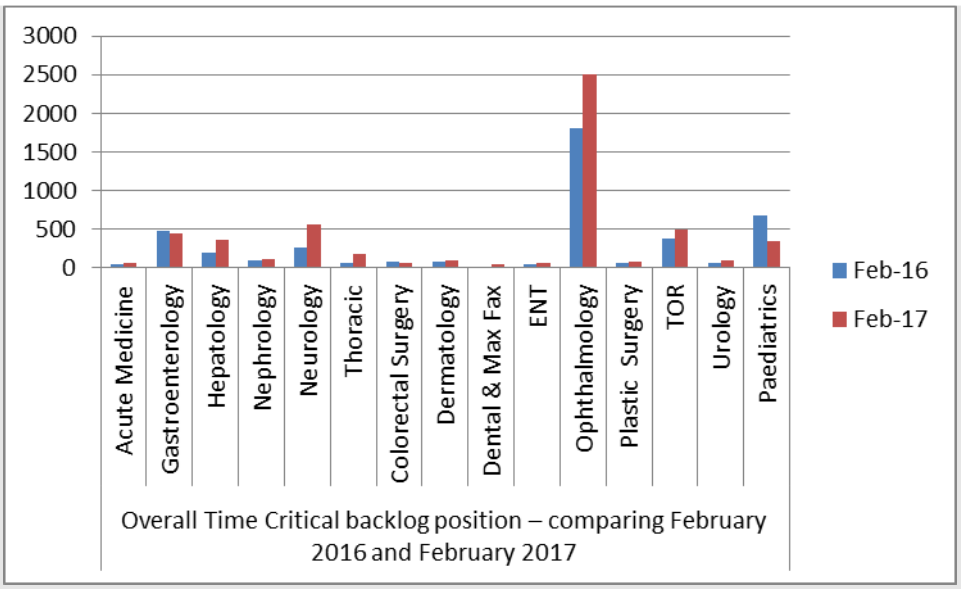




| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2016 | October | 28,349 | 94 | **28,443** | 2,137 | **30,580** | **5,417** |
| 2016 | November | 26,619 | 181 | **26,800** | 1,976 | **28,776** | **4,974** |
| 2016 | December | 29,901 | 185 | **30,086** | 2,336 | **32,422** | **5,806** |
| 2017 | January | 27,642 | 161 | **27,803** | 2,211 | **30,014** | **5,538** |
| 2017 | February | 27,920 | 200 | **28,120** | 2,224 | **30,344** | **5,602** |




**Tables below show comparison between February 2016 and February 2017 of overall backlog and time critical backlog.**

**Source: FBM**




**Comment on Current Performance**

The end of February saw a small increase in the follow up backlog; there were 30,132 patients past their 'see-by-date', a rise of 289 on the previous month and 5,602 patients are flagged as being at clinical risk, a rise of 64 on the end of January.

The profile of length of wait past see by date has improved in the last 12 months across all time parameters with a reduction in the number of the longest waiting patients. There has also been a reduction in the patients waiting longer than a year past their see by date. At the end of February there were 564 patients waiting longer than one year compared to 1,215 patients at the end of February 2016.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.3 | 1. Continue to reduce the longest waiting patients by lowering the threshold of the managed discharge programme, where clinically appropriate to do so, from the current + 52 weeks to 9 months and then a further reduction to 6 months.<br>2. Develop a plan across the high volume service lines of patients currently on the waiting list to determine if the patients can be managed in primary care, managed via a shared care model with both primary and secondary care or if they need to remain within secondary care.<br>3. To develop a plan with the high volume service lines for developing alternative approaches to follow up care, e.g. Patient Initiated Care (PIC).<br>4. Work with Ophthalmology to transfer some of the follow up of cataract operations to a community setting, to free up hospital capacity to contribute to seeing high risk backlog patients.<br>5. Where alternative methods of follow up cannot be introduced for clinical reasons each service line will develop a plan as to how they will reduce the number of backlog patients.<br>6. Review any incidents recorded on Datix related to the follow up backlog. | Sue Cook | 30/09/17 |

**Update on Actions**

The end of February saw an increase in the number of patients waiting in the overall and the time critical backlogs, however, the competing priorities for the limited capacity continues to impact on the Trust's ability to reduce the backlog

and time critical figures substantially further.

**Long wait patients (52+ weeks)**

The Trust continues to manage this group of patients to achieve the internal standard of having no patient wait longer than one year past the see by date, consistent with the 52 weeks RTT standard. The progress made over the last 18 months has seen the number reduce from c1,800 to 564 and 39% of these patients had an appointment date at the end of February.

The managed discharge process continues to be implemented to remove long wait patients from the waiting lists where clinically appropriate to do so in conjunction with GP practices to ensure the continuity in care management. Patients are offered the opportunity to remain on the waiting list should they wish to and if they choose to remain on the waiting list they are prioritised for a face to face or a virtual appointment. Dermatology, Gastroenterology, Cardiology and Thoracic Medicine continue to manage patients via this process. Neurology also manages a selected group of patients through this process.

The threshold for the managed discharge process has been lowered from +52 week to 40 weeks within Gastroenterology, Dermatology and Neurology.

**Time Critical (high risk) patients**

The end of February saw a small increase in the number of time critical patients. As at 28th February 2017, 45% of the 5,602 time critical patients had been given a clinic date. 69% (3,874) of the time critical patients in backlog fall within a 3 month timescale with 22 patients having waited over a year, compared to 125 patients at the same time last year. As previously identified, the competing priorities for limited capacity continues to impact on the Trust's ability to reduce the number of time critical patients further.

The number of 'time critical' patients is higher compared to last year. There have been significant improvements made within Gastroenterology and Paediatrics over the last 12 months. The service lines with the largest volume of time critical patients, i.e. Ophthalmology, Neurology and Paediatrics are developing recovery plans to reduce the number of time critical patients.

The 'time critical' numbers are contributed to by patients who DNA. At the end of February there were 496 patients within this category who have been offered an appointment but have not attended, 348 of these patients are backlog time critical patients and remain on the waiting list within the backlog until they attend a further appointment. The Trust has been developing a local policy for follow up DNA's. The clinical sign off of this policy has taken longer than initially first anticipated as it is now being discussed at clinician level in the individual service lines.

Of the backlog 'time critical' patients there are 111 patients at the end of February where the booking teams are unable to book appointments as the patients are still awaiting investigations or a review of results.

**Future Plans**

Having made improvements through the robust systems of prioritisation and ensuring capacity is maximised, the Trust has reached a point where a further step improvement is required to continually significantly reduce the overall backlog and time critical numbers which is beyond the process improvement of the current systems and practices.

The large volume service lines have quantified the opportunity for joint working with primary care (mainly general practice) by reviewing patients on the follow up waiting list to determine if they can be managed in primary care, managed via a shared care model with primary and secondary care or if the patients need to remain in secondary care. Following on from this review of patients, a pilot with 6 GP practices has commenced to sample 150 patients per practice in Respiratory Medicine, Neurology and Paediatrics (50 patients per speciality). The review of patients is expected to be completed by mid - May and meetings arranged shortly after to gain clinician to clinician agreement as to which patients can return to primary care. The pilot will then be reviewed with regards to the potential of rolling out this process to all backlog patients in other GP practices.

