ACTION PLAN

Project Title:	**CQC Action Plan**		
Programme:	**2018**		
Senior Responsible Owner (SRO):	**Greg Dix**	**Project Ref:**	v1.1
Project Lead:	**Julie Morgan**	**Date:**	13/09/2018

NHS University Hospitals Plymouth NHS Trust

Ref No.	GYR Status	Domain (SCERW)	Requirement Notice	Area for Improvement	Core Service	Executive Lead	Planned Action(s)	Financial Impact (where relevant)	Planned Outcome and how will you ensure ongoing assurance of compliance?	Responsible Lead	Target Completion Date	Status	Actual Date Completion	Percentage Complete			
														25	50	75	100
Urgent and Emergency																	
1.1	G	Safe	**MUST DO**	Urgently progress the redesign of the emergency department to ensure there is adequate space to care for patients safely and that patient needs are met.	Urgent & Emergency	Chief Operating Officer	1.HM Treasury approval of capital monies required for the progression of the written Strategic Outline Case. 2. Full project management to deliver strategic plan. Project Board to be developed.	Capital Project - see business case	**Planned outcome** Sufficient space to accommodate the current numbers of patients attending the Department: inclusive of resus and paediatric capacity. Infection control standards met through reduction in clutter. Improved privacy and dignity. Security arrangement for paediatric area meets requirements. **Ongoing Assurance** Trust Management Executive. Trust Board. Care Group Board: Oversee progression of improvement, escalating to corporate level that which is not within the care group management team's gift to resolve. Service line business pillar.	Redacted	31/03/2023						
1.2	G	Safe	**MUST DO**	Provide sufficient equipment to monitor patients at all times.	Urgent & Emergency	Chief Nurse	1. Project plan and manage the expansion of the resus capacity into majors once minors has been relocated to provide a step down monitored area. 2. Purchase or arrange short term loan via Medical Equipment Library of essential mobile observation equipment for those patients held in the central area when crowded.	Capital expenditure cost to be determined by the Planning Team.	**Planned outcome** Reduce the need to locate patients in the central corridor. Essential equipment will be readily available to monitor patients held in the central ED area when the department is crowded. **Ongoing Assurance** Trust Management Executive. Trust Board. Service line governance pillar to confirm the action has been completed and how.	Redacted	01/12/2018						
1.3	G	Safe	**MUST DO**	Ensure patients are observed, or at least have the means to call for assistance, when waiting outside X-ray.	Urgent & Emergency	Chief Nurse	1. Install fixed alarm call bells in the waiting area outside ED imaging department. 2. Collaborate with Imaging to write a Standard Operating Procedure (SOP) detailing roles and responsibilities between ED and ED Imaging for observing and monitoring patients. 3. Scope ability to revise the department's fundamentals of care or Matrons audit to enable differentiation of auditing observations for patients who are allocated cubicles and patients not allocated cubicles/bays in Majors area.	Quote pending from Estates department.	**Planned outcome** Patients will be able to summon help when placed in the waiting area outside the X-ray rooms. **Ongoing Assurance** Service line governance pillar to review and approve the SOP. Monitor compliance locally within service line, via Matron and Ward Manager activity. Reporting from Meridian audits for ED will confirm the level of assurance.	Redacted	31/12/2018						
1.4	G	Safe	**MUST DO**	Ensure all equipment is serviced as required, and put in place appropriate monitoring systems to provide oversight of equipment servicing.	Urgent & Emergency	Medical Director	MEMS action: 1. Implement new medical devices database with service scheduling and accumulate data for reporting. This is linked to the RFID project (and Scan4Safety), which will enable better tracing of medical devices for maintenance. 2. Increase capacity in Clinical Engineering's Technical Inspector role which carries out routine testing of medical devices. Department Action: Revise department fundamentals of care audit to monitor equipment service dates: equipment in daily use and equipment not in daily use.	Database already purchased (£10,500 for first year, £5,200 per year thereafter). RFID project still to be purchased, but approved in principle (£200k for first year, £60k each for second and third years) Additional capacity funded by increased income from new contracts.	**Planned outcome** Medical devices servicing is all within date, indicated by the service date label. **Ongoing Assurance** Reporting from new medical devices database will give assurance of compliance. Monitor compliance locally within service line, via Matron and Ward Manager activity. Reporting from Meridian fundamentals of care for ED will confirm the level of assurance.	Redacted	Database goes live Nov 2018. Accumulated annual data available Nov 2019. RFID project planned to be implemented during 2019. Additional Technical Inspector recruitment planned for Autumn 2018. Local action 31/12/2018						

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1.5	G	Safe	**MUST DO**	Ensure patients have regular observations completed and documented, with easy to recognise trigger points for increased regularity of observations.	Urgent & Emergency	Medical Director	Introduction and pilot of NEWS 2 started on 1/8/18. Process and intervention changes to be made as part of a continuous PDSA project; with Service Improvement support.	None	**Planned outcome** To improve patient safety and experience of care, minimise the risk of patients deteriorating without being seen. Promote individualised person centred care related to the frequency of observations required. **Ongoing Assurance** Quality Improvement Committee will oversee the introduction of NEWS2. Service line governance pillar will record local improvement.	Redacted	31/10/2018 Quality Improvement work will be ongoing.						
1.6	G	Effective	**MUST DO**	Ensure patients presenting with possible sepsis are recognised, started on a treatment pathway and administered antibiotics within 60 minutes.	Urgent & Emergency	Medical Director	1. Continuous prospective audit of all cases presenting with severe sepsis with recurrent PDSA of interventions to improve to 90%. 2. Introduce NEWS2 with specific focus on improving sepsis care and management.	None	**Planned Outcome** To achieve 90% compliance. **Ongoing Assurance** Audit and report monthly to QIC. Collecting screening and time to ABX data. Quarterly summary report to CCG and national CQUIN team.	Redacted	1.Ongoing 2. 31/10/2018						
1.7	G	Safe	**MUST DO**	Ensure the data reported in relation to time to initial assessment is an accurate record from arrival at the emergency department, not using the ambulance service's observations.	Urgent & Emergency	Chief Operating Officer	Continue with process change as part of a recurrent PDSA improvement cycle relating to the FLIC initiative; with Service Improvement support.	None	**Planned Outcome** With the inception of FLIC inaccuracies will be eradicated ambulance handover times improved. **Ongoing Assurance** A&E quality indicator data sets reporting into the ED Delivery board. Data fed to NHSI for external oversight. Service line business pillar.	Redacted	This is part of a Quality Improvement programme so is therefore ongoing						
1.8	G	Safe	**MUST DO**	Urgently review nursing and medical staffing numbers to ensure there are always sufficient numbers on duty to keep patients safe.	Urgent & Emergency	Chief Nurse / Medical Director	1.Undertake a staffing review as part of an external review - completed. 2.Take action on recommendations made within the external review. 3. Paediatric area to be incorporated in to the level 12 paediatric nurse rostering practice - completed. 4.Agree and sign off the escalation policy across the Trust.	Cost pressure	**Planned Outcome** To successfully recruit to the agreed uplifted establishment. To improve timeliness of safety checks during periods of escalation in activity. **Ongoing Assurance** Strategic Command for final approval of establishment review and present at HMSC / CME. Monitor delivery of recruitment plan via the A&E Delivery Board. Service line business pillar	Redacted	30/04/2019	Also inherent in external review recommendations. See 1.12.					
1.9	G	Safe	**MUST DO**	Ensure medicines are always stored securely to prevent unauthorised access.	Urgent & Emergency	Chief Nurse	1. Review and improve current process and compliance with storage of medicines. 2. A secure drug prep area is to be an integral feature of the department's reconfiguration works.	To be determined	**Planned Outcome** A) Safe storage of medicines in line with Trust policy. B) Medicines cupboards to be locked when not in use to prevent unauthorised access. **Ongoing Assurance** Medicines Utilisation and Assurance Committee ED Business pillar. Monitor compliance locally within service line, via Matron and Ward Manager activity. Reporting from Matrons' full environment audit for ED (Meridian system) will confirm the level of assurance. Safe Storage of Medicines Audits.	Redacted	1. 01/10/2018 2. 31/03/2023	**03/09/2018** Current monitoring practice is for Duty band 7 to undertake checks as part of a daily 07:30 inspection. The Matrons' full audit (meridian) requires a check on locked medicines cupboards.					

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1.10	G	Caring	**MUST DO**	Ensure the privacy and dignity of patients is always maintained.	Urgent & Emergency	Chief Nurse	1.Progress the redesign of the emergency department to ensure that there is adequate space to care for patients safely and that patient needs are met. 2. Agree/sign off the ED escalation policy, to include the Trust's response for appropriate additional staffing to manage risks to patients.	Capital Project - see business case	**Planned Outcome** Sufficient space to accommodate the current numbers of patients attending the Department and thereby improve privacy and dignity. Sufficient numbers of staff to respond to patients' needs. **Ongoing Assurance** Strategic Command for final approval of escalation policy and present at HMSC / CME. Service line Governance pillar to monitor concerns / Datix / complaints / patient feedback for ongoing improvement. Care Group Board: Oversee progression of improvement, escalating to corporate level that which is not within the Care Group management team's gift to resolve Patient Experience Committee (PLACE inspection).	Redacted	1. 31/03/2023 2. 31/10/2018						
1.11	G	Responsive	**MUST DO**	Put in place appropriate escalation processes that ensure a timely response to supporting the emergency department to keep patients safe and improve patient flow.	Urgent & Emergency	Chief Operating Officer	1. Agree/sign off the ED escalation policy, to include the Trust's response for appropriate additional staffing to manage risks to patients. Policy to reflect the capability of the Trust's existing workforce to respond. 2. Successfully recruit to the agreed uplifted establishment.	None	**Planned Outcome** Reduce the requirement to require Trust response during escalation, by use of own establishment. Improved responsiveness for additional support during periods of escalation. **Ongoing Assurance** Strategic Command for final approval of escalation policy and present at HMSC / CME. Service line Governance pillar to monitor concerns / Datix / complaints for ongoing improvement Care Group Board: Oversee progression of improvement, escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	30/11/2018						
1.12	G	Well Led	**MUST DO**	Ensure an external review takes place as soon as possible to identify the risks in the department and then take the actions recommended to reduce them.	Urgent & Emergency	Chief Operating Officer	External review completed. Take actions to address identified risks: in progress.	None	**Planned Outcome** Eliminate, substitute or fully mitigate risks related to patient care arising from staffing, environmental and resource constraints. **Ongoing Assurance** Service Line business pillar. Care Group Board: Monitor progression of improvement, escalating to corporate level that which is not within the Care Group management team's gift to resolve. Hot Floor Steering Group. ED Delivery Board.	Redacted	30/04/2019						
1.13	G	Safe	**SHOULD DO**	Ensure all staff are up-to-date with mandatory and safeguarding training.	Urgent & Emergency	Director of People	1. Corporate remit: All staff that require level 2 safeguarding to be booked onto the relevant e-learning course to complete when their current training expires. 2. Service line manager to produce annual forward planner detailing protected time for named medical staff to undertake all e-learning requirements, as part of their PA time. Matron to oversee production of an annual forward planner detailing protected time for named nursing staff to undertake all e-learning requirements and embed this into rostering practice. Traceable reasons to be inherent for non attendance/compliance.	None	**Planned Outcome** Service line monthly compliance to be at or above the desired 95% Trust compliance but at least at or above the Trust tolerance of 85%. **Ongoing Assurance** Via monthly internal service line and Care Group performance meetings, review and scrutinise mandatory training compliance trends. Identify barriers and set actions and support solutions. Via the Care Group Board: Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/10/2018						
1.14	G	Safe	**SHOULD DO**	Ensure the kitchen in the clinical decision unit is secure when unattended to prevent patients gaining access.	Urgent & Emergency	Director of Planning and Site Services	Reconfigure the Clinical Decision Unit to relocate the kitchen within the department; security features to be inherent in design.	To be determined	**Planned Outcome** **A**ccess to the kitchen restricted to authorised staff only. **Ongoing Assurance** Monitored via service line governance pillar.	Redacted	31/10/2018	Estates work in progress since August 2018					