The returning of patients to primary care will be managed through an organised structured process similar to the current managed discharge programme for the over 52 week wait FU patients.

Creating clinic capacity through identifying alternative working arrangements will help to secure the required capacity to ensure that time critical patients can be seen in the required timescales. This will not always be possible due to sub specialism i.e. not all capacity will be transferable to meet the specific needs of particular patient groups.

In addition to this work the Ophthalmology service have been working up a proposal to change the pathway so that patients who have a first, final and second, final cataract operation are followed up by a community optometrist; the service specification is expected to be completed by the end of April 2017. The Ophthalmology service has also

completed a pilot for virtual eye clinics for glaucoma and diabetic patients and 60% of patients reviewed were discharged back to primary care. The implementation plan for the roll out is expected to be completed by the end of April 2017. This would have the benefit of vastly improving the review time of these patients and help reduce the overall backlog due to the more timely response.

A review in urology of patients within the backlog with a booking category of 'Do Not Book' has been completed which has identified administrative and clinical issues around how patients are managed whilst on the waiting list. As a result of this review, work is about to begin to deliver changes in process to manage these patients in a more effective way to ensure they are removed from the waiting list at an appropriate time. This review of process is also to start five other high volume service lines.

**Incidents related to FU backlog**

In the last 6 months there has been one incident recorded on Datix in Ophthalmology related to the backlog in follow up .

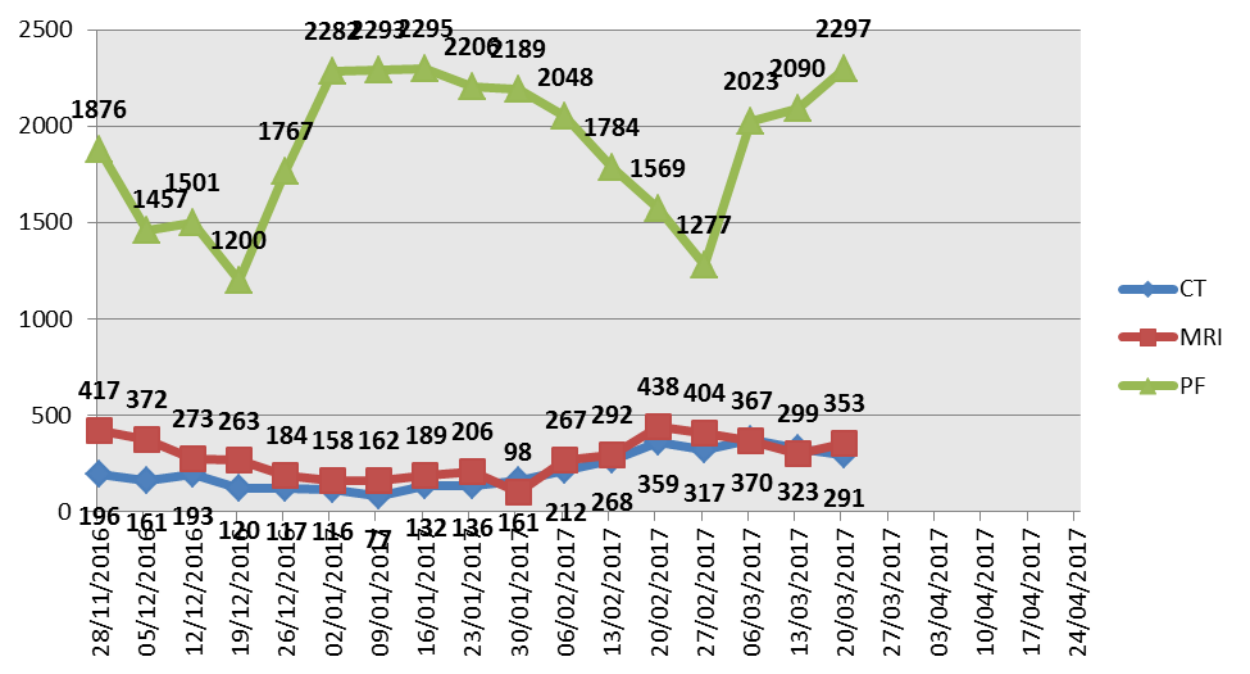
**SHOULD DO (Derriford): The provider should minimise risk and harm caused to patients through excessive waits on the reporting of images.**

**Current Performance**

The Planned outcome will be to meet the national targets for reporting. Provision of assurance will be a review of weekly performance. As part of the Service Line Strategy and assurance provision the Consultants Job Plans will be very transparent around reporting capacity. Once this has been completed (April 2017) an improved Capacity v Demand analysis can take place of reporting capacity to enable planning of the service demands going forward. Various staff members allocate exams to be reported to reporting consultants and this is overseen by operational management. Work has been undertaken to formulate this into a Standard Operating Procedure (SOP).

**Comment on Current Performance**

At present there are 4.08 WTE gaps in the Radiologist workforce. The reporting capacity lost through this is provided through outsourcing to 3rd party providers. Outsourcing of reporting is also used regularly to meet the additional images taken to meet the 6/52 standard when outsourcing of exams is performed. A weekly report is gathered and provided and shared with all imaging staff so reporting length of waits is communicated with both patients and referring clinicians including GP's. Below is a graph of all outstanding unreported diagnostic scans. Plain film reporting has deteriorated over the past few weeks and we are working to find a solution to the backlog. Of the 2297 noted above over 85% are at less than 7 days old. Around half of these are IP or ED attenders. We are working on a way of improving the process and timeliness of the auto reporting.




**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.4 | The Service Line will review the process for images awaiting reporting weekly and then monitor performance through weekly data charts. | Mark Walker | 30/06/17 |

**Update on Actions**

At present, imaging has a process where Images awaiting reporting are pushed to Reporters by the admin and clerical team who have vision of the reporters' annual leave and other absence. This is reviewed daily and longer than normal waiters are chased or removed from the relevant reporting Silos and subsequently reassigned. During times of reduced capacity outsourcing is used as a result to deliver timely exam turnaround times. A SOP has now been written to provide the service line with continuity of actions around allocation. A further 3rd party for external reporting is also being sought to improve further resilience for the reporting.

**SHOULD DO (Derriford): The provider should put process in place that ensure all diagnostic images that required documented evaluations have one.**

**Current Performance**

| Service Line | Last audited | Number audited | Written evaluation present? | Status |
|---|---|---|---|---|
| Pain | April-16 | 15 | 60% | Ongoing |
| Cardiothoracics | -- | 0 | | **Not started** |
| Dental & Max Fax | May-16 | 30 | 80% | Ongoing |
| General & UGI | -- | 0 | | **Not started** |
| Neurosurgery | Apr-16 | 15 | 93% | Ongoing |
| Plastic Surgery | Mar-17 | 30 | 65.5% | Audit ref: CA_2015-15-079 Rolling audit default audit tool not used |
| Trauma & Orthopaedics | Nov-16 | 50 | 90% | Ongoing |
| Urology | Jan-17 | 30 | 100% | Ongoing |

**Comment on Current Performance**

For those who have performed initial audits, the results have been extremely variable and follow up audits with action plans to improve will be required. These actions are an important way of reducing this known risk to our patients.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.5 | The Radiology Service Governance Manager will perform an audit of service lines who should be documenting all auto reports in the patients notes. | Mark Walker/Kylie Glynn/Brent Drake | 30/06/17 |

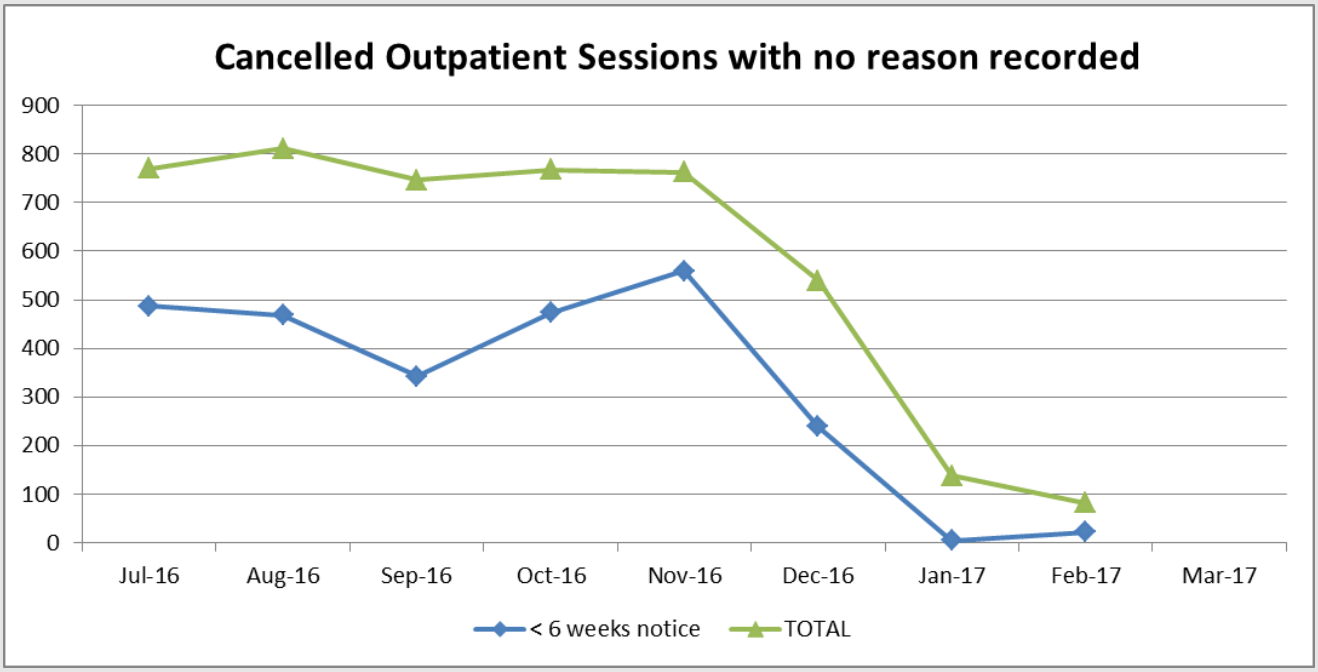
**Update on Actions**

The Radiation Protection Committee Chair has written to the Care Groups to ensure that audits are now performed with completion within the next two months and this action is placed on the associated service line risk register. Audits which have not commenced will be chased and enforced by a member of the Executive team who sits on the RPC board.

**MUST DO: Reduce the number of clinics cancelled and capture the reasons why.**
**SHOULD DO: Ensure staff comply with annual leave policy when cancelling sessions with less than six weeks notice to patients.**
**(Derriford and Mount Gould)**

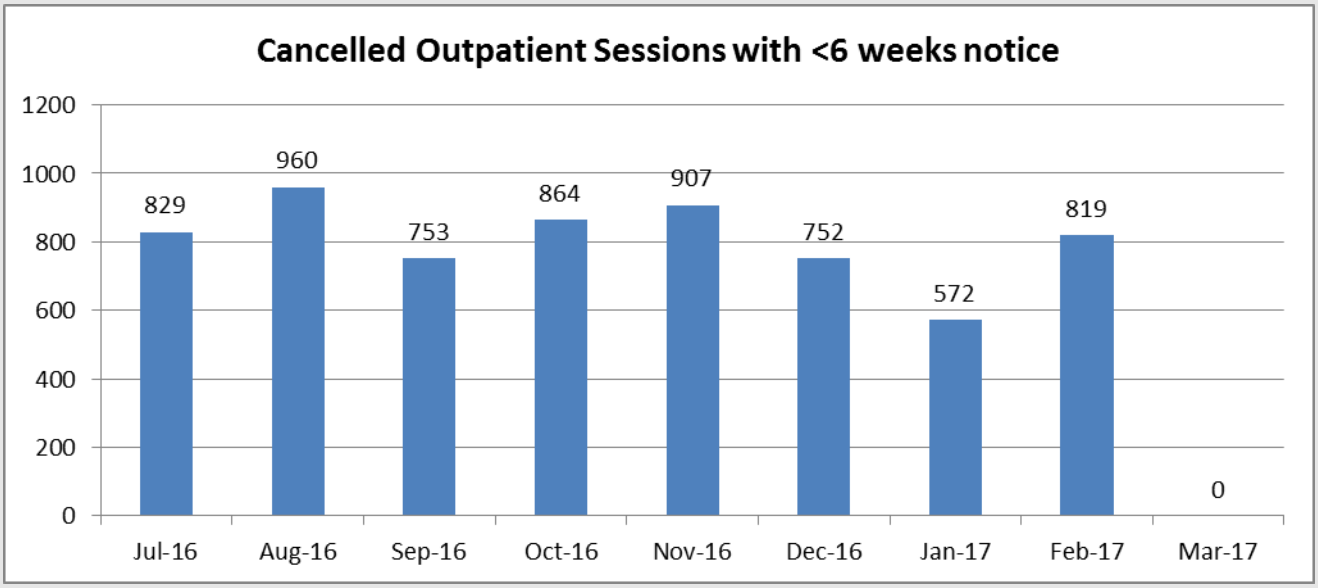
**Current Performance**

**Graph 1: Completeness of "reason for cancellation" recording**




| | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 |
|---|---|---|---|---|---|---|---|---|
| < 6 weeks notice | 487 | 469 | 342 | 474 | 559 | 239 | 5 | 22 |
| >6 weeks notice | 283 | 342 | 404 | 294 | 204 | 300 | 133 | 60 |
| **TOTAL** | **770** | **811** | **746** | **768** | **763** | **539** | **138** | **82** |

**Graph 2: No. of Outpatient Sessions Cancelled with <6 week notice**




**[Note: excludes short notice cancellations due to sick leave, special leave & capacity not required)**

**Comment on Current Performance**

Graph 1 shows how the level of sessions with no cancellation reason recorded has been reasonably consistent but, following a notice to all staff in November that this was now mandatory, an improvement in performance has been seen since December 2016 with best performance to date being seen in February 2017; 82 with no reason recorded which equates to 5.7%.