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1.15	G	Safe	**SHOULD DO**	Repair or replace the flooring in the clinical decision unit toilets/shower rooms to enable effective cleaning and minimise infection control risks.	Urgent & Emergency	Director of Planning and Site Services	Submit new works request to assess, replace or repair the floor.	To be determined	**Planned Outcome** Trip hazard removed and environment optimised to prevent infections. **Ongoing Assurance** Monitored via service line governance pillar.	Redacted	31/10/2018						
1.16	G	Safe	**SHOULD DO**	Review the security arrangements for the paediatric department to prevent unauthorised entry and exit.	Urgent & Emergency	Director of Planning and Site Services	1. Create modular extension to paediatric area; ensuring security features are inherent in design. **2.** Engage with the Trust Security Team to review security requirements within the current footprint, including secure access, CCTV monitoring and electrical safety.	To be determined	**Planned outcome** Security arrangements to meet national guidelines for paediatric emergency department **Ongoing Assurance** Service line business and governance pillars.	Redacted	31/12/2018						
1.17	G	Safe	**SHOULD DO**	Ensure children in the paediatric department do not have access to electrical sockets.	Urgent & Emergency	Director of Planning and Site Services	1. Create modular extension to paediatric area; ensuring safety features of electrical sockets are inherent in the design, e.g. height of electrical sockets. 2. Engage with Trust Estates Team to review the requirement for electrical sockets in the existing footprint. 3. Long Term: Progress the redesign of the emergency department.	To be determined	**Planned outcome** Meet IET Wiring Regulations - BS7671:2008 (2015), so that electrical socket outlets in the paediatric area have shutters and preferably be of a type complying with BS1363. **Ongoing Assurance** Service line business and governance pillars.	Redacted	31/12/2018	**04/09/2018** Reminder that protective electrical socket inserts were removed as part of an NHS Estates and Facilities alert issued June 2016.					
1.18	G	Safe	**SHOULD DO**	Provide training and/or guidance to reception staff that enables them to recognise 'red flag' symptoms.	Urgent & Emergency	Director of People	Undertake a scoping exercise that includes the following hierarchy: - Ascertain what other Trusts' practice is around this issue. - Explore the professional scope of practice and patient safety considerations in relation to providing training and/or guidance to reception staff that enables them to recognise 'red flag' symptoms. - Create appropriate list of 'red flags'. - Produce Standard Operating Procedure that builds safeguards into decision making steps commensurate to staff job descriptions and their professional and legal boundaries. Action to incorporate the Minor Injury Units.	None	**Planned Outcome** Timely clinical response to changing risks in people in the main waiting area who are awaiting triage. **Ongoing Assurance** Service line governance pillar to review and approve proposed practice. Service line reporting via the Care Group Risk and Assurance Meeting: annual assurance report.	Redacted	31/12/2018						
1.19	G	Responsive	**SHOULD DO**	Consider how patients arriving by ambulance can be protected from the weather while being transferred to the department.	Urgent & Emergency	Director of Planning and Site Services	1. Review Care Group risk register. Due to reconfiguration of paeds and resus plus proposed rebuild, there is unlikely to be a timely resolution to this issue in the immediate future. 2. Implement process change as part of a recurrent PDSA improvement cycle relating to the FLIC initiative; with service improvement support. 3. Long term: Subject to securing the Treasury capital funds, progress the redesign of the emergency department.	To be determined	**Planned Outcome** An ambition inherent in the PDSA of the FLIC initiative is to reduce ambulance waiting times wherever practicable. **Ongoing Assurance** Service line business and governance pillars, escalating to Care Group issues of concern. Via the Care Group Board: Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	Risk register: 01/10/2018 FLIC: this is part of a Quality Improvement programme so is ongoing. Redesign: 31/03/2023						
1.20	G	Safe	**SHOULD DO**	Make sure clinical waste bins are emptied before becoming over-full.	Urgent & Emergency	Chief Nurse	1. Review the service level agreement with hotel services to ensure that there is the ability to flex the service provided according to Trust escalation status. 2. Consider including in the Trust Escalation Policy.	None	**Planned Outcome** Waste bins are emptied when they are two-thirds full and at intervals commensurate to the busyness of the department and do not become overfull. **Ongoing Assurance** Matrons environment audit. Monitor compliance locally via Matrons and Ward Managers activity.	Redacted	31/10/2018						
1.21	X	Safe	**SHOULD DO**	Consider how patients can be safely transferred across the road from the helipad when security staff are not present to stop the traffic.	Urgent & Emergency	Director of Planning and Site Services	Contingency plan in place using the Indigo staff if security staff are otherwise engaged - completed.	None	**Planned Outcome** Controlled and fully mitigated risk related to collision with traffic or members of the public when transferring patients from the helipad to the emergency department. **Ongoing Assurance** Via service line governance pillar, review of incidents, complaints, patient and public feedback.	Redacted	01/08/2018	Action completed	01-Aug-18				

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1.22	G	Safe	**SHOULD DO**	Review the front loaded initial care (FLIC) model to ensure it provides appropriate timely decision-making and treatments.	Urgent & Emergency	Medical Director	Implement process changes as part of a recurrent PDSA improvement cycle relating to the FLIC initiative; with service improvement support.	None	**Planned Outcome** Augmented patient experience and clinical risk reduction due to appropriate timely decision-making and treatments. **Ongoing Assurance** Via service line governance process monitor for themes and learning related to excellence and areas for improvement: incidents, complaints and other patient feedback mechanisms.	Redacted	This is part of a Quality Improvement programme so is therefore ongoing						
1.23	G	Well Led	**SHOULD DO**	Review the security arrangements for storing patient records in the clinical decision unit.	Urgent & Emergency	Chief Nurse	Reset the expected practice and discipline around keeping patient records: - in folders at the foot of the patient's bed, ensuring only essential nursing records e.g. observations, drug charts and risk assessments are accessible and kept together. - medical records are filed complete and locked in a secure dedicate notes trolley when not in use.	None	**Planned Outcome** Compliance with information governance mandates. Compliance with the Trust's Health records policy ensuring that notes are in a good physical condition, that the folder is robust and that all relevant documentation is filed and stored securely. **Ongoing Assurance** Matron's environment audit. Monitor compliance locally via Matrons and Ward Managers activity. Service line governance pillar to have assurance around health records practice.	Redacted	31/10/2018						
1.24	G	Safe	**SHOULD DO**	Make sure incident reporting, learning and feedback is given sufficient priority to encourage improved incident reporting from staff.	Urgent & Emergency	Chief Nurse	1. Review the current PA time for the clinical governance lead. 2. Review the division of labour, roles and responsibilities among the service line's clinical, management and administrative support teams. 3. Implement PDSA approach related to incident reporting in conjunction with the Medical Assessment Unit: producing a standardised format for reporting recurring high volume themes related to incidents within the Datix reporting system. 4. Scope the feasibility of developing a block review feature within the Datix system for an agreed type of incident (external incidents) with support from the Head of Quality Governance.	None	**Planned Outcome** Best use is being made of available time, and resource, to meet current expectations around quality governance, e.g. reporting, reviewing and acting on incident reports. Improved time management of high volume incident reporting: final approvals to be within Trust target of 5 cases (tolerance 10 cases). Staff will report incidents in line with Trust policy and expectations to a standard that enhances the review and feedback process. **Ongoing Assurance** Via monthly service line governance pillar to scrutinise trends. Identify barriers to improved incident reporting and management; and support solutions. Via monthly service line performance review, scrutinise compliance trends as recorded on the service line dashboard. Identify barriers and support solutions.	Redacted	31/01/2019	**05/09/2018** Project related to secretarial support for governance meetings started, overseen by the Service Line Support Manager and Care Group Quality Manager.					
1.25	G	Safe	**SHOULD DO**	Make sure allergy information is recorded on all relevant paperwork.	Urgent & Emergency	Medical Director	1. Undertake awareness campaign related to managing and recording allergy status. 2. Scope the reconfiguring of the Fundamentals of Care audit in ED to include a Multidisciplinary focus. This would aim to include a question related to clinical and nursing record keeping with regards to allergy information.	None	**Planned Outcome** Clinical risk reduction related to patients' allergies not being recognised, leading to safe administration of medicines. **Ongoing Assurance** Monitor compliance locally via Matrons and Ward Managers activity. Reconfigured audit to provide assurance.	Redacted	31/12/2018						
1.26	G	Safe	**SHOULD DO**	Ensure staff always clean their hands between patient contacts.	Urgent & Emergency	Chief Nurse	1. Undertake an awareness campaign related to decontaminating hands including resources and standards expected during periods of escalation when patients are being placed in the central corridor. 2. Procure as department stock individual hand gel dispensers with clips for staff to carry and use during periods of escalation.	None	**Planned Outcome** Optimise the opportunity for patients to receive care from staff who can decontaminate their hands immediately before and after episodes of direct contact or care; where contact with bodily fluid is not an inherent aspect of care. **Ongoing Assurance** Hand hygiene audit as published on the balanced score card and monitored via the service line governance meeting.	Redacted	31/12/2018						

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1.27	G	Effective	**SHOULD DO**	Make sure patients waiting in the department for long periods are not left without access to drinks and food, where appropriate.	Urgent & Emergency	Chief Nurse	1. Review the service level agreement with hotel services, ensuring there is the ability to flex the service provided according to Trust escalation status. 2. Consider including in the Trust Escalation Policy. 3. Revise Fundamentals of Care audit to include whether the patient has access to fluids and been offered food.	None	**Planned Outcome** Patient experience of care enhanced. Clinical risk reduction related to hydration and nutrition. **Ongoing Assurance** Fundamentals of care audit. Monitor compliance locally via Matrons and Ward Managers activity.	Redacted	31/12/2018					
1.28	G	Effective	**SHOULD DO**	Record patients' pain scores routinely and make sure pain relief is provided promptly when required.	Urgent & Emergency	Chief Nurse	1. With support from Service Improvement progress the current PDSA test change of NEWS2 within the department to recognise the frequency of observations required on a patient by patient basis depending on clinical presentation. 2. Long Term: Progress the redesign of the emergency department to eliminate the need to place patients in the central corridor during crowding.	None	**Planned Outcome** Patient experience of care enhanced Clinical risk reduction due to patients receiving improved pain management. **Ongoing Assurance** Fundamentals of care audit. Monitor compliance locally via Matrons and Ward Managers activity. Review themes arising from patient feedback at service line governance pillar forum. Oversight of NEWS 2 via the Quality Improvement Committee	Redacted	NEWS2: 31/12/2018 Redesign: 31/03/2023					
1.29	X	Effective	**SHOULD DO**	Continue to participate in relevant audits to monitor and improve patient outcomes through consistent compliance with national standards.	Urgent & Emergency	Medical Director	Participation in national and local audit programmes continues and outputs feed via service line governance process.	None	**Planned Outcome** Incremental improvements towards patients receiving the most appropriate care in accordance with national guidance. **Ongoing Assurance** Present and **r**eview audit findings via service line governance pillar; escalating any issue to Care Group that is not within the gift of the service to resolve locally.	Redacted	Complete		31-Aug-18				
1.30	X	Effective	**SHOULD DO**	Provide annual appraisals for all staff.	Urgent & Emergency	Director of People	Introduce process of forward planning overseen by the Service Line Support Manager (completed).	None	**Planned Outcome** Invest in and value our staff to improve well-being, job satisfaction and retention. Staff receive the appropriate training and support to undertake their roles to a high standard. **Ongoing Assurance** Review service line dashboard for compliance via local service line and care group performance reviews.	Redacted	30/09/2018		06-Sep-18				
1.31	G	Effective	**SHOULD DO**	Ensure staff working in resuscitation as part of a team wear the correct tabards to help with role identification.	Urgent & Emergency	Medical Director	Internal professional standard to be written outlining the requirement to wear the correct labelled tabards to help with role identification during Trauma care.	None	**Planned Outcome** Delivery of safe trauma care in resus area. **Ongoing Assurance** Approve the professional standard via the Service line Governance pillar.	Redacted	30/09/2018						
1.32	G	Effective	**SHOULD DO**	Review how patients can be better supported to manage and support their own healthcare.	Urgent & Emergency	Chief Nurse	1. Engage with Patient Experience Manager to review the range of discharge information provided. 2. Review how to ensure easy access to promotional materials within the department, e.g. leaflets, electronic adverts.	None	**Planned Outcome** Patients are supported to make decisions that enable them to manage their own healthcare or signpost them to support services; where this is their choice. **Ongoing Assurance** Review themes arising from patient feedback at Service line Governance meeting	Redacted	31/01/2019						

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1.33	G	Effective	**SHOULD DO**	Consider providing nursing staff the skills required to undertake mental capacity assessments.	Urgent & Emergency	Chief Nurse	1. Preferred action is to increase uptake in medical staff trained to undertake mental capacity assessments. 2. Matron and Head of Nursing to scope the feasibility of nursing staff of an appropriate seniority to support completion of mental capacity assessments: factoring in professional scope of practice.	None	**Planned Outcome** Patient experience of care enhanced. Clinical risk reduction due to patients having Mental capacity assessments completed in a timely way and treatment started; where this is deemed necessary. **Ongoing Assurance** Subject to scoping, review and approve via nursing governance process Service line governance pillar to monitor progression.	Redacted	31/12/2018					
1.34	G	Responsive	**SHOULD DO**	Provide patients requiring the toilet with appropriate facilities without undue delay.	Urgent & Emergency	Chief Nurse	1. Increase in establishment across all disciplines approved. Recruit to establishment. 2. Reinvigorate intentional rounding format 3. Long Term: progress the redesign of the emergency department to improve access to toilet facilities and eliminate delays.	None	**Planned Outcome** There is an expectation that once vacancies are fully recruited into the responsiveness to patients' basic care needs will improve. Patient experience of care enhanced in terms of privacy and dignity. 80% compliance with intentional rounding. **Ongoing Assurance** Privacy and Dignity Topic Compliance Assessment report to Quality Assurance Committee Review themes arising from patient feedback at service line governance meeting	Redacted	1 & 2. 31/12/2018 3. 31/03/2023					
1.35	G	Caring	**SHOULD DO**	Keep patients in the corridor up-to-date with their care and treatment plans.	Urgent & Emergency	Chief Nurse	1. Engage with the Patient Experience Manager to review a range of options: consider seeking patient feedback on solutions. 2. Review intentional round template: include update on patient's awareness of their care plan.	None	**Planned Outcome** Patient experience of care is enhanced in terms of knowledge related to their pathway of care through ED. **Ongoing Assurance** Review themes arising from patient feedback at service line governance meeting.	Redacted	31/12/2018					
1.36	G	Responsive	**SHOULD DO**	Communicate current estimated waiting times to patients arriving at the department.	Urgent & Emergency	Chief Operating Officer	Obtain a quote for a wall mounted screen in waiting areas (Main, minors and paediatric areas) to display wait times, this must be able to be an automated system.	To be determined	**Planned Outcome** Patient experience of care is enhanced in terms of improved communication relating to waiting times. **Ongoing Assurance** Review themes arising from patient feedback at Service line Governance meeting.	Redacted	31/12/2018					
1.37	G	Responsive	**SHOULD DO**	Look to make the environment more suitable for patients with dementia.	Urgent & Emergency	Chief Nurse	1. Replenish dementia resources (dementia box). 2. Design in dementia friendly features as part of the department's interim reconfiguration in majors and minors areas: consideration to be given to dementia friendly colours, materials, signage and a centrally located multiface clock.	To be determined	**Planned Outcome** Patient experience of care enhanced through application of The King's Fund environmental design principles to support people with dementia in unfamiliar buildings. **Ongoing Assurance** Review themes arising from patient feedback at Service line Governance meeting. PLACE inspection report.	Redacted	1. 30/09/2018 2. 31/03/2019					
1.38	G	Well Led	**SHOULD DO**	Agree and record a clear vision for the emergency department, and produce a strategy that enables the vision to be achieved.	Urgent & Emergency	Chief Operating Officer	The department has a clear vision contained in each governance pillar and the Strategic Outline Case for the service. The service line's priorities are integral to the Medical Care Group's overarching strategy.	None	**Planned Outcome** Strategic direction of the department aligns to that of the Trust and wider STP. **Ongoing Assurance** Oversight and support by ED Delivery Board. Oversight and support by Care Group Board. Oversight and delivery by Service Line Business Pillar.	Redacted	31/10/2018	05/09/2018 The service line's operational strategy is integral to the Medical Care Group Strategy, due for ratification at Care Group Board Sept 2018				
1.39	G	Well Led	**SHOULD DO**	Improve minutes and action tracking for team meetings.	Urgent & Emergency	Chief Nurse	1. Adopt the Medical Care Group's branded suite of meetings' templates and meetings' standard operating procedure (part of governance tool kit); Terms of Reference for the meeting to be written. 2. Provide commensurate administrative support to the meetings; training on meetings administration to be provided if required.	None	**Planned Outcome** Standard office practice principles to be applied to ensure archived organisational memory. **Ongoing Assurance** Service line assurance report to the care group (annual).	Redacted	31/10/2018					

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														25	50	75	100
1.40	G	Well Led	**SHOULD DO**	Review how the provision of psychiatric liaison services is monitored to ensure performance meets patients' needs and improvements can be identified if needed.	Urgent & Emergency	Chief Operating Officer	24 hour, 7 day psychiatric liaison service is in place. Formalise referral reporting. Plan to feed into Strategic Command.	None	**Planned Outcome** Patient experience of care is enhanced in terms of care pathway through ED 60 minute target to be met (time from referral to assessment). **Ongoing Assurance** Business Intelligence (Livewell) feeding into integrated team currently.	Redacted	31/10/2018	Formalisation of referral reporting is pending - PDSA data quality issues are being resolved.					
1.41	G	Well Led	**SHOULD DO**	Identify ways of obtaining feedback from the public to develop and improve services.	Urgent & Emergency	Chief Nurse	Supported by the Trust Patient Experience Manager write a local patient engagement strategy outlining approaches for seeking feedback from patients attending the department.	None	**Planned Outcome** Enhance patients' experiences of care through an effective engagement strategy that informs service improvement. **Ongoing Assurance** Strategy to be reviewed and monitored via the service line governance pillar. Service line assurance report to the Care Group (annual).	Redacted	31/12/2018						
Medical Care										Redacted							
2.1	G	Safe	**MUST DO**	Ensure nursing staffing levels meet the nursing establishment on the endoscopy unit to enable planned investigations can be carried out and not to hamper service improvement projects.	Medical Care	Chief Nurse	Establishment review to be undertaken in the context of demand and capacity planning: including future workforce requirements to meet the predicted growth in screening and diagnostic services.	To be determined	**Planned Outcome** Enable staffing establishments to be met on a session by session basis, 7 days a week. Staffing levels to meet national requirements and standards for Endoscopy. **Ongoing Assurance** Establishment review to pass through review and approval processes: via the Care Group Board, Trust Management Executive and Financial Improvement Group. Monitor progression of business case via Care Group Board. JAG accreditation.	Redacted	30/12/2018						
2.2	G	Safe	**MUST DO**	Ensure that all patients are assessed for venous thromboembolism (VTE) as soon as possible after admission, or by the first consultant review and that this is re-assessed within 24 hours in line with national guidance.	Medical Care	Medical Director	Scope IT solution using SALUS whiteboard with use of an icon tracking completion of VTE risk assessment.	To be determined	**Planned Outcome** To comply with NICE CG 98. Service lines' monthly compliance to be at or above 95% Trust compliance. **Ongoing Assurance for the Medical Care Group** Via monthly service line performance review, scrutinise compliance trends as recorded on workforce dashboard. Identify barriers and support solutions. Via Medical Care Group Risk and Assurance meeting: a) Quarterly report from VTE lead nurse to care group covering the VTE Topic Compliance Assessment. Identify barriers and solutions needed to support improvements. VTE topic compliance report to Quality Assurance Committee. Via the Care Group Board: Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve. Submit Care Group Board report as underpinning evidence to the Trust Management Executive via the Medicine Care Group Review meeting.	Redacted	31/12/2018						

Ref No.	GYR Status	Domain (SCERW)	Requirement Notice	Area for Improvement	Core Service	Executive Lead	Planned Action(s)	Financial Impact (where relevant)	Planned Outcome and how will you ensure ongoing assurance of compliance?	Responsible Lead	Target Completion Date	Status	Actual Date Completion	Percentage Complete			
														25	50	75	100
2.3	G	Well Led	**MUST DO**	Review processes for effective systems to scrutinise morbidity and mortality (M&M) data. Standardise the format of minutes of M&M meetings to ensure effective sharing of information with those who were unable to attend. Review and improve the format M&M data was presented to ensure it is transparent, and can allow for challenge.	Medical Care	Medical Director	1.Process of quarterly service line reporting into Care Group performance meeting (started May 2018). Service lines will submit a written summary report covering mortality screening compliance, arrangements for conducting mortality screening, scrutiny of HSMR and SHMI; subject judgement reviews, and how the outputs of screening feed into Service Line governance meetings. 2. Revise Service Line meetings' toolkit to ensure scrutiny of HSMR/SHMI and screening compliance is undertaken and recorded in the relevant forum; be that embedded in a clinical governance meeting or standalone M&M meeting. Engage with clinical governance leads in design and format, as part of the Medical Care Group's 2018/19 governance plan of which reinvigorating and revamping the clinical governance leads meeting forum is inherent. .	None	**Planned Outcome** Incremental test change approach towards standardisation of recorded evidence at service line level, that ensures there is scrutiny over M&M data within the services that comprise the Medicine Care Group. **Ongoing Assurance for Medical Care Group** Via the Medical Care Group Risk and Assurance meeting: a) On a quarterly basis produce a report on analysis of data supplied by the service lines from their performance reviews. Identify barriers and solutions needed to support improvements. b) Service lines to submit a sample of minutes as part of annual assurance reporting. Via the Medical Care Group Board: Oversee progression of solutions identified, escalating to corporate level that which is not within the Care Group management team's gift to resolve. Trust Mortality Review Panel - Presentation of Care Group report; utilising this forum to escalate for corporate support where a solution is not within the Care Group's gift to solve.	Redacted	31/12/2018	**28/08/2018** The first test of change of a planned 4 reviews covering mortality within the Medical Care Group was undertaken in May 2018. A draft report was presented to the Medical Care Group risk and assurance meeting on 15th August 2018. Action plan to be drafted for final approval of report.					
2.4	G	Effective	**MUST DO**	Ensure Deprivation of Liberty Safeguards are applied for in accordance with legal requirements.	Medical Care	Chief Nurse	1. Revision to the Trust's DOLS process to be undertaken by the corporate leads, to provide a more user friendly service at ward level - refer to action 7.2. 2. Care Group to develop action once corporate process review and surveillance systems are approved and in place by the corporate lead.	None	**Planned Outcome** All patients requiring Deprivation of Liberty Safeguards will be correctly identified and the process required actioned in accordance with legal requirements. **Ongoing Assurance for Medical Care Group** Trust level: Safeguarding Committee Use of Care Group escalation framework once corporate revision complete and monitoring process known.	Redacted	31/03/2019						
2.5	G	Effective	**MUST DO**	Improve training compliance for medical staff undertaking mental capacity assessment.	Medical Care	Medical Director	1. Service Line Managers to produce annual forward planners outlining protected time for named medical staff to complete e-learning and mandatory face to face training relevant to the scope of their practice. Traceable reasons to be inherent for non attendance/compliance. 2.Negotiate with Workforce/Performance Manager the ability to determine medical staffing % compliance as a subset report within service line dashboards.	None	**Planned Outcome** Service Lines' monthly compliance to be at or above the desired 95% Trust compliance but at least at or above the Trust tolerance of 85%: with the same level of compliance for the subset of medical staff. **Ongoing Assurance for Medical Care Group** Via monthly Service Line performance, review and scrutinise mandatory training compliance trends. Identify barriers and set actions and support solutions. Via the Care Group Board: Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/10/2018						
2.6	G	Responsive	**MUST DO**	Improve arrangements and work with the wider healthcare system to reduce delayed transfer of care. Patients who were medically fit for discharge were unable to leave hospital, which put them at risk of deconditioning and deterioration.	Medical Care	Chief Operating Officer	The reporting process is integrated so that issues to flow can be monitored and addressed system wide. The same approach will be applied to intermediate care placements and reablement.	None	**Planned Outcome** System-wide ambition that no more than 3.5% of occupied beds will comprise patients experiencing delays in transfer of care to other provider. **Ongoing Assurance** Daily performance reports Ongoing identification of themes and issues through patient flow meetings in acute and community setting - this will ensure ongoing attention to issues as they potentially arise. Oversight by System Integration Board.	Redacted	31/03/2019	**28/08/2018** Multi agency MDT patient flow meetings held daily. These have been used to identify issues and themes causing delays which are then resolved with community and commissioning partners. This approach has been successful in Acute reducing delays to less than 3.5%. The same approach is now being taken to community delays					

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														25	50	75	100
2.7	G	Safe	**SHOULD DO**	Review the nursing establishment to ensure safe nursing staff levels on inpatient wards based on data collected to ensure this meets national guidance.	Medical Care	Chief Nurse	Undertake a review into establishment covering nursing and care support roles; including future workforce requirements to meet the predicted growth in specialist treatments and include a target turnover rate.	To be determined	**Planned Outcome** Follow national quality guidance to maintain patient safety within available resources on a shift by shift (or session by session) basis, 7 days a week. **Ongoing Assurance** Summary of review to be presented to Trust Board.	Redacted	31/10/2018						
2.8	G	Safe	**SHOULD DO**	Review the level of child protection training and compliance for staff providing care and treatment for young adults under the age of 18 years.	Medical Care	Director of People	1. Trust level: Trust lead to scope the suitability and feasibility of providing enhanced level 2 face to face training to ensure that senior staff have a greater understanding than basic level 2 in child protection, MCA and DoLS. 2.Care Group level: Service Line Managers to produce annual forward planners detailing protected time for named medical staff to undertake face to face training relevant to the scope of their practice. Matrons to produce annual forward planners detailing protected time for named nursing staff to undertake face to face training relevant to the scope of their practice. Traceable reasons to be inherent for non attendance/compliance.	None	**Planned Outcome** Service Lines' monthly compliance to be at or above the desired 95% Trust compliance but at least at or above the Trust tolerance of 85%. **Ongoing Assurance** Trust level: Safeguarding Steering Group. Care Group level: Via monthly Service Line performance, review and scrutinise mandatory training compliance trends. Identify barriers and set actions and support solutions. Via the Care Group Board: Oversee progression of solutions identified, escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/03/2019						
2.9	G	Effective	**SHOULD DO**	Improve training compliance with Mental Capacity Act and Deprivation of Liberty Safeguards.	Medical Care	Director of People	1. Corporate remit: All staff that require level 2 safeguarding to be booked onto the relevant e-learning course to complete when their current training expires. 2.Service Line Managers to produce annual forward planners detailing protected time for named medical staff to undertake all e-learning requirements, as part of their PA time. Matrons to oversee ward managers production of annual forward planners detailing protected time for named nursing staff to undertake all e-learning requirements and embed this into rostering practice. Traceable reasons to be inherent for non attendance/compliance.	None	**Planned Outcome** Service Lines' monthly compliance to be at or above the desired 95% Trust compliance but at least at or above the Trust tolerance of 85%. **Ongoing Assurance** Via monthly Service Line performance, review and scrutinise mandatory training compliance trends. Identify barriers and set actions and support solutions. Via the Care Group Board: Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/10/2018						
2.10	G	Safe	**SHOULD DO**	Review arrangements for the safe administering of intravenous fluids for patients receiving haemodialysis.	Medical Care	Chief Nurse	1. Dialysis machines on Mayflower ward to be upgraded to online priming which allows fluid to be given as part of the dialysis programme, when required. 2. Staff to receive training as part of the upgrade. 3. Standard Operating Procedure to be written for staff to follow in the rare event that intravenous fluids are required in an emergency situation; supported by a patient group directive (PGD)	To be determined	**Planned Outcome** Administration of intravenous fluids during dialysis to be compliant and aligned to the practice at Estover Dialysis Unit. **Ongoing Assurance** Service Line clinical governance meeting to record: - achievement of upgrade and confirmation of staff training in new feature. - List of staff who have received training in upgraded machines. - Service line review and approval of SOP. - PGD approved via Pharmacy governance process.	Redacted	31/10/2018						
2.11	G	Safe	**SHOULD DO**	Improve emergency equipment daily checks in line with national guidance. This was highlighted in a previous CQC inspection and we did not find this had been improved adequately.	Medical Care	Chief Nurse	1. Matron Audit (Meridian) to include the need to escalate omissions in any aspect of environment safety or equipment checking. 2. Declarations from Matrons outlining the routines in place within each clinical area within their remit related to daily emergency equipment checks. Standardised proforma to be designed, completed and submitted to the Care Group management team. 3. Feedback to Care Groups via Nursing & Midwifery Board from annual audit undertaken by the Resuscitation Team.	None	**Planned Outcome** All clinical areas to provide assurance of a workable routine being in place to ensure emergency equipment checks are undertaken in line with Trust policy. **Ongoing Assurance** Monitor compliance locally via Matrons and Ward Managers activity. Completed declarations relating to ward routines to be submitted and reviewed at Medicine Care Group service line performance reviews. Via Care Group risk and assurance meeting, review a summary report outlining declared process and status; hold services to account through action log for closing off any gaps.	Redacted	31/12/2018						