Graph 2 shows that the total number of outpatient sessions cancelled with < 6 weeks notice has ranged from 752 to 960 during the months of July 2016 to December 2016. An improvement was seen in January 2017 but February 2017 has seen a return to previous levels.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.6 | 1. Amend Access Policy to make recording of clinic cancellation reason mandatory. | Sam Sheridan | 31/01/17 – complete & closed |
| | 4. Publicise number of clinics cancelled with < 6 weeks notice at Service Line Level - understand reasons why and develop actions to combat areas where cancellations are not reasonable e.g. due to annual leave. | Jacqui Beer | 31/03/17 |
| | 5. Agree escalation policy for sessions cancelled with < 6 weeks notice as they happen - reporting mechanism required. | Graeme Hemsley | 28/02/17 |

**Update on Actions**

The Access Policy has been amended to make recording of the clinic cancellation reason mandatory.

The need to record the reason for cancellation of Outpatient sessions is also being emphasised at the monthly RTT meeting where all Service Line Management Teams attend. Information showing levels of unrecorded reasons and those cancelled with < 6 weeks notice is being publicised on a regular basis along with the iPM Users involved.

The current report shows which specialties still have some data quality issues (see table below).

| Specialty | 6 Weeks Plus | Less than 6 weeks | Grand Total |
|---|---|---|---|
| Paediatrics | 23 | 2 | 25 |
| Anaesthetics | 8 | | 8 |
| Diabetic Medicine | 8 | | 8 |
| Neurosurgery | 2 | 3 | 5 |
| Uro - Gynaecology | | 5 | 5 |
| Obstetrics | 4 | | 4 |
| Neurology | 4 | | 4 |
| Clinical Immunology | 2 | 1 | 3 |
| Rheumatology | 2 | | 2 |
| Thoracic Medicine | 1 | 1 | 2 |
| Audiological Medicine | | 2 | 2 |
| Cardiology | | 2 | 2 |
| Clinical Haematology | 2 | | 2 |
| Gastroenterology | 1 | 1 | 2 |
| Maxillo Facial Surgery | | 2 | 2 |
| Clinical Oncology | 1 | | 1 |
| Clinical Biochemistry | 1 | | 1 |
| Gynae - Hysteroscopy | | 1 | 1 |
| Nephrology | | 1 | 1 |
| Orthodontics | 1 | | 1 |
| Pain Management | | 1 | 1 |
| Grand Total | 60 | 22 | 82 |

Paediatrics is still showing as having the most clinics cancelled without a reason recorded. This has been investigated and is due to the fact that the majority of these clinics were cancelled back in the autumn of 2016 before the mandate was established.

A new report has been set up to monitor the issue in-month to ensure all are recorded accurately prior to the month end

reporting.

Now that the data quality is improving we can review the reasons each month with more confidence.

The table below shows the data of all cancelled sessions with < 6 weeks notice for February 2017. Currently we are classifying the following reasons as acceptable for short notice cancellation: Sick leave, Special leave & Capacity not required. The data is now being shared with the Service Lines to review. "Annual leave" is the largest cohort and work is underway with the key Service lines to understand why this is happening; anecdotally we are being told that the correct notice is being given but there is a delay in recording this on iPM.

| Canc Reason | Total |
|---|---|
| Annual Leave | 303 |
| Clinic Profile Change | 102 |
| External Duties | 49 |
| Management Commitments | 65 |
| No reason Given | 22 |
| Study Leave | 55 |
| Support Staff Unavailable | 142 |
| Take Commitments | 70 |
| Theatre - Awaiting new Consultant | 1 |
| Theatre - Consultant unavailable - Annual leave | 2 |
| Theatre - Consultant unavailable - Other | 3 |
| Theatre - See Comments | 4 |
| Theatre - Session entered in error | 1 |
| Grand Total | 819 |

The escalation policy has been drafted and been out to consultation with the Care Groups. It is hoped that this will be agreed and signed off by OPDG before the end of March 2017.

**SHOULD DO (Mount Gould): Consider reviewing risk registers, to enable risks to be captured by site.**

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.7 | Risk Management Review Group to consider the feasibility of adding offsite locations to Datix to enable risks to be captured by site. | Steve Mumford | Complete and closed |

**Update on Actions**

We have enabled the 'Unit' field to the Risk Register module of Datix (as set up on the Incident module) which allows new risks to be captured by site. The list of offsite locations detailed under the 'Unit' field have been reviewed and updated. The list now contains the following offsite locations:

- Cumberland Centre
- Derriford Hospital
- Kingsbridge Hospital
- Launceston Hospital
- Liskeard Community Hospital
- Mount Gould Hospital
- Plymouth Dialysis Unit
- Royal Cornwall Hospitals Trust (Treliske)
- Scott Hospital
- Stratton Hospital
- Tavistock Hospital.

**SHOULD DO (Mount Gould): Consider reviewing cleaning audits carried out by external companies in relation to the environment in the outpatient, diagnostic imaging and pain management. Review its systems and process which give assurance that services delivered by external companies are carried out in a way that keeps people safe.**

**Current Performance**

To be determined.

**Comment on Current Performance**

To be determined.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 8.8 | 1. Implement appropriate measures into the Inter Trust Agreements in the new contracting round for 17/18.<br>2. Implement requirement for quarterly contract monitoring reviews where we look at quality of care, risks and issues, incidents and manage patient feedback etc. | Chris Rapson | 30/03/17 |

**Update on Actions**

Requirement for Quarterly reviews has been built in to new Inter Trust Agreements and agreed with other providers. Specific schedules for all services still to be completed. Agreement for 1st Quarterly review to take place in April 17. Working to finalise list of attendees from each organisation

**SHOULD DO (Mount Gould): Consider reviewing secretarial staff numbers to help clear the typing backlog of Mount Gould clinic letters. Ensure the digital dictation system is fully implemented to help reduce typing delays at Mount Gould Hospital.**