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														25	50	75	100
2.12	G	Safe	**SHOULD DO**	Improve compliance with mandatory training for medical staff to meet the trust target.	Medical Care	Medical Director	Service Line Managers to produce annual forward planners outlining protected time for named medical staff to complete e-learning and mandatory face to face training relevant to the scope of their practice. Traceable reasons to be inherent for non attendance/compliance.	None	**Planned Outcome** Service Lines' monthly compliance to be at or above the desired 95% Trust compliance but at least at or above the Trust tolerance of 85%. **Ongoing Assurance** Via monthly Service Line performance, review and scrutinise mandatory training compliance trends. Identify barriers and set actions and support solutions. Via the Care Group Board: Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/10/2018						
2.13	G	Safe	**SHOULD DO**	Ensure substances hazardous to health are stored in line with regulations.	Medical Care	Director of Corporate Business	1. Conduct awareness campaign related to safe storage of Actichlor Plus tablets (COSHH). 2. Obtain declarations from Service Line Managers confirming the presence of a COSHH cupboard within the sluices of their clinical areas. Standardised proforma to be designed, completed and submitted to the Care Group management team. 3. Review of Matrons environment audit; to revise the dedicated question related to checking secure storage of disinfectant tablets to definitively evidence compliance that Actichlor Plus tablets are in a 'locked COSHH cupboard'.	To be determined	**Planned Outcome** All inpatient wards to have a COSHH cupboard of a sufficient size to accommodate stock of disinfectant tablets for use in sluice areas. This needs to be in addition to any existing COSHH cupboard that wards choose to have elsewhere on the ward containing clinical chemicals meeting COSHH regulations. **Ongoing Assurance** Monitor compliance locally via Matrons and Ward Managers activity. Completed declarations to be submitted and reviewed at Medicine Care Group service line performance reviews. Via Care Group risk and assurance summary report outlining declared process and status.	Redacted	31/12/2018	**28/08/2018** Awareness campaign started via daily e-mail and Vital Signs.					
2.14	G	Safe	**SHOULD DO**	Monitor, record and audit air pressure levels in positive and negative air pressure rooms in line with national guidance.	Medical Care	Director of Corporate Business	1. Install analogue pressure gauges to the 2 Bracken ward negative pressure isolation rooms A & B and lobby; also the following 10 negative/positive pressure rooms throughout the Terence Lewis Building. • L4 Penrose Rm11 & 12 • L6 Torrington Rm 11 & 12 • L6 Torcross Rm 20 & 21 • L7 Clearbrook Rm H • L7 Crownhill Rm K • L8 Bickleigh Rm H • L8 Braunton Rm K 2. Estates Team to create a daily check sheet to be used by ward staff to record the room pressures (once the gauges have been installed) in accordance with guidance. 3. Write an SOP to provide details on how to undertake and record the daily isolation room pressure checks.	To be determined	**Planned Outcome** All wards in the trust with air handling units (positive and negative pressure) to comply with national guidance (HBN 04-01 supplement 1). **Ongoing Assurance** Matrons quarterly reporting via Infection Prevention Sub-Committee. Confirm completion of works; review and approve the planned monitoring SOP; and report escalation of Estates related concerns via Ventilation Safety Group.	Redacted	31/12/2018						
2.15	G	Safe	**SHOULD DO**	Consider more innovative ways to recruit to consultant vacancies in the medical care group.	Medical Care	Medical Director	1.Care Group Strategy to include the development of robust 3-5 year workforce plans within Medicine Care Group services. 2. Recruitment strategy and a plan to be written with consideration towards: - Baseline position; - Review of benefits and perks for each specialty; - Staff ambassador roles; - Tapping into existing staffs' networks for referral and recommendations; - Targeted approach: trade press, professional associations and university departments; - Overseas recruitment options to be explored; - Review recruitment perks with existing consultants to retain existing staff: aim for parity in terms and conditions of employment with the incentive benefits to recruitment drives.	To be determined	**Planned Outcome** Consultant numbers across services will meet service demands and allow sufficient flexibility to cope with temporary variations in demand. **Ongoing Assurance** Service Line business meetings. Care Group Risk and Assurance Meeting: Monthly review of risk register. Care Group Board: Oversee progression of recruitment strategy, escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	30/11/2018	**29/08/2018** Draft Care Group overarching strategy ready for review and approval at September 2018 Care Group Board.					

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														25	50	75	100
2.16	G	Safe	**SHOULD DO**	Review the suitability of Postbridge ward to accommodate inpatients and overnight.	Medical Care	Chief Operating Officer	Complete risk assessment to determine suitability of Postbridge ward to accommodate inpatients during periods of operational escalation: incorporate option appraisal of not using Postbridge.	None	**Planned Outcome** Utility of Postbridge as an escalation ward for inpatient occupancy during periods of Trust escalation will ensure patients receive safe care and treatment. **Ongoing Assurance** Via relevant Trust Management Executive forum (operational) submit the risk assessment for review and approval.	Redacted	31/10/2018						
2.17	G	Responsive	**SHOULD DO**	Improve documentation to easily identify when patients were moved to a different ward and document the reasons for doing so.	Medical Care	Chief Operating Officer	1. Scope enhanced utility of an electronic solution (IPMS & SALUS) to enable 24/7 traceable recording that identifies when patients are moved to a different ward and document the reasons for doing so. 2. Based on the identified solution develop a Standard Operating Procedure	To be determined	**Planned Outcome** Optimum use of information about patient moves to enhance the patient experience **Ongoing Assurance** Via relevant Trust Management Executive forum (operational) monitor progression of the scoping exercise, review and approve option chosen, ensuring an impact assessment has been inherent in the decision making process; SOP to be ratified via relevant Trust Management Executive forum (operational); Monitor use of information via Patient Experience Committee.	Redacted	31/03/2019						
2.18	G	Safe	**SHOULD DO**	Ensure nursing care plans are individualised and hold sufficient information to ensure safe and effective care can be delivered by all staff.	Medical Care	Chief Nurse	Nursing and Midwifery Strategic Priorities for 2018-2021 to include a review and renewal of all nursing care plan documentation.	None	**Planned Outcome** Improved Patient Experience and effectiveness through individualised patient care planning. **Ongoing Assurance** Review and approval via Nursing and Midwifery Operational Committee	Redacted	31/03/2019						
2.19	G	Safe	**SHOULD DO**	Improve documentation of when liquid medicines are opened to ensure they are not administered when they have expired.	Trustwide - Pharmacy	Chief Nurse	1. Review Medicines Management Policy to ensure that liquid medicines are included. 2. Ensure that liquid medicines are part of the medicines management audit.	None	**Planned Outcome** Safe and in date administration of oral liquid medication in line with Trust Medicines Management policy. **Ongoing Assurance** Revised process to be approved and monitored via Medicines Utilisation Assurance Committee.	Redacted	30/11/2018						
2.20	G	Effective	**SHOULD DO**	Review clinical guidelines on the trust intranet to ensure they are all current and reflect the most up-to-date national guidance.	Medical Care	Medical Director	Service Lines' Clinical Governance Leads to oversee review of clinical guidelines where the document owner sits within their service and ensure these are acted upon through their departmental clinical governance structures and submitted to the Audit Assurance and Effectiveness team for publication on Trustnet.	None	**Planned Outcome** All clinical guidelines, where the document owner sits within Medicine Care Group will be up to date by 31/12/2018 **Ongoing Assurance** Quarterly reporting into Medical Care Group forums on the number of up to date guidelines: report generated from Audit Assurance and Effectiveness Team. Record evidence of clinical guideline updating at Service Lines' local governance meetings. Via Care Group level clinical governance leads meeting review progress on updated guidelines. Care Group Board: Oversee progression of improvement, escalating to corporate level that which is not within the care group management team's gift to resolve.	Redacted	31/01/2019	28/08/2018 Care Group Director has e-mailed service line leads to request updating of clinical guidelines where the document owner sits within their service and to ensure these are acted upon through their departmental clinical governance structures.					

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														25	50	75	100
2.21	G	Safe	**SHOULD DO**	Ensure awareness of the sepsis care bundle is rolled out to all inpatient wards and departments.	Medical Care	Medical Director	1. Quality Improvement programme agreed with the CCG in place; concentrating on admission and assessment areas. 2. Educational programme - Turbo teaching, posters; investigate any case where severe sepsis has resulted in severe decline or death. 3. NEWS2 will go live in MAU areas as of September 2018, and remaining inpatient areas by December 2018 to increase likelihood of sepsis identifications	None	**Planned Outcome** • Improve screening of patients presenting with severe sepsis to 90% by quarter 4 in all emergency admission areas, ED MAU SAU Paediatrics • To administer antibiotics within 1 hour of possible diagnosis of severe sepsis in greater than 90% of patients in all admission areas by Quarter 4 • To ensure NEWS 2 scoring assessment takes place for >90% of patients with severe sepsis in ED by quarter 4 • To ensure the appropriate 3 day review of antibiotics in >90% of patients identified with severe sepsis in all emergency admission areas • To develop capability of staff in understanding of sepsis and sepsis management in five ward areas where patients are most likely to have or develop signs of severe sepsis. o Monkswell o Brent o Shaugh o Stonehouse o Hexworthy **Ongoing Assurance** Monthly reporting via Quality Improvement Committee Quarterly CQUIN reporting to Clinical Commissioning Group.	Redacted	31/03/2019 Quality Improvement programme will be ongoing.						
2.22	G	Effective	**SHOULD DO**	Improve documentation from treatment escalation plans to ensure these are completed to demonstrate patients' choices are considered.	Medical Care	Medical Director	Corporate Level: 1. Implement awareness campaign related to roll out of version 11 TEP forms (completed). 2. Ensure that all resuscitation training programmes have TEP education as integral to the curriculum (completed). 3. Undertake monthly audit of TEP via emergency call data collection (ongoing). 4. Continue ongoing bi-annual hospital audits of TEP forms via Meridian system undertaken by the Resus and End of Life (EoL) teams with results sent to Care Groups for action and further audit as appropriate (audit due by 31/10/2018). 5. Review at End of Life Committee and Resuscitation Committee the provision of guidance on a percentage achievement related to accurate completion of TEP forms; and how this will be formally monitored. Care Group: 6. Clinical Governance Leads to lead on TEP improvement plan for their services based on baseline audit results (October 2018 audit).	None	**Planned Outcome:** Improved completion of TEP forms in line with guidance provided from corporate forum. **Ongoing Assurance** Corporate remit: Audit reports to EoL committee and Topic Compliance Assessment to Quality Assurance Committee. Within Care Group: Record evidence of TEP coverage and local action planning at Service Lines' local governance meeting. Via Care Group level clinical governance leads meeting review findings of corporate audit results and devise local action plan for improvement. Care Group Board: Oversee progression of improvement, escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/03/2019	29/08/2018 All new Doctors have been briefed on version 11 TEP completion (August 2018).				
2.23	G	Safe	**SHOULD DO**	Develop a standard operating procedure to provide guidance for staff about the safe use of escalation areas including safe staffing levels.	Medical Care	Chief Operating Officer	Review the Trust's escalation framework to ensure that a standard operating procedure is an inherent feature that: - ensures suitable patients and maximum numbers of patients are transferred to the designated area. - provides guidance and a checklist for staff about the safe use of the designated area including safe staffing levels.	None	**Planned Outcome** Utility of changing the use of any area to accommodate inpatient care during periods of Trust escalation will ensure patients receive safe care and treatment. Traceable action to be held in electronic format. **Ongoing Assurance** Via relevant Trust Management Executive forum (operational) ratify the revised escalation framework with associated SOP inherent.	Redacted	31/10/2018						
2.24	G	Well Led	**SHOULD DO**	Ensure regular scheduled clinical governance meetings are held and attended.	Medical Care	Medical Director	Clinical Governance Leads meetings to be held within Medicine Care Group bi-monthly. Revised arrangement to start October 2018.	None	**Planned Outcome** Clinical Governance leads are supported to deliver their remit in line with their Job Description. **Ongoing Assurance** Terms of Reference Forward planner, detailing standard agenda. Meetings minutes and action log. Attendance list.	Redacted	31/10/2018						

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														25	50	75	100
2.25	G	Effective	**SHOULD DO**	Evaluate training needs for training in mental health conditions to enhance staff's understanding and ability to care for patients admitted to the acute trust and who suffer from mental health conditions.	Medical Care	Chief Nurse	1. Scope out the minimum level of mental health training for all clinical staff through collaboration with Livewell Liaison Psychiatry colleagues and by contacting Mark Radford, Director of Nursing NHSI for any guidance. Draft a minimum standard for UHP to adopt and a proposal for how this can be actioned. 2. Actions to be implemented and governed by Care Groups.	None	**Planned Outcome** Defined minimum standard of training supported by plan for delivery. **Ongoing Assurance** Safeguarding Committee. Mental Health Topic Compliance Assessment Report to Quality Assurance Committee. Use of Care Group escalation framework once training requirements have been developed.	Redacted	1. 31/12/2018 2. 31/03/2019	We have developed stronger links on behalf of UHP from an external perspective. The Deputy Chief Nurse meets with commissioners monthly around Liaison psychiatry and CAMHS services to ensure we are getting access to the best services and support with the available monies and to ensure good evaluation of services against this. We were successful in our bid for funding for Beyond Places of Safety which means we will be having estates work done to provide more assessment and review space near ED to see MH patients in an acute crisis. We completed a mock CQC inspection at the end of 2017 and presented the findings and action plan to TME. We are working on full delivery of the action plan. We are completing our first PCA in order to determine our progress and compliance against the NCEPOD report 'Treat as one' publication.					
Surgery										Redacted							
3.1.1	G	Responsive	**MUST DO**	Ensure referral to treatment time for incomplete pathways are improved and improve the cancer waiting times for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.	Surgery	Chief Operating Officer	Ensure achievement of the improvement trajectory as agreed with NHSI. Maintain incomplete pathways and reduce 52 week waits by 50% compared to March 2018 position in line with national planning guidance and commissioned levels of activity	If demand is above commissioned levels then risk of additional financial spend.	To achieve agreed trajectory. Monitored daily, reported to Board monthly and reviewed at IDM with NHSI bi-monthly.	Redacted	31/03/2019						
3.1.2	G	See 3.1.1	See 3.1.1	See 3.1.1	Surgery	Chief Operating Officer	The Care Group will continue with Project Persist to ensure that all available Theatre time is optimised to an 85% opportunity and the Service Line Managers will report to the Care Group Manager around individual efficiencies within the Service Lines at the Care Group Board meetings.	If demand is above commissioned levels then risk of additional financial spend.	The outcome measure is the comparison between the March 2018 and March 2019 RTT position. This will be monitored and reported via the following measures; A daily report on 52 week waiters and greater than 40 week waiters, Weekly RTT reviews at Speciality level, Weekly reporting for Operation Persist all feeding into monthly reporting to TME via Planning Delivery Unit (PDU) structure.	Redacted	31/03/2019						
3.2	G	Safe	**SHOULD DO**	Improve mandatory and safeguarding training levels so that they achieve the trust's target.	Surgery	Director of People	Review and monitor delivery of all service line action plans. Care Group to review all trajectories with Cluster Managers during the Monthly HR Performance Review Meetings and monthly Clinical Governance Performance Review meetings. Individual performance addressed via 1-1 meetings and outcomes escalated at Service Line Clinical governance meetings.	None	Compliance with mandatory training across all staff groups. Ongoing monitoring through Care Group reviews and service line reviews.	Redacted	31/05/2019						
3.3	G	Safe	**SHOULD DO**	Ensure cross infection processes are followed in all ward and theatre areas.	Surgery	Chief Nurse	Base line review of current implementation of standards at ward level to be conducted in Cardiothoracic Theatres and Moorgate ward using the Infection Prevention and Control Team ward round review. Action plans for improvement to be agreed if these clinical areas are found to be unsatisfactory.	None	Clinical areas to comply with Trust policy for Infection Prevention and Control. Satisfactory review conducted by Infection Prevention and Control Team and monthly review of data presented via the Balanced Score Card.	Redacted	31/12/2018						
3.4	G	Safe	**SHOULD DO**	Ensure products deemed as hazardous to health are locked away and not accessible to patients.	Surgery	Chief Nurse	Baseline review of current storage practice at ward and department level to be undertaken by the ward or department Manager. Action plans to be developed for non compliance.	None	Hazardous Items to be stored correctly in all Clinical Areas. Service Line Managers to include this as part of the monthly governance meetings and report compliance as part of their quarterly assurance report to the Care Group	Redacted	31/03/2019						
3.5	G	Safe	**SHOULD DO**	Improve compliance with 95% of venous thromboembolism (VTE) (blood clot) assessments being carried out for patients in line with national guidance.	Surgery	Medical Director	Baseline review of current implementation of standards at ward level to be provided by Clinical Nurse Specialist (CNS) for VTE. Action plans for non compliance to be drafted where required.	None	Satisfactory compliance with VTE Risk Assessments. CNS for VTE to report quarterly on performance to the Care Group Governance Meeting.	Redacted	31/03/2019						

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														25	50	75	100
3.6	G	Safe	**SHOULD DO**	Improve compliance with the WHO checklist in the specialities where the 95% compliance target was not being achieved.	Surgery	Medical Director	Continue reviews of non compliance in regular reporting to Theatres Clinical Governance Committee. Plan in progress to move to an electronic theatre reporting system to improve data quality.	None	All specialities to achieve a minimum of 95% compliance. Monitoring via Theatres Clinical Governance Committee who will feedback to individual clinicians and escalate to Care Group Governance Meetings.	Redacted	31/03/2019						
3.7	G	Safe	**SHOULD DO**	Continue to improve staffing levels and ensure they match the acuity of patients on all wards.	Surgery	Chief Nurse	Corporate Establishment review in progress. The Surgical Care Group will interrogate leavers exit interview data and monitor via Clinical Governance Meetings.	None	Ongoing safe staffing as evidenced by Safe Care. SOP for level 1 areas to reflect national trends. Leaver trends to be reported to the Care Group via the quarterly assurance reports by the Service Lines. Care Group Clinical Governance Meeting to review leaver data.	Redacted	31/03/2019						
3.8	G	Effective	**SHOULD DO**	Improve appraisal levels so that they achieve the trust's target.	Surgery	Director of People	Review and monitor delivery of all service line action plans. Care Group to review all trajectories with Cluster Managers during the Monthly HR Performance Review Meetings and monthly Clinical Governance Performance Review meetings. Individual performance addressed via 1-1 meetings and outcomes escalated at Service Line Clinical governance meetings.	None	Compliance with the Trust target. Monitor through Care Group monthly reviews and service line reviews.	Redacted	31/03/2019						
3.9	G	Effective	**SHOULD DO**	Undertake sepsis audits on all wards where sepsis might occur.	Surgery	Medical Director	The incidence of sepsis on surgical wards is infrequent. Work has therefore focussed on the key areas where the risks are higher - see action 2.21.	See 2.21	See 2.21	Redacted	See 2.21						
3.10	G	Effective	**SHOULD DO**	Improve mental capacity and deprivation of liberty training levels for medical staff and nursing staff so they achieve the trust's target.	Surgery	Chief Nurse	Link in with trust wide programs to support and educate staff. Support the action to ensure mandatory updates undertaken.	None	Compliance with Trust target. Monitoring of incidents via Care Group Governance meeting report and compliance with training via Service Line Performance Reviews.	Redacted	31/03/2019						
3.11	G	Responsive	**SHOULD DO**	Clearly display information directing patients on how to make a complaint.	Surgery	Chief Nurse	All Matrons to review current processes in clinical areas and ensure that information is easily accessible.	None	Information on how to make a complaint will be accessible. Matrons to report issues by exception.	Redacted	31/12/2018						
3.12	G	Responsive	**SHOULD DO**	Ensure all areas used in times of escalation protect patient's dignity and meet their needs.	Surgery	Chief Operating Officer	Review operating procedures for converting temporary areas to inpatient areas, including baseline assessments for prospective areas. Ensure staff are inducted into the area and are aware of mechanisms for escalation.	None	Privacy and dignity of patients will be protected when the Trust is escalated. The Care Group will engage with escalation plans via the Winter Planning meetings to ensure adequate preparation of designated escalation areas.	Redacted	31/10/2018						
3.13	G	Well Led	**SHOULD DO**	Continue to improve theatre utilisation and reduce the number of theatres cancelled.	Surgery	Chief Operating Officer	Continue roll out of Operation Persist which aims to improve theatre utilisation through a focus on Pre-assessment, Scheduling, Start times and Team Work with continuous evaluation and communication to permeate theatre culture towards maximising efficiency safely.	None	Optimise theatre efficiency to an 85% opportunity. Monitor through Project Board and then to TME via PDU Board.	Redacted	Quality Improvement Project ongoing with potential to roll out to other areas - no end date.	Ongoing					
3.14	G	Well Led	**SHOULD DO**	Improve the number of risks on the risk register actioned within the agreed timescales.	Surgery	Chief Nurse	The current process of review via monthly Care Group Governance meetings and feedback to Service Line Managers to continue. Process to be actively managed with Service Line Managers to improve compliance.	None	A reduction in the number of Risks with actions which are overdue. Review monthly at Care Group Governance meeting.	Redacted	31/03/2019	Ongoing					
3.15	G	Well Led	**SHOULD DO**	Standardise the format of minutes of mortality and morbidity meetings to ensure effective sharing of information.	Surgery	Medical Director	Link in with the Mortality Review Group work to standardise HSMR and SHMI triggers to prompt a review of mortality trends. Information will be available to the Service Lines via service line dashboards. The group have agreed a set of principles when reviewing the data that will require a response from the Care Group / Service Line if. 1. The Service Line Lower Confidence Limits show us as an outlier compared with similar services. This is consistent with the Service Line dashboards. 2. 5 consecutive data points are showing a negative trend. 3. NHSI alert received in relation to any patient group. Individual service line review at governance meetings to feed up to the Care Group Board and Governance Leads meetings to facilitate shared learning. Also feeding back to the Morbidity and Mortality Review Group to facilitate trust wide learning when relevant. M&M key findings will be added as an agenda item to the Governance Leads minuted monthly Meeting with the Care Group Director which will ensure the key learnings are shared.	None	Mortality review findings to be reported in to Service Line Governance Meetings to formalise reporting and facilitate shared learning with the Care Group and Trust wide. Review at Care Group Board. We will capture any work that the service line have conducted in reviewing the deaths so there is a central record of investigations. The Care Groups will be requested to attend the Mortality Review Group to update the Group on • What we have learned both good and what needs improvement. • What action has been taken.	Redacted	31/03/2019						
Maternity																	

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														25	50	75	100
4.1	G	Safe	**MUST DO**	Ensure all staff in maternity have in date mandatory training, including emergency procedures and safeguarding.	Maternity	Director of People	1. 'Making Every Conversation Count' training to be included and documented. 2. Additional training sessions to be put in place for Evacuation of pool training. Train additional B7 coordinators 'train the trainers' to ease burden on the room and be able to train more staff. 3. Split the data into midwifery, clinical and admin personnel for accuracy of interpretation and understanding any problems.	None	Ability to provide data to confirm that trained staff are available on every shift. Data split by staff groups on dashboard. To be reviewed at the monthly performance service line meetings.	Redacted	30/11/2018							
4.2	G	Safe	**MUST DO**	Review the systems and processes for ensuring all staff, including medical staff who do not attend mandatory training are followed up and training is completed.	Maternity	Director of People	Bi monthly meeting with HR, Matrons, Practice Development Midwife and Cluster Manager to review all non attenders. Escalation to Director of Midwifery, Service Line Clinical Director and Care Group Manager respectively for non attenders.	None	Review data on 1:1's with Matrons and SLM's on staff members that have DNA'd training sessions.	Redacted	31/10/2018						
4.3.1	G	Safe	**MUST DO**	Review the systems and processes to ensure all equipment has been maintained, checked and cleaned ready for clinical use, including equipment for use in emergencies.	Maternity	Medical Director	MEMS action: 1. Implement new medical devices database with service scheduling and accumulate data for reporting. This is linked to the RFID project (and Scan4Safety), which will enable better tracing of medical devices for maintenance. 2. Increase capacity in Clinical Engineering's Technical Inspector role which carries out routine testing of medical devices.	Database already purchased (£10,500 for first year, £5,200 per year thereafter). RFID project still to be purchased, but approved in principle (£200k for first year, £60k each for second and third years) Additional capacity funded by increased income from new contracts.	Planned outcome is that medical devices servicing is all within date, indicated by the service date label. Reporting from new medical devices database will give assurance of compliance.	Redacted	Database goes live Nov 2018. Accumulated annual data available Nov 2019. 2. RFID project planned to be implemented during 2019. 3. Additional Technical Inspector recruitment planned for Autumn 2018.						
4.3.2	G	See 4.3.1	See 4.3.1	See 4.3.1	Maternity	Medical Director	Service Line action: 1. Revise Maintenance Checklist. 2. Formalise and Monitor handover between band 2 staff. 3. Implement Audit programme of cleaning and present and monitor through Clinical Effectiveness Committee.	None	All equipment will be cleaned, maintained and fit for purpose. Matrons and Serco audits to demonstrate compliance. This will be reported through to the Matrons and reviewed monthly at CEC.	Redacted	31/10/2018						
4.4	G	Safe	**MUST DO**	Review the systems and processes for the safe management of medicines, including replenishment and storage, both within the hospital and in community.	Maternity	Chief Nurse	1. Review Homebirth team medicine storage. 2. Add safe storage of medicines to homebirth team induction. 3. Implement process for checking of drugs in enhanced observation room.	None	All staff will be aware of correct storage of medicines. Routine daily check list and spot check of Homebirth kit will provide ongoing evidence of compliance.	Redacted	30/11/2018						
4.5	G	Safe	**MUST DO**	Ensure the process for approval to work under Patient Group Directions are consistent with trust policy and national guidance.	Maternity	Chief Nurse	Circulate PGD Trust policy to all staff ensuring that all staff sign stating they will adhere to Trust policy. A PGD midwifery specific package will be developed and added to mandatory training with a test demonstrating knowledge and competence. PGD discussion during PROMPt training.	None	All staff will be compliant with local policy. Prescription chart and notes audit to be completed tri-annually and reviewed by Maternity risk team and audit lead midwife.	Redacted	30/11/2018						
4.6	G	Safe	**MUST DO**	Consistently achieve internal targets for the use and completion of the WHO safety checklist.	Maternity	Medical Director	Complete audit of WHO safety checklists. All failed forms to go to the Theatre lead for investigation; accurate fails are sent to the Patient Safety Trust Lead and to all those involved in the theatre teams for response. Cluster Manager to discuss with GN regarding keeping target at optimum level and will meet with GN on a monthly basis to review problem areas.	None	Achievement of internal target. Reviewed at both Theatre and Obstetrics governance meetings.	Redacted	31/10/2018	Current data for Month 4 is green at 98%.					
4.7	G	Safe	**MUST DO**	Ensure patient information is protected in clinical areas and records are amalgamated and stored securely following discharge from the service.	Maternity	Director of Corporate Business	1. Clear backlog of notes - complete. 2. Communicate the importance of completing paperwork in a timely way to Midwifery teams. 3. Weekly audit to be completed by Admin management team on notes in the office for amalgamation. 4. Review current storage of notes and ensure that notes are stored securely.	None	Notes will be up to date in being sent back to Bush Park. Regular checks are in place to ensure that the process of retrieving and filing of paper notes is within current guidelines.	Redacted	31/10/2018						
4.8	X	Well Led	**MUST DO**	Review governance, risk management, and performance processes to ensure threats and defects in the service are visible and escalated appropriately.	Maternity	Chief Nurse	Appoint Care Group Quality Manager to ensure that risks are considered outside of Care Group Management Team for appropriate check and challenge.	None	Quality Manager in place.	Redacted	03/09/2108	Completed	03-Sep-18				
4.9	G	Well Led	**MUST DO**	Comply with the trust process for the introduction of new roles and practices to ensure the associated risks are fully understood.	Maternity	Director of People	1. Re visit Band 5 Nurses Orientation Programme and ensure competencies for all aspects of role are achieved and maintained and that no aspect of role is outside of registration or training. 2. Implement specific supervision with Band 5 nurses by PMA to ensure differences in roles and responsibilities are understood between nursing and midwifery staff.	None	Nurses to have clearly defined boundaries and responsibilities. Assessed annually through appraisal.	Redacted	30/11/2018						