**Current Performance**

**Graph 1: No. of letters awaiting typing at end of each month with > 5 days delay**

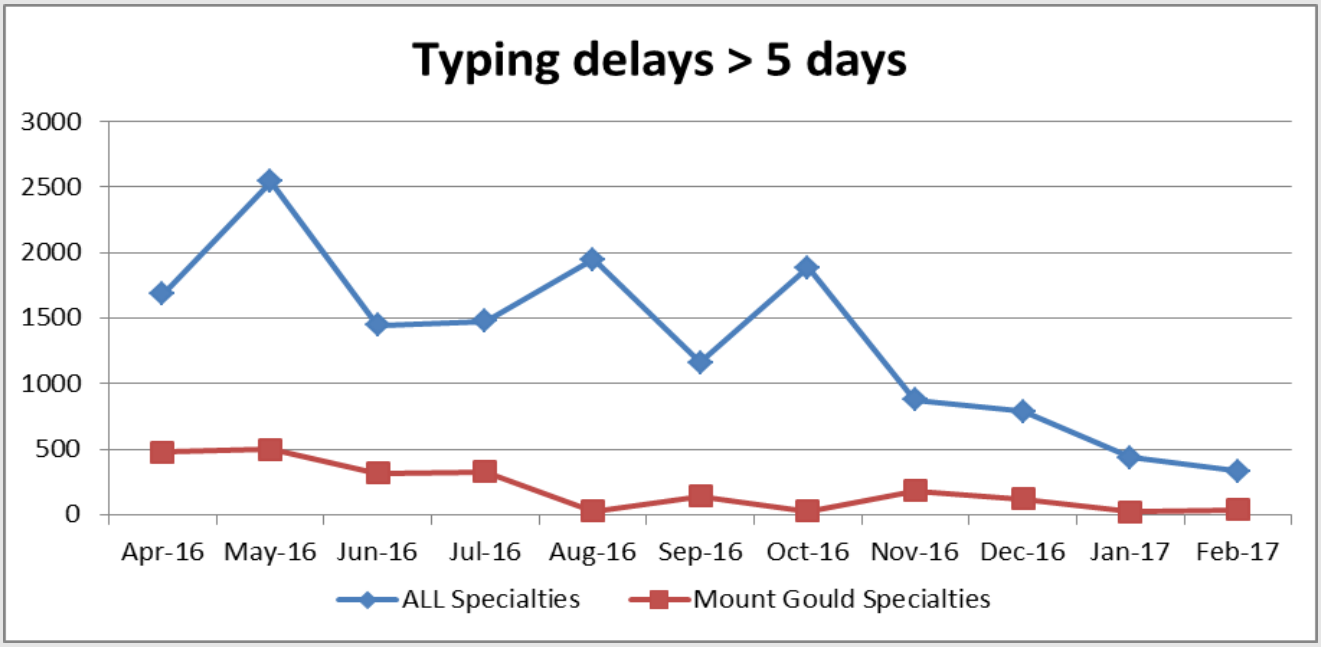



**Table 1: No. of letters awaiting typing at end of each month with > 5 days delay for specialties that have some clinics at Mount Gould Hospital**

| Mount Gould Specialties | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Endocrinology & Diabetes | 1 | 0 | 0 | 20 | 0 | 2 | 0 | 4 | 0 | 0 | 0 |
| ENT | 0 | 9 | 14 | 0 | 11 | 0 | 11 | 0 | 0 | 0 | 0 |
| Health Care of the Elderly | 1 | 3 | 47 | 5 | 0 | 0 | 0 | 0 | 22 | 12 | 0 |
| Neurology | 279 | 157 | 124 | 172 | 2 | 93 | 2 | 31 | 5 | 5 | 0 |
| Ophthalmology | 27 | 82 | 86 | 81 | 0 | 0 | 0 | 8 | 4 | 3 | 0 |
| Orthopaedics & Trauma | 27 | 63 | 2 | 0 | 0 | 28 | 0 | 7 | 3 | 0 | 27 |
| Pain Management | 0 | 0 | 0 | 41 | 0 | 0 | 0 | 92 | 62 | 0 | 0 |
| Rheumatology | 0 | 137 | 0 | 0 | 13 | 15 | 13 | 9 | 0 | 0 | 0 |
| Thoracic Medicine | 142 | 38 | 46 | 9 | 1 | 2 | 1 | 12 | 3 | 5 | 14 |
| Upper GI HPB | 0 | 8 | 0 | 0 | 0 | 0 | 0 | 20 | 21 | 0 | 0 |
| Upper GI OG | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL Mount Gould Specialties** | **477** | **497** | **319** | **329** | **27** | **140** | **27** | **183** | **120** | **25** | **41** |

**Information on digital dictation usage to be developed.**

## Comment on Current Performance

**Typing delays**

Graph 1 shows that the number of letters with a typing delay of greater than 5 days has been reducing since May 2016. In May 2016 the number was 2,541 compared to end of February 2017 when the number was 332; a reduction of 2,209 delays.

We are not able to separate letters for patients who attended Mount Gould hospital accurately so the graph also shows the position for all specialties who have some activity at Mount Gould as a proxy. It can be seen that this number has also reduced from 497 in May 2016 down to 41 at the end of February 2017; a reduction of 456 delays.

Table 1 shows these numbers broken down by specialty (where some activity occurs at Mount Gould) and demonstrates that the 2 specialties with the greatest number of delays in April 2016 (Neurology & Thoracic medicine) have improved significantly. Now only very low numbers exist in a few specialties and this is being monitored weekly to manage.

The wider Trust position is also being actively managed. The table below shows the 6 specialties that contribute to 92% of the delays.

| | |
|---|---|
| Urology | 152 |
| Thoracic Medicine (Junior) | 45 |
| Neurosurgery | 37 |
| Orthopaedics & Trauma | 27 |
| Maxillo Facial Surgery | 23 |
| Cardiology | 21 |

**Use of Digital dictation**

Digital dictation has been rolled out across the organisation with, based on the original scope of the project, only 1 clinician not taking advantage of the new technologies. Work is in progress to develop an automated way of assessing whether all currently employed clinicians are using the technology.

## Planned action

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

| | | | |
|---|---|---|---|
| 8.9 | 1. Review current secretarial staff numbers at Service Line level. | Sam Sheridan | 30/06/17 |
| | 2. Create a methodology to assess level of secretarial staff needed to carry out required functions within Trust standard timescales. | Sam Sheridan | 30/06/17 |
| | 3. For Service Lines with backlogs of typing (>5 days), create an action plan for improvement which may involve Transformation Team input to redesign processes. | Jacqui Beer/Louise Shalders | 30/06/17 |
| | 4. Report any clinicians not yet using the digital dictation system to the Medical Director. | Jacqui Beer | 31/03/17 – Complete with monitoring ongoing |
| | 5. Support those individuals to switch to required technology. | Sam Sheridan | 31/03/17 – Complete with monitoring ongoing |

**Update on Actions**

**Review of secretarial staff numbers**

Due to lack of engagement from the Service lines with regard to this work, a slot has been reserved at the Operational Performance & Delivery Group meeting on 11th April 2017 to gain agreement on a way forward.

**Action plans for Typing delays**

Despite the improvement already seen, work continues to identify specialties where the number of > 5 day delays remains too high. The Transformation Team have worked with Gastroenterology and Hepatology to review processes and staffing levels, the result being zero typing delays as at the end of November 2016; this remains the case through to the current time. This work is planned to be rolled out across more specialties as part of the Elective Care Transformation Programme.

**Update on specialties with the remaining backlogs:**

Urology – due to absence but being actively managed by sharing workloads

Thoracic Medicine - short term issue relating to absences

Neurosurgery – been improving for last 2 months

Orthopaedics – short term issue relating to annual leave

Maxillo-Facial Surgery - short term issue relating to absences

Cardiology - been improving for last 2 months

**Use of Digital dictation**

Support has been provided to the Service Line with the non-Users. The one remaining non-User has now agreed to commence use of the new Digital Dictation system from the 1st April 2017 following return of a device which is being repaired.

# Staffing and Training

**MUST DO: Ensure safeguarding training for staff in the emergency department and across all areas is completed to ensure trust compliance targets are met.**

**Current Performance**

| Area | Month | Level 1 | Level 2 | Level 3 |
|---|---|---|---|---|
| ED | March 2017 | 100.00% | 95.12% | 86.71% |
| ED | February 2017 | 100.00% | 100.00% | 84.9% |
| ED | January 2017 | 100.00% | 100.00% | 88.65% |
| ED | October 2016 | 100.00% | 95.00% | 78.42% |
| Trust wide training | March 2017 | 98.20% | 90.66% | 84.86% |
| Trust wide training | February 2017 | 97.8% | 90.2% | 83.2% |
| Trust wide training | January 2017 | 97.86% | 90.39% | 84.52% |
| Trust wide training | October 2016 | 97.62% | 90.34% | 75.47% |

**Comment on Current Performance**

Training at all levels continues to be monitored and reported on at departmental and organisational level. Local Safeguarding Children's Board trainers have been accommodating in allowing increased numbers of staff to be trained at level 3. Safeguarding team continue to monitor training figures and encourage staff and individual practitioners compliance.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 9.1 | 1. Identify staff who are non-compliant and send reminders regularly to individuals and to managers as appropriate - Complete<br>2. Contact LSCB trainer to agree that we can book more staff onto each course to try to improve compliance - Complete.<br>3.Safeguarding team to direct staff who have completed the basic course previously to other more specialist Level 3 courses with more capacity available - Complete.<br>4. Working with LSCB lead trainer, arrange further review of training spaces available to allow PHNT to access any free places between now (Nov 2016) and March 2017.<br>5.In liaison with LSCB lead trainer, on completion of review of current places available at level 3 LSCB training, they will consider provision of more basic courses with half the spaces available to health staff. This will increase the amount of spaces available for Level 3 basic safeguarding training in the New Year. | Alison O'Neill Named Nurse Safeguarding | Improvement expected month on Month with 100% compliance aim by April 2017 |

**Update on Actions**

Training department and safeguarding team have been working at ensuring accuracy of recording staff at the right level of training need and this has improved over the last 12 months. There have been amendments to training status to ensure staff are allocated to the correct level. This will continue to be monitored regularly. Staff who are not compliant have been reminded via practice educators or individually as appropriate. Trust safeguarding training report is reviewed at the Safeguarding Steering group bi-monthly.

A review of the Trust target will be undertaken at the next Safeguarding Steering Group in May to determine whether this should be re-set.

**SHOULD DO: Use clearer processes in order to be able to identify and evidence, at all times, the percentage of staff across the trust who were compliant with mandatory and role specific training. This would also provide greater safety assurance at service line, care group and trust levels that governance information was reliable and valid.**

**Current Performance**

**Trustwide:**

| | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Basic Life Support | 83% | 85% | 85% | 86% | 86% | 84% | 83% | 83% | 84% | 86% | 84% | 84% |
| Manual Handling | 91% | 91% | 92% | 92% | 91% | 92% | 92% | 91% | 91% | 91% | 91% | 91% |
| Trust Update | 84% | 85% | 85% | 86% | 86% | 86% | 86% | 86% | 86% | 86% | 87% | 88% |
| Child Protection | 91% | 92% | 92% | 92% | 92% | 92% | 91% | 91% | 92% | 92% | 92% | 92% |

**Maternity:**

ILS and BLS: 91% in date

Manual handling: 92% in date

Child protection: 86% in date

PROMPT: 99% attendance

Neonatal life support: 65% in date (48 midwives are booked for training, 12 are awaiting availability of training)

Water birth training: 18% in date – it is anticipated that 90% of staff will be trained by end of 2017. At least 1 member of staff is trained at evacuation of the pool on every shift.

Aseptic non touch technique: 92% in date.

**Comment on Current Performance**

A full review of mandatory training has been undertaken by the L&OD department to ensure that all aspects of mandatory training are relevant to the staff member undertaking them as well as giving assurance around compliance. HR Business Partners are supporting Care Groups with plans to improve mandatory training compliance performance within Service Lines.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 9.2 | Trustwide:<br>1. A reminder of how to access training information will be sent to all managers and the senior management team.<br>Maternity & Gynaecology:<br>2. Practice Development Midwife will publish the training matrix percentage of staff in training in the maternity newsletter on a quarterly basis.<br>3. Practice Development Midwife will send all training matrix to Matrons and clinical risk manager on a quarterly basis. | 1. Bill Chapman<br><br>2&3. Sue Wilkins | 1. 31/01/17 - Complete<br><br>2&3. 30/04/17 |

**Update on Actions**

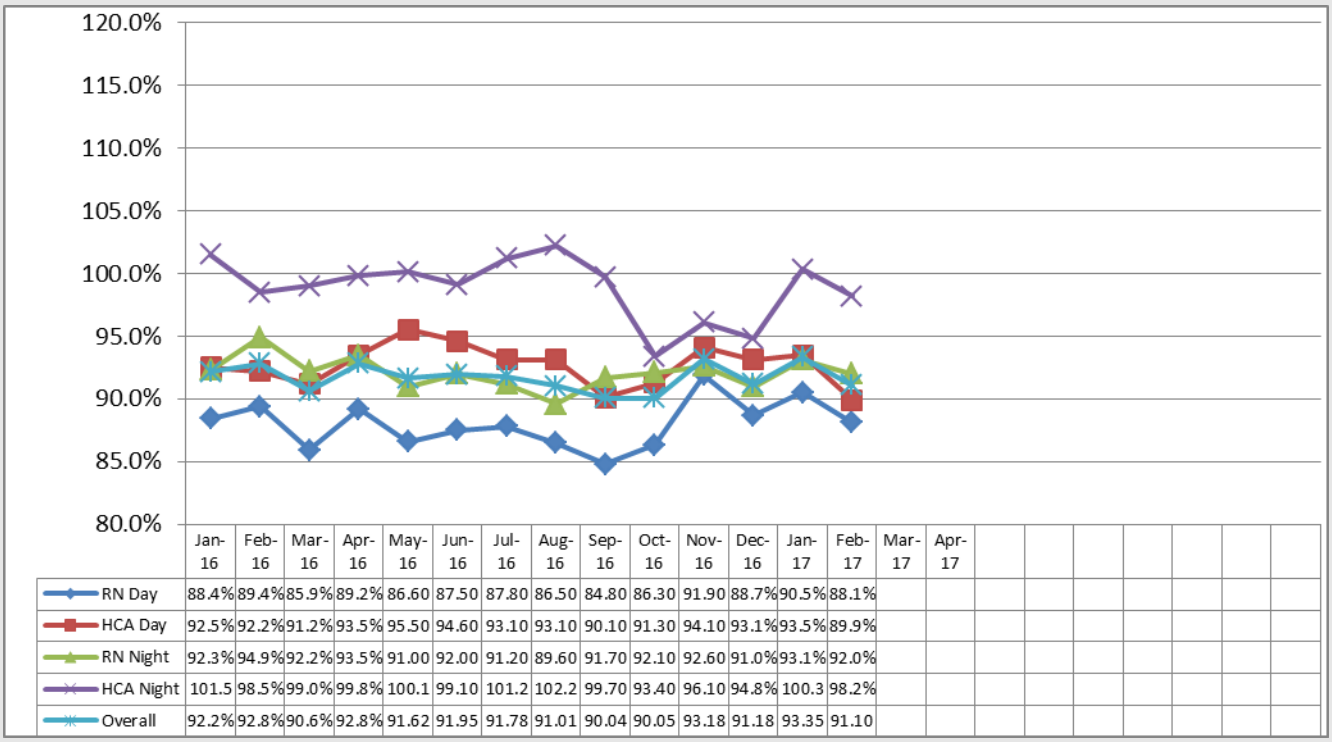
Action 1 complete.