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														25	50	75	100
4.10	G	Effective	MUST DO	Improve the process for document control to ensure policies and procedures are reviewed considering national guidance, before the time of expiry, and only the most recent version is available to staff.	Maternity	Medical Director	1. Review of all guidelines 6 months prior to expiry. 2. Historic and rolling review of version control to be revisited to align with review schedule.	None	No paper copies of documents present in clinical areas. All available guidelines to be current. Ward Managers to provide CEC meeting with assurance that this information is not kept in lever arch folders in ward areas. Reiterate at ward meetings. Audit, Assurance & Effectiveness Team provide monthly assurance report. This can be presented at CEC.	Redacted	31/03/2019						
4.11	G	Effective	MUST DO	Ensure all nurses and midwives delivering care within the high dependency unit have been assessed as competent to care for the critically ill woman.	Maternity	Director of People	1. Change the name of the room to 'Escalated Observation Area' 2. Ensure staff are aware that this is NOT an HDU area. 3. Band 7 coordinators to routinely assess that staff working within area feel able to undertake and escalate appropriately in the context of enhanced observations. 4. Ensure that documentation for patients who are admitted to Enhanced Observation Area reflects the clinical guidelines for that area.	None	All staff can provide midwifery care in the Enhanced Observation Area. They provide regular observations on the patients but with more frequency than patients in the other level zero beds. Audit the MEOWS of patients who have been cared for in the Enhanced Observation Area; this is incorporated into the compliance monitoring that is within the new guidelines.	Redacted	31/10/2018						
4.12	G	Safe	MUST DO	Ensure Modified Early Obstetric Warning Score (MEOWS) charts are used consistently and escalation occurs in accordance with policy.	Maternity	Chief Nurse	Audit MEOWS charts of inpatients every 6 months.	None	All patients have MEOWS chart completed and escalated where appropriate. Monitoring of audit through Clinical Effectiveness Committee.	Redacted	30/11/2018						
4.13	G	Safe	MUST DO	Review the process for classifying serious incidents and external reporting to ensure that all incidents meeting the criteria are reported appropriately. Ensure backlog of actions for serious incidents is completed.	Maternity	Chief Nurse	1. Implement LMS agreement for Pan-Devon Definition of Serious Incidents within Maternity. 2. Backlog to be cleared.	None	Ratified agreement through LMS. Clearance of backlog.	Redacted	30/11/2018						
4.14	G	Safe	SHOULD DO	Consider how to make morning multi-disciplinary handover on delivery suite more efficient and if the two handovers can be merged to maximise a coordinated approach. Consider how actions and information resulting from these handovers is captured.	Maternity	Medical Director	1. Joint review of handover by Maternity Matron and Service Line Director. 2. Electronic or paper capture of handover to be commenced.	None	Presentation of feasibility of aligning shift start times to Care Group Management Team. Audit of compliance of handover documentation through Clinical Effectiveness Committee.	Redacted	31/01/2019						
4.15	X	Well Led	SHOULD DO	Consider implementing a quality manager role, in line with other care groups in the organisation, to support risk management, governance, and oversight from patient to board.	Maternity	Chief Nurse	Quality Manager appointed and commenced in post August 2018.	None	Not Applicable.	Redacted	31/08/2018	Completed.	31-Aug-18				
4.16	G	Responsive	SHOULD DO	Continue with the plans already initiated for a midwifery-led service to comply with national guidance.	Maternity	Chief Nurse	Continue to raise awareness through the LMS, Board Reporting and the Risk Register of inequality with the backdrop of the financial position.	None	Annual Board report. Local Maternity System.	Redacted	Ongoing						
4.17	G	Well Led	SHOULD DO	Expand the use of clinical audit and other improvement tools to proactively measure service delivery.	Maternity	Medical Director	1. Band 6 support Midwife (0.4 wte) to support Audit schedule. 2. Formal allocation of audits. 3. Reporting of audits and monitoring of schedule through Maternity Clinical Effectiveness Committee and in Maternity Governance Report through Quality Assurance Committee.	0.4 WTE of band 6	Band 6 to be in post and leading on formal allocation of audits. Audit schedule compliance and monitoring of findings through Clinical Effectiveness Committee and Trust visualisation in Governance report through Quality Assurance Committee.	Redacted	30/11/2018						
4.18	G	Safe	SHOULD DO	Evaluate the roster to identify if midwifery staff shortages are disparate across the service and disproportionally affect one part of the pregnancy.	Maternity	Director of People	Rosters will be reviewed and, if required, staff will be re-allocated to balance areas.	None	Monitoring through acuity data and information in local and trust staffing report.	Redacted	31/10/2018	Staff are fully rotational and can work in any area and respond accordingly to the peaks and troughs of the service.					
4.19	G	Safe	SHOULD DO	A risk assessment for the safe storage of medical gases should always be available to staff.	Maternity	Director of Corporate Business	Risk assessment to be completed and shared with staff.	None	Staff will have access to the safe storage of medical gases SOP.	Redacted	31/10/2018						
4.20	G	Safe	SHOULD DO	Review the process for ensuring hazardous chemicals are consistently locked away and not accessible to unauthorised persons.	Maternity	Director of Corporate Business	Review the process for ensuring hazardous chemicals are consistently locked away and not accessible to unauthorised persons.	None	All hazardous chemicals will be stored in an area with restricted access. This will be audited across the area by the Matrons.	Redacted	30/11/2018						
4.21	G	Well Led	SHOULD DO	Consider how to increase information technology in the community, and specifically access by community midwives to maternity guidance and blood results.	Maternity	Director of Planning and Site Services	Business case for the solution to be repeated and placed on Risk Register if not financially or physically achievable.	TBC	Staff working in community setting will have access to IT regardless of their place of work. If this is not achievable, the risk will be placed on the Risk Register.	Redacted	31/12/2018						
Outpatients										Redacted							

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														25	50	75	100
5.1	G	Safe	**MUST DO**	Make sure all staff within the outpatient departments have undertaken mandatory training updates in line with trust policy.	Outpatients	Director of People	Service lines are responsible for ensuring that their staff are up to date with training. All OP staff are included in the Care Groups monthly dashboard and performance meetings and part of the Care Group Performance Action plan. For Medicine Care Group: Service Line Managers to produce annual forward planners detailing protected time for named medical staff to undertake all e-learning requirements, as part of their PA time. Matrons to oversee ward managers production of annual forward planners detailing protected time for named nursing staff to undertake all e-learning requirements and embed this into rostering practice. Traceable reasons to be inherent for non attendance/compliance.	None	**Planned Outcome** Service Lines' monthly compliance to be at or above the desired 95% Trust compliance but at least at or above the Trust tolerance of 85%. **Ongoing Assurance** Via monthly Service Line performance, review and scrutinise mandatory training compliance trends. Identify barriers and set actions and support solutions. Via the Care Group (Board): Oversee progression of solutions identified: escalating to corporate level that which is not within the Care Group management team's gift to resolve.	Redacted	31/10/2018						
5.2	G	Responsive	**MUST DO**	Bring the current outpatient referral to treatment time target into line with targets.	Outpatients	Chief Operating Officer	Ensure achievement of the improvement trajectory as agreed with NHSI. Maintain incomplete pathways and reduce 52 week waits by 50% compared to March 2018 position in line with national planning guidance and commissioned levels of activity	If demand is above commissioned levels then risk of additional financial spend.	To achieve agreed trajectory. Monitored daily, reported to Board monthly and reviewed at IDM with NHSI bi-monthly.	Redacted	31/03/2019						
5.3	G	Responsive	**MUST DO**	Bring the current cancer wait targets, especially for two-week wait and 62-day pathways into line with targets.	Outpatients	Chief Operating Officer	To achieve the 62 day standard trajectory as agree with NHSI and achieve the 2ww standard. (detailed action plan in place)		To achieve agreed trajectory. Monitored daily, reported to TME bi-weekly, Board monthly and reviewed at IDM with NHSI bi-monthly. Monthly reporting to Devon Wide Cancer Strategic & Operational Delivery Group	Redacted	31/03/2019						
5.4	G	Safe	**SHOULD DO**	Make sure all staff working in clinical outpatient areas are 'bare below the elbow' in line with best practice and trust policy.	Outpatients	Director of Corporate Business	Reiteration to all outpatient areas via daily email. Completion of Spot Checks. Department Assurance Assessment Framework (DAAF) to be completed Areas/service to produce action plans to improve any deficiencies.	Not Applicable	Compliance with Policy. Audit and spot checks with feedback to appropriate individuals and service lines.	Redacted	31/12/2018						
5.5	G	Responsive	**SHOULD DO**	Take steps to provide sufficient seating and outpatient waiting areas facilities for patients attending appointments.	Outpatients	Director of Corporate Business	Service lines to review their waiting areas and submit plans to provide sufficient seating to OPD Board.	To be confirmed.	Improve facilities where possible. Review progress at OPD Board.	Redacted	31/12/2018	Serious risk within Medicine Care Group Risk ID 5659 Risk to quality of patient care, staff experience, and organisation reputation, due to the quality of the estate. This incorporates the insufficient size of key OPDs overseen by the MCG.					
5.6	G	Safe	**SHOULD DO**	Make sure patient notes are stored securely when not in use in outpatient clinics.	Outpatients	Director of Corporate Business	Reiteration to all outpatient areas through daily email. Completion of Spot Checks. Department Assurance Assessment Framework (DAAF) to be completed. Areas/service to produce action plans to improve any deficiencies. Liaise with Vanessa Bennett in relation to the Health records audits that are undertaken to gain a better understanding of what is audited and what can be audited in future and increase regularity if possible.	Not Applicable	Patient notes held securely. Review progress at OPD Board.	Redacted	31/12/2018						
5.7	G	Well Led	**SHOULD DO**	Ensure that learning from any serious incidents is embedded within the relevant department and the wider organisation.	Outpatients	Director of Corporate Business	Serious incidents are discussed, shared and disseminated through the Care Group and Service Lines Clinical Governance Structure. Appropriate learning will be shared across the Trust via the OPD Board. Develop reports for Trustwide review of serious incidents in OPD areas with the aim for OPD Performance and Governance to understand trends and themes.	Not Applicable	Learning will be embedded. Where SIRI's in OPD have occurred, service line to present RCA/SBAR and actions at OPD Board.	Redacted	31/12/2018						
5.8	G	Responsive	**SHOULD DO**	Keep patients informed of delays in outpatient clinics making sure staff communicate effectively with patients with disabilities and sensory loss.	Outpatients	Director of Corporate Business	Gain understanding of ways to improve communication using different types of technology and understanding best practice across Trust at OPD Forum. Implement identified actions across OPD areas.	To be confirmed.	Friends and Family Test reduction in concerns raised in relation to delays in OPD clinics as well as informal and formal complaints.	Redacted	31/12/2018						
Diagnostic Imaging										Redacted							
6.1.1	G	Safe / Responsive / Well Led	**MUST DO**	Address and resolve the issue of unrecognised or unaddressed risks in the diagnostic imaging teams connected with patient safety, staff pressures, performance, and governance failings.	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Risk Owners to review and update risks on the Risk Register.	None	All serious & moderate risks should be reviewed monthly. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead. Risk Register will be routinely reviewed at the Imaging Board.	Redacted	28/09/2018	Completed.	17/08/2018				