Maternity training matrix due end April17 then every quarter moving forward.

**SHOULD DO: The provider should ensure that all wards and departments are adequately staffed.**

**Current Performance**

**Fill rates for February 2017**:




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RN Day | 88.4% | 89.4% | 85.9% | 89.2% | 86.60 | 87.50 | 87.80 | 86.50 | 84.80 | 86.30 | 91.90 | 88.7% | 90.5% | 88.1% | | |
| HCA Day | 92.5% | 92.2% | 91.2% | 93.5% | 95.50 | 94.60 | 93.10 | 93.10 | 90.10 | 91.30 | 94.10 | 93.1% | 93.5% | 89.9% | | |
| RN Night | 92.3% | 94.9% | 92.2% | 93.5% | 91.00 | 92.00 | 91.20 | 89.60 | 91.70 | 92.10 | 92.60 | 91.0% | 93.1% | 92.0% | | |
| HCA Night | 101.5 | 98.5% | 99.0% | 99.8% | 100.1 | 99.10 | 101.2 | 102.2 | 99.70 | 93.40 | 96.10 | 94.8% | 100.3 | 98.2% | | |
| Overall | 92.2% | 92.8% | 90.6% | 92.8% | 91.62 | 91.95 | 91.78 | 91.01 | 90.04 | 90.05 | 93.18 | 91.18 | 93.35 | 91.10 | | |

| | Feb-17 |
|---|---|
| RN Day shift | 88.1 |
| HCA Day shift | 89.9 |
| RN Night shift | 92.0 |
| HCA Night shift | 98.2 |
| Overall | 91.10 |

**Comment on Current Performance**

The monthly safer staffing figure for February 2017 is 91.10 % overall which is slightly down on the previous month's safer staffing figure. This continues to reflect the current vacancy rate and the challenges with filling vacancies across the South West. NHSI are visiting the Trust this month to test the new nursing ward dashboard which forms part of the model hospital; our staff will be able to influence how staffing levels are reported nationally. Staffing levels and patient acuity and dependency continues to be recorded in real time using the Safe Care system and is reviewed continuously throughout the twenty four hour period and via staffing meetings. The current nursing workforce position has remained stable over the last 6 months and an establishment review is about to commence.

**Planned action**

| Ref | Action | Lead | Deadline |
|---|---|---|---|
| 9.3 | Immediate and Ongoing<br>1. Continue to actively recruit to all vacant posts utilising financial incentives where approved by the executive director.<br>2. Manage all department staffing rosters using Healthroster.<br>3. Maintain daily use of safecare acuity and dependency to ensure safe staffing in real time.<br>4. Implement safe care on Postbridge by end Jan-17 to give | Bev Allingham | 31/12/17 |

| | | | |
|---|---|---|---|
| | visibility to the staffing on Postbridge when it is opened as an inpatient area. Complete.<br>5. Implement Safe care in theatres to provide visibility of the non-medical staffing in each theatre to assess the safety of the staffing and any gaps.<br>6. Review individual areas to see if it is possible to safely and effectively introduce additional non-registered roles. This will mean a change to the skill mix requiring agreement by Director of Nursing and agreement at ERP before recruitment.<br>7. Work towards delivering the trust Recruitment and Retention plan; making revisions where gaps are identified.<br>8. Research and investigate how best to cross fertilise staff within different specialist departments.<br><br>Long Term<br>9.Respond to any changes in bed base or bed modelling with appropriate staffing solutions. | | |

**Update on Actions**

The level of vacancies in the Trust remained static between January 2017 and February 2017. Minor budget changes have meant that the percentage vacancy rate has decreased marginally from 8.71% to 8.69%. It should also be noted that our overall levels of staff in post have increased by over 172 FTE staff in post over the past 12 months. Rolling annual turnover to the end of December 2016 is at 11.00% compared to 11.77% for the year to December 2015.

The 12 month rolling average to end February 2017 shows that sickness has increased over the past 12 months to 4.14% (from 3.9% from the same period in 2016) against a target of 3.5% and the key staff areas with the highest levels of sickness are professional and technical staff and additional clinical services (HCAs).

We continue to review our processes in order to provide further reductions in recruitment timeframes and have been working with OHWB to reduce the Occupational Health Lead times. This will also provide significant assistance when recruiting the preceptees for 2017 for which we are currently forecasting greater numbers than in 2016.

Final work is underway to complete the rebranding of our advertising via the website and social media. On Twitter, we have introduced a 'Job of the Week' tweet which has seen a good response and have continued to offer and support department advertising through social media.

We have had an extremely successful Open Day for Medicine on the 21st January which appointed 50 new Nursing staff and our latest Open Day on the 11th March 2017 for Surgery and Medicine which appointed another 26 new nursing staff. After our attendance at the ODP event in Swindon, we also invited and ran an Open Day for ODPs and Scrub Nurses which resulted in appointing 8 new staff into Theatres. We will also be attending the Nursing Times Event on the 30th March as part of our regional initiative to introduce nurses to the County in partnership with RD&E, DPT and Torbay. Further internal PHNT open days are now being scheduled.

We continue to recruit in small numbers with 4 EU nurses joining in late February. We are providing interviews for a further 4 candidates on Friday 17th March and reviewing future intakes and the Radiography intake over the next few months.

## Actions Completed and closed

| Ref | Core Service | Requirement | Action Taken |
|---|---|---|---|
| 1.6 | Urgent & Emergency | Review the storage of intravenous fluids in the emergency department to prevent tampering. | Added locks to cupboard. |
| 1.13 | Urgent & Emergency | Ensure patients arriving at the emergency department by ambulance are protected from the elements as best as possible. | The initial plans have now been reviewed and are not considered to be appropriate. The costs for this were prohibitive and also required planning permission, hence the reason it will now be considered as part of the scheme to develop ED. |
| 1.15 | Urgent & Emergency | Review the hospital's procedure for crowding in the emergency department to include the actions required by the wider hospital in order to support safe patient care. | New policy in draft and has been presented to OPDG Tuesday 14th March 2017. Policy produced in conjunction with Care Groups and is being tested live with ongoing developments. The policy is being developed with the CCG to align plans with the community. |
| 1.17 | Urgent & Emergency | Progress the work to install an adequate area for the preparation of medicines in the resuscitation area of the emergency department. | Completed and in use. |
| 1.21 | Urgent & Emergency | Ensure staff in the emergency department all have name badges which include the role they are in. Consideration should also be given to providing patients with a leaflet that details the different types of uniforms and what they designate. | The provision of name badges to all staff has been completed and checks undertaken at team review. All Consultants and Registrars have named scrub tops. The junior doctors have name badges with "Hello my name is ...." given to them just after they arrive. |
| 2.3 | Medicine | Encourage staff to report mixed-sex breaches. | Published awareness across the trust regarding the need to report mixed sex breaches. |
| 2.7 | Medicine | The provider should ensure that patient records are consistently completed and are kept up to date. | Completed a pilot of the new risk assessment booklet. Roll out of assessment booklet across the adult inpatient areas completed Fundamentals of care audits embedded in this report show attainment above the 95% standard. The Heads of Nursing plan to review all ward areas with the Nursing Assessment and Assurance Framework (NAAF) audit in Autumn 2017. |

| Ref | Core Service | Requirement | Action Taken |
|---|---|---|---|
| 3.1 | Surgery | Review why surgery has received the most complaints. | An analysis of the 2016 complaints has been completed. The reasons for complaints within Surgery are discussed at the Care Group Governance Meeting. Reviewing of complaints and PALs themes forms part of the forward work plan for the Care Group Governance Meeting and is part of the assurance framework when service lines present to the Care Group. |
| 3.3 | Surgery | Continue to look at ways of reducing the number of cancelled operations and the numbers not re-booked within the 28-day time scale. Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks. | Theatre Improvement Programme in place. |
| 3.6 | Surgery | Make sure chemicals and substances that are hazardous to health are secured and not accessible to patients and visitors in the Fal unit sluice area. | The only hazardous substance in the Fal sluice is actichlor tablets which have been removed and stored appropriately in the Postbridge sluice yellow metal (COSHH) cupboard. A notice has been put up in Fal sluice informing staff of the new storage location and instructing that they are not to store actichlor tablets in an unlocked cupboard. |
| 8.6 (part) | Outpatients | Reduce the number of clinics cancelled and capture the reasons why. Ensure staff comply with annual leave policy when cancelling sessions with less than six weeks notice to patients. | The Access Policy has been amended to make recording of the clinic cancellation reason mandatory. |
| 8.7 | Outpatients | Consider reviewing risk registers, to enable risks to be captured by site. | We have enabled the 'Unit' field to the Risk Register module of Datix (as set up on the Incident module) which allows new risks to be captured by site. The list of offsite locations detailed under the 'Unit' field have been reviewed and updated. |

## Actions Completed and evidence to be submitted

| Ref | Core Service | Requirement | Action Taken |
|---|---|---|---|
| 1.1 | Urgent & Emergency | Commence Super Wednesday every third Wednesday of the month which will review governance framework / actions with a recorded auditable trail. | All governance and safety business meetings are agenda'd and minuted and held on the ED Clinical Governance shared drive that is accessible for the whole department – clinical / admin / managerial employees. This has been in place since November 2016. |
| 1.2 | Urgent & Emergency | Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny. | Team has completed admin review. This has identified further work to be carried out. A time, motion assessment will be completed with the help of Service Improvement. |
| 1.3 | Urgent & Emergency | Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed. | January audit complete and plan to repeat this monthly. |
| 1.10 | Urgent & Emergency | Review the paediatric unit in the emergency department to ensure it is adequately secure to keep children safe. | Implemented Spot Checks on door lock. |
| 1.11 | Urgent & Emergency | Ensure patients in the minors' waiting area in the emergency department are observed so any deterioration can be quickly responded to. | Triage nurse increased awareness of minor patients to team. |
| 1.12 | Urgent & Emergency | Ensure all patients awaiting X-ray in the emergency department who are not escorted have access to the portable call bell in accordance with the department's standard operating procedure. | Ensured that Porters are aware of the need to attach portable call bells to all trolleys when patients are awaiting X-ray. |
| 1.14 | Urgent & Emergency | Review the transfer team in the emergency department to ensure that when patients are transferred to a ward a clinically safe handover is completed in all cases. | Spreadsheet commenced to record any transfer related incidents and if occurs will transfer to Datix for action. SBAR form has now been pre-printed on part B admission booklet. |
| 1.18 | Urgent & Emergency | Ensure wasted controlled drugs in the emergency department are disposed of in accordance with trust policy. | Medicines management to be repeated at team review in the near future. Fiona Veale to complete questionnaire for staff to check knowledge. |
| 1.19 | Urgent & Emergency | Review and upgrade computer systems in the emergency department to allow integration with wider hospital | EDIS / SALUS / IPM remain isolated at present. This is an ongoing issue. The only effective solution would be the procurement of an electronic |

| Ref | Core Service | Requirement | Action Taken |
|---|---|---|---|
| | | systems.(IT/CT issue). | patient record with a cost of c£40m. Surgeon Commander Henning is working with IMandT to ensure systems are as integrated as they can be. He is working on a pioneering link between iCM and EDIS. Also introducing SALUS to CDU and effecting a wider rollout of ADF terminals into the main ED. This will be an ongoing piece of work. |
| 1.20 | Urgent & Emergency | Ensure computer records are adequately secured when computers are left unattended to prevent unauthorised access. | Screen savers come on automatically. |
| 3.9 | Surgery | Make sure that all staff ideas are listened to and reasons given if they cannot be actioned.(Interventional Radiology) | Daily team brief implemented at 08:30. There is also a Staff meeting held on CME mornings. The actions have been completed and this is now routine which will be monitored by the matron for the area. |
| 6.1 | Children and Young People | Consider staffing allocation to allow for management and supervision from senior staff in all paediatric areas. | Community: Monthly meetings now set for continence team; records to be kept. Closed action 9/2/17 SMT agree that minutes of supervision are available.<br>Acute: Supervisory role of Ward Managers reviewed. 24/7 support from paediatric senior nurse in place if Ward Manager not available due to days off, annual leave etc. Matron available weekdays and Ward Managers also cross cover. |
| 6.2 | Children and Young People | Ensure height and weight measurements of children are readily available for staff prescribing<br>medications. | Community: Email to staff sent to remind them that children should be weighed at each appointment and if prescribing. SMT have agreed that this will be added to the yearly records audit for monitoring.<br>Acute: Staff reminded via email reminder. Fundamentals of Care change request submitted so compliance can be audited. |
| 6.3 | Children and Young People | Ensure only current medicine guidance is available in all paediatric areas. (BNF) | All removed from CDC.<br>All removed from Level 12 and Plym by Paediatric Pharmacist. |
| 6.5 | Children and Young People | Make sure the equipment log is up to date with all servicing of equipment. | Community: All equipment checked and now up to date and on one database. Ongoing checking process in place and monitored by specific staff. Database will be monitored by Service line governance group. |

| Ref | Core Service | Requirement | Action Taken |
|---|---|---|---|
| | | | Acute: Link nurses identified for paediatric wards and equipment. Log obtained from MEMs, cross checking in place. |
| 7.2 | End of Life Care | Ensure that local audits for the 'Last days of Life Care Plan' are put in place to provide evidence or any changes needed in practice. | Audit completed, Plan to be presented to EOL Committee April 17 and integrated with overall EOL plan. |