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														25	50	75	100
6.1.2	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Updated Risk Register to be reviewed by Care Group Manager CSS and Project Director	None	All serious & moderate risks should be reviewed monthly. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead. Risk Register will be routinely reviewed at the Imaging Board.	Redacted	28/09/2018	In progress					
6.1.3	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Governance Manager to review Never Event actions to establish current status of implementation. Summary report to be produced for Project Director.	None	All outstanding actions will be reviewed. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead.	Redacted	28/09/2018						
6.1.4	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Governance Manager to review implementation of Safer Surgery Checklist. Summary report to be produced for Project Director.	None	Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead.	Redacted	28/09/2018						
6.1.5	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Governance Manager to review patient improvement action plan to establish current status of implementation. Summary report to be produced for Project Director.	None	All outstanding actions will be reviewed. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead.	Redacted	28/09/2018						
6.1.6	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Review status of radiation protection audit plan to establish current status of implementation. Summary report to be produced for Project Director.	None	All outstanding actions will be reviewed. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead.	Redacted	28/09/2018						
6.1.7	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Review all severe risks.	None	All serious & moderate risks should be reviewed monthly. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead. Risk Register will be routinely reviewed at the Imaging Board.	Redacted	28/09/2018						
6.1.8	G	See 6.1.1	See 6.1.1	See 6.1.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Review all risks graded 'low'.	None	All serious & moderate risks should be reviewed monthly. Overview by Imaging Governance Manager. Escalation to Service Line Manager and Clinical Governance Lead. Risk Register will be routinely reviewed at the Imaging Board.	Redacted	28/09/2018						
6.2.1	G	Responsive	**MUST DO**	Make significant improvements to meeting the needs of patients in the diagnostic imaging departments in terms of timeliness of their appointments.	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Corporate response: Ensure achievement of the improvement trajectory as agreed with NHSI. Reduce DMO1 reportable tests > 6 week waits to 3.4% by March 2019 (detailed action plan in place).	If demand is above commissioned levels then risk of additional financial spend.	To achieve agreed trajectory. Monitored daily, reported to Board monthly and reviewed at IDM with NHSI bi-monthly.	Redacted	31/03/2019						
6.2.2	X	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Service Line response: Develop plans to provide additional scanning capacity.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Completed. Plans in place and coming onstream to provide additional scanning capacity.	01-Aug-18				
6.2.3	X	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Develop scanning trajectories to illustrate the reduction in backlog for CT, MRI & US.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Completed	01-Aug-18				
6.2.4	X	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Develop weekly cancer WT performance tracker for each modality.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Completed	07-Aug-18				
6.2.5	X	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Commission Admin/Booking review.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Completed	07-Aug-18				
6.2.6	X	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Secure funding for 2WW Co-ordinator.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Completed	07-Aug-18				
6.2.7	G	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Implement plans to further increase scanning capacity.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	In progress					

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														25	50	75	100
6.2.8	G	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Update scanning trajectories based upon latest plans.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	In progress					
6.2.9	X	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Present proposal to increase reporting capacity to Exec Directors.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Proposal agreed.	04-Sep-18				
6.2.10	G	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Agree proposal to increase reporting capacity with Consultant Radiologists.	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018						
6.2.11	G	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Agree plan to provide protected access to beds for Imaging (PIU, Norfolk or Lynd).	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Not started					
6.2.12	G	See 6.2.1	See 6.2.1	See 6.2.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Secure approval for x3 additional Booking Clerk posts (FTC).	TBC	To substantially reduce WT's with the aim of meeting national and local WT standards and to create sufficient operational contingency to enable lagging to cope with increases in demand or machine downtime.	Redacted	Substantial improvement in WT by 26/10/2018	Not started					
6.3.1	X	Well Led	**MUST DO**	Ensure the leaders within the diagnostic imaging departments have the capacity to lead and provide assurance of the quality, safety, and responsiveness within the service.	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Commission initial 'self assessment' of capacity versus responsibilities.	TBC	Service Line Manager & Superintendant Radiographer to agree time that each lead requires and an action plan to achieve that.	Redacted	28/09/2018	Completed	20-Aug-18				
6.3.2	G	See 6.3.1	See 6.3.1	See 6.3.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Service Line Manager & Superintendant Radiographer to identify proposals to address the shortfall identified via the self assessment of capacity versus responsibilities..	TBC	Service Line Manager & Superintendant Radiographer to agree time that each lead requires and an action plan to achieve that.	Redacted	28/09/2018	In progress					
6.4	G	Well Led	**MUST DO**	Support and improve the culture and wellbeing for the diagnostic imaging staff.	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Develop Action Plan to support and improve culture and wellbeing. Key actions: - Reinstate HR Leadership Meetings fortnightly with Clinical Leads w/c 03.08.18. - Actions to support the development of Senior Leads. - Implement Communication Boards. - Ensure regular senior management Walkabouts. - Implement 'SCORE' in Interventional Radiology. - Ensure that musculoskeletal risks are on the risk register and are being adequately managed.	TBC	Action plan in place with timescales for delivering improvement. Progress reviewed in fortnightly meetings between Project Director, Service Line Manager and HR Business Partner.	Redacted	26/10/2018	Not started					
6.5.1	X	Safe	**MUST DO**	Replace imaging equipment which is beyond its 'end of life', and continue to develop and act upon in a timely way, the imaging capital replacement programme, to increase business continuity and minimise risks of harm to patients.	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Service Line Manager to review Imaging equipment register on the Site Development Plan.	TBC	A comprehensive, up to date, risk assessed register of all Imaging equipment, prioritised for replacement with planned and projected dates for replacement. This should be co-owned by the SL, Finance & Estates	Redacted	28 September 2018	Completed	10-Aug-18				
6.5.2	G	See 6.5.1	See 6.5.1	See 6.5.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Governance Manager to cross check with Risk Register any equipment nearing or beyond 'end of life' to ensure that all such items have been risk assessed.	TBC	A comprehensive, up to date, risk assessed register of all Imaging equipment, prioritised for replacement with planned and projected dates for replacement. This should be co-owned by the SL, Finance & Estates	Redacted	28/09/2018	In progress					
6.5.3	G	See 6.5.1	See 6.5.1	See 6.5.1	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	Assess/update risk and assign prioritisation for replacement.	TBC	A comprehensive, up to date, risk assessed register of all Imaging equipment, prioritised for replacement with planned and projected dates for replacement. This should be co-owned by the SL, Finance & Estates	Redacted	28/09/2018	Not started					
6.6	G	Safe	**MUST DO**	Make sure all patients of child-bearing age have the appropriate pregnancy checks recorded.	Diagnostic Imaging (Warning Notice)	Chief Operating Officer	1.Assess and deliver any training & communication needs. 2.Audit compliance and take appropriate action.	None	Agreed and communicated SOP and audit programme in place.	Redacted	28/09/2018	SOP in place but was confusing. DN has written to Radiographer Leads asking them to confirm that the requirements have been communicated to staff.					
6.7	G	Safe	**MUST DO**	Progress the e-referral system implementation to reduce risks to patient safety, particularly around unnecessary exposure, and incorrect referrals.	Diagnostic Imaging	Chief Operating Officer	1. Review e-referral risks on Risk Register. 2. Project Director to meet with Director of IM&T & CSS Care Group Manager to agree next steps. 3. Service Improvement to be commissioned to process map the process in ED. Next steps will be decided once this is complete.	TBC	A shared understanding of the risks, agreed mitigating action and clear next steps with responsibilities and timeframes.	Redacted	30/09/2018	Project Director has reviewed risks on the Risk Register. Project Director and CGM have met with Director of IM&T.					

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														25	50	75	100
6.8	G	Safe	SHOULD DO	The service needs to improve compliance rates for mandatory training, to ensure all staff are up to date with the latest practices and processes to keep patients and themselves safe.	Diagnostic Imaging	Chief Operating Officer	1. Obtain list of staff with outstanding mandatory training. 2. Confirm course availability, ensure that staff are booked to attend training and have supportive conversations with staff where required.	None	Trust target for completion of mandatory training will be achieved	Redacted	26/10/2018	Not started					
6.9	G	Safe	SHOULD DO	Complete paperwork associated with infection prevention and control and that it is appropriately countersigned by a senior radiographer.	Diagnostic Imaging	Chief Operating Officer	1.Review and address existence and suitability of SOP. 2.Assess and deliver any training & communication needs. 3.Audit compliance and take appropriate action.	None	Compliance with Trust Infection Control Policy.	Redacted	28/09/2018	Not started					
6.10	G	Effective	SHOULD DO	Improve compliance with audits such as the hip fracture audit and the trauma audit.	Diagnostic Imaging	Chief Operating Officer	This is assessed as part of ISAS accreditation and is not considered to be an issue. Evidence to be provided.	TBC	Confirmation of compliance with ISAS expectations.	Redacted	26/10/2018	Not started					
6.11	G	Effective	SHOULD DO	Ensure that all staff receive, annually, an up to date appraisal.	Diagnostic Imaging	Chief Operating Officer	1. Obtain list of outstanding appraisals. 2. Obtain summary of outstanding job plans for Service Line Clinical Director. 3. Address outstanding appraisals and job plans.	None	All outstanding appraisals will have been completed. All job plans will be up to date.	Redacted	28/09/2018	In progress					
6.12	G	Caring	SHOULD DO	Improve privacy and dignity for patients in the diagnostic imaging department. Particularly in plain film X-ray, MRI and nuclear medicine.	Diagnostic Imaging	Chief Operating Officer	Undertake privacy & dignity assessment and develop an Action Plan.	TBC	Action plan in place with timescales for delivering improvement.	Redacted	28/09/2018	Not started					
6.13	G	Well Led	SHOULD DO	Ensure that targets set in diagnostic imaging are achievable, realistic, and encourage the service to improve.	Diagnostic Imaging	Chief Operating Officer	Agree KPI's and Performance Standards.	None	A comprehensive list of achievable KPI's which will inform performance management	Redacted	28/09/2018	SLCD to sign off and then circulate for agreement to modality Consultant leads.					
Trustwide										Redacted							
7.1.1	G	Well Led	MUST DO	Address and resolve the remaining issues with staff and staff groups who do not feel valued and supported. Ensure that action is taken to address behaviour that is inconsistent with the values of the organisation.	Trustwide	Director of People	Make a Trust values commitment statement - set out a clear message from the Chief Executive about values, Trust commitment to truly living by them, commitment to action etc	None	This action will set a clear message to staff about the priority and commitment to a positive culture and sets the landscape for other actions	Redacted	30/09/2018						
7.1.2	G	See 7.1.1.	See 7.1.1.	See 7.1.1.	Trustwide	Director of People	Expand and increase profile of the Your Voice methodology as a means of enabling staff to speak up. Through all leadership roles, within Care Groups. Require Care Groups to report on Your Voice sessions that have taken place and emerging themes to Care Group review. Key themes to be reviewed and followed up .	None	This action will deliver the outcome of increasing the number of conversations with staff to check-in on culture. Measured via Care Group review target of number of sessions to actual. Demonstrate actions taken.	Redacted	Embedded within Care group review process by 30/11/2018.						
7.1.3	G	See 7.1.1.	See 7.1.1.	See 7.1.1.	Trustwide	Director of People	Increase the Freedom to Speak Up Guardian numbers and publicise widely.	None	This action will widen the access to this support mechanism	Redacted	30/09/2018						
7.1.4	G	See 7.1.1.	See 7.1.1.	See 7.1.1.	Trustwide	Director of People	Explore the introduction of an independent raising concerns mechanism (Speak in Confidence) for staff concerns.	None	This action will provide an additional independent route for staff to raise concerns and allows anonymous reporting.	Redacted	30/11/2018						
7.1.5	G	See 7.1.1.	See 7.1.1.	See 7.1.1.	Trustwide	Director of People	Introduce a 360 degree appraisal process as part of leadership development.	None	This action will ensure leaders (Band 7 and above) receive feedback about behaviour and receive coaching support to address any areas for improvement.	Redacted	31/03/2019						
7.1.6	G	See 7.1.1.	See 7.1.1.	See 7.1.1.	Trustwide	Director of People	Promote a top 20% Staff survey response rate.	None	This action will ensure that a majority of staff have the opportunity to share their views on working in the Trust and provide reliable data.	Redacted	31/12/2018						

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														25	50	75	100
7.2	G	Effective	**MUST DO**	Be assured that the trust is meeting its obligations to have a legal basis to deprive someone of their liberty. Ensure that Deprivation of Liberty Safeguard rules applications are fully understood, recognised and created by those staff who are accountable and responsible for the application.	Trustwide	Chief Nurse	1. Repeat communication to all staff via the internet, Team Brief and daily huddles for the next quarter. 2. Matrons will be requested to ensure the process is displayed within all clinical environments to ensure that staff who don't access their emails are made aware of the process. 3. Meeting will be held via Matron's forum to ensure that all senior staff are aware of responsibility and can share and support further implementation. 4. Training and ward specific update re MCA and DoLS has commenced throughout the Trust and will continue. 5. Continue Audit to evidence improvement in staff awareness of safeguarding issues and specifically MCA and DoLS processes. Target support to wards that do/should apply DOLS regularly or where issues are identified. 6. A review of Safeguarding Adults processes within the Trust has been completed and the results of this will be available in Mid September 2018. The outcome will be considered and changes made to process to ensure risk is reduced. 7. The Medical lead for MCA has recently retired and Executive review is taking place to ensure that there is medical oversight and liaison within the Trust. This will further strengthen the ability to improve information sharing and liaise with staff at all levels and drive the service forward at Executive level. This is secondary to the Trust Safeguarding Nursing service contribution.	Moderate	• Evidenced through awareness audit and feedback from staff, managers and multi-agency partners. • Changes in policy to be implemented via the safeguarding steering group. • Communication evidence via vital signs and minutes from Matron Meetings. • Poster to be visible in wards and departments.	Redacted	01/10/2018					
7.3	G	Responsive	**MUST DO**	Work with stakeholders and commissioners to address the failure to meet almost all the national targets or standards for patient care. This includes most significantly the cancer standards and the failure of diagnostic standards.	Trustwide	Chief Operating Officer	COO to write to Chair of Western Locality Board to arrange a discussion on how best to pick these issues up. Series of UHPNT/CCG Exec to Exec meetings to be arranged to agree areas of joint work.	If demand is above commissioned levels then risk of additional financial spend.	To achieve agreed trajectory. Monitored daily, reported to Board monthly and reviewed at IDM with NHSI bi-monthly.	Redacted	31/03/2019						
7.4.1	G	Safe / Responsive / Well Led	**MUST DO**	Address and resolve the issue of unrecognised or unaddressed risks in the pharmacy teams connected with patient safety, staff pressures, performance, and governance failings.	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Complete Gap Analysis against Royal Pharmaceutical Society Hospital Pharmacy Standards to identify and manage unrecognised areas of risk.	None	Updated and maintained 'active' risk register. Managed by the newly formed Pharmacy Board and owned by designated leads in accordance with the Trustwide Risk Management Policy. Measurement: Risk Report (monthly). Monitoring will be ongoing through MUAC and Pharmacy Board reporting to Safety and Quality Committee and Trust Management Executive.	Redacted	30/09/2018	ongoing					
7.4.2	G	See 7.4.1	See 7.4.1	See 7.4.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Review and update Pharmacy Risk Register to include items identified in the recent CQC inspection for example theft of medicines with no timescales of actions.	None	Monitoring will be ongoing through MUAC and Pharmacy Board reporting to Safety and Quality Committee and Trust Management Executive. Risk Management Group will review Serious Risks and escalate as per Risk Management Policy.	Redacted	30/09/2018						
7.4.3	X	See 7.4.1	See 7.4.1	See 7.4.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Improve corporate oversight of pharmacy risk register by removing pharmacy reporting via Clinical Support Services and create a pharmacy specific report.	None	Pharmacy Specifically added to the corporate risk management report.	Redacted	01/08/2018	Complete	10-Aug-18				
7.5.1	X	Safe / Well Led	**MUST DO**	Address and resolve the cultural, wellbeing, staffing, resource, and workload issues within the pharmacy service and as they affect both the service and the wider trust.	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Put in place an Interim management regime to support pharmacy that are committed to displaying the values of the organisation whilst being accessible and visible to Pharmacy staff.	Yes	Interim Chief Pharmacist appointed. Interim Service Line Manager appointed.	Redacted	03/04/2018	Complete	03-Apr-18				
7.5.2	X	See 7.5.1	See 7.5.1	See 7.5.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Additional senior expertise requested to support Pharmacy with the aim to speed up implementation of change.	None	Tiger Team put in place to support improvements in Pharmacy Service. Metrics: - Complete internal staff survey to enable measurement of early change. - Staff Temperature check - Reduction in absenteeism, improved recruitment and retention. - Appraisals booked (and/or completed). Monitoring will be ongoing through MUAC and Pharmacy Board reporting to Safety and Quality Committee and Trust Management Executive.	Redacted	30/07/2018	Complete	30-Jul-18				

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														25	50	75	100
7.5.3	X	See 7.5.1	See 7.5.1	See 7.5.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Secure interim support from partner organisation to support clinical leadership.	None	Pharmacists from Livewell to provide support at UHP.	Redacted	30/05/2018	Complete	30-May-18				
7.5.4	G	See 7.5.1	See 7.5.1	See 7.5.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Implement a series of leadership and team development days planned to support staff.	None	Regular team development and engagement sessions planned	Redacted	Ongoing	To date - - 2 leadership days -76% attended. - 5 development days - 66% attended. Further dates are planned to mop up those who have not had the opportunity to attend the initial sessions.					
7.5.5	X	See 7.5.1	See 7.5.1	See 7.5.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Conduct a gap analysis of current establishment.		Agreement with FIG to recruit to all existing vacancies but will be reviewed as required.	Redacted	01/07/2018	Complete	01/07/2018				
7.5.6	G	See 7.5.1	See 7.5.1	See 7.5.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Recruit to current vacancies as identified in establishment review.	To be determined	Resumption of Normal Service of Ward Based Pharmacists. All vacancies recruited to as measured by the Vacancy rate.	Redacted	30/04/2019	Band 6 pharmacists posts offered with start dates Aug-Sept 18. Band 8a specialist pharmacists posts offered and also out to advert. Complete % for vacancies is actual pharmacists started in post.					
7.5.7	G	See 7.5.1	See 7.5.1	See 7.5.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Conduct a workforce review in line with the planned pharmacy integration with Livewell.	To be determined	Workforce paper to TME.	Redacted	01/04/2019						
7.6.1	G	Safe	MUST DO	Urgently produce standard operating procedures to ensure patients leave the hospital with critical medicines, and attend or are made aware of any critical follow-up appointments.	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	To implement a system to monitor TTAs returned to pharmacy containing critical medicines.	None	Documented evidence of monitoring of TTAs returned to pharmacy containing critical medicines.	Redacted	14/09/2018						
7.6.2	G	See 7.6.1	See 7.6.1	See 7.6.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Any critical medicine that is returned without a valid reason will be escalated.	None	Confirmation of new process implemented - standard operating procedure produced.	Redacted	14/09/2018						
7.6.3	G	See 7.6.1	See 7.6.1	See 7.6.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Develop a system to enable and encourage ward staff to state a reason for the return of TTAs containing critical medicines to pharmacy. An electronic tracking system which could help with this is due to go live over the summer of 2018 (subject to capacity of the Software Development Team). Obtain update on progress with implementation.	None	Confirmation of status of implementation of electronic tracking system.	Redacted	28/02/2019	The pilot for EPMA has a delayed start date of February 2019.					
7.6.4	G	See 7.6.1	See 7.6.1	See 7.6.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Lynher Ward Manager (part of Pharmacy Tiger Team) to meet with Dispensary Supply Manager and Head of Nursing for Medicine with a view to unpicking the ward process around discharge and TTAs to make this process more robust. Appropriate actions will then be developed.	None	Development of process to ensure that patients leave hospital with critical medicines.	Redacted	26/10/2018						
7.6.5	G	See 7.6.1	See 7.6.1	See 7.6.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	1. Undertake a review of the confirmation letter process – both content of letter and adherence to process. 2. Undertake a review of the ward admin process relating to follow up appointments related to discharge process review.	None	Patients will be aware of, and attend, their critical follow up appointments. Monitor via DNAs & Patient Cancellations	Redacted	30/11/2018						
7.7.1	G	Well Led	MUST DO	Ensure effective governance within the pharmacy service to provide a high quality and safe service.	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Undertake a review of the current pharmacy governance framework and make recommendations to Trust Management Executive for a revised structure.	None	An accepted interim proposal by Trust Board for where Pharmacy Governance reports. To be ratified at the Pharmacy Board. Monitoring will be ongoing through MUAC which will now report to Safety and Quality Committee. A newly formed Pharmacy Board will report directly to Trust Management Executive.	Redacted	30/09/2018	Proposal will be presented to pharmacy board on 24/09/2018					
7.7.2	G	See 7.7.1	See 7.7.1	See 7.7.1	Trustwide - Pharmacy (Warning Notice)	Chief Nurse	Additional review and redesign of the Medicines Utilisation and Assurance Committee (MUAC) with recommendation to Safety and Quality Board for revised reporting.	None	Terms of reference (TOR) reviewed and updated for MUAC and a new TOR for the Pharmacy Board.	Redacted	31/10/2018						

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														25	50	75	100
7.8	G	Well Led	**SHOULD DO**	Demonstrate in the board papers the open and professional challenge we were told happened.	Trustwide	Director of Corporate Business	Board Secretary to ensure that any challenge at the Board and its Committees is minuted and the nature of the challenge is accurately and clearly stated in the minutes. Invitations to Board members to raise questions on any item are always minuted, as is any response made. When no questions arise, this is also minuted to reflect no challenge having been made. This approach to minute taking will continue for the Board and its Committees. Director of Corporate Business, Chairman and Committee Chairs to review all Minutes to ensure that challenge is adequately captured.	Not Applicable	Board and Committee minutes will reflect any and all challenge made. This will be confirmed in the Board and Committee's review of minutes of previous meetings.	Redacted	31/10/2018						
7.9	G	Well Led	**SHOULD DO**	Maintain the personnel files of the trust's directors to demonstrate that the evidence to support them being Fit and Proper Persons can be reviewed and checked.	Trustwide	Director of People	1. Create a checklist for Safe Recruitment and Fit and Proper Persons test and add it to all Executive Director and Non Executive Director personnel files. 2. As checklist is added to files, complete an audit and act as necessary to ensure compliance. 3.Put in place an annual audit schedule, next due September 19.	None	This will ensure consistency, that all relevant checks are completed and that all files are up to date and remain up to date.	Redacted	31/10/2018						
7.10	X	Well Led	**SHOULD DO**	Update the policies and procedures relating to criminal record checks to ensure they are current and referring to the current processes.	Trustwide	Director of People	Policies have been updated.	None	Policies will be checked annually to ensure compliance is maintained or earlier if legislative change.	Redacted	Completed	Completed	31/08/2018				
7.11	G	Well Led	**SHOULD DO**	When producing the Quality Report or published documents for people who use the service, make sure they demonstrate whether the organisation has met its objectives to people who use services.	Trustwide	Chief Nurse	On production of the Quality Account we will ensure that key metrics are included that demonstrate whether we have met the targeted objective.	Not Applicable	Quality Account June 2018/19 will demonstrate whether we have met our objectives.	Redacted	30/06/2019						
7.12	G	Well Led	**SHOULD DO**	Address the recognised gap between the care groups in terms of the assurance process and as it flows upwards to the trust board. Consider, as would be best practice, an external review of governance as a possible way of addressing this.	Trustwide	Director of Corporate Business	We will commission an external review of our governance arrangements to independently test the robustness of assurance from Care Groups to the Trust Board.	£10,000	We will receive independent advice on our governance framework and take action to implement any recommendations for improvement where appropriate.	Redacted	31/12/2018						
7.13	G	Well Led	**SHOULD DO**	Produce reliable data on the working hours of doctors and dentists in training to be able to gain assurance that the trust was meeting the requirement for these staff to work safety and undertake their training and development.	Trustwide	Director of People	Reliable data and assurance on the working hours of doctors and dentists will be gained through the Trust roll out of e-roster for medical staff	None	The Trust will have access to reliable information through a central database for Carter areas and Medicine. Compliance monitoring via TME and HR&OD Committee.	Redacted	31/10/2019						
7.14	G	Well Led	**SHOULD DO**	Provide the board with assurance that duty of candour, as a statutory regulation, is being consistently applied where required.	Trustwide	Chief Nurse	Add the Duty of Candour metric to Integrated Performance Report.	Not Applicable	Assurance will be provided via the Integrated Performance Report.	Redacted	30/09/2018						
7.15	G	Well Led	**SHOULD DO**	Demonstrate that progress is made on reducing the disproportionate level of violence and aggression from patients and the public to staff identifying as from a Black and minority ethnic background.	Trustwide	Director of People / Chief Nurse	1. To incorporate into leadership training (Manager's Passport) the promotion of a zero tolerance approach to acts of violence, aggression and harassment from members of the public/patients, towards staff, and outline management responsibility in supporting staff. 2. Develop posters for display within staff areas across the Trust outlining zero tolerance to violence, aggression and harassment from the public/patients and the assistance and support that is available for staff. 3. With the recent appointment of a dedicated Physical Interventions Lead for the Trust, continue to roll out training for staff in conflict de-escalation, breakaway techniques and physical interventions, with a targeted approach to offer training for all patient/visitor facing staff identifying as from a Black and minority ethnic background.	None	Leadership development will ensure that E&D and violence and aggression zero tolerance is embedded. Posters to be displayed Trust wide with promotion of conflict de-escalation, breakaway techniques and physical interventions training for staff. Progress will be monitored via the staff survey although the impact of the actions are unlikely to be felt until the 2019 staff survey. This will be monitored at EDIWG.	Redacted	1. Manager's Passport training roll out commenced June 2018. 2/3. Promotion of zero tolerance of violence and aggression, support channels and conflict resolution/de-escalation training by 30 November 2018						
7.16	G	Well Led	**SHOULD DO**	Look again at the work plan for the Equality, Diversity and inclusivity group to ensure its objectives and achievable and realistic.	Trustwide	Director of People	Review EDIWG Work Plan to ensure that objectives are achievable and reporting timeframes realistic.	None	Achievement against the work programme will be monitored through EDIWG and reviewed at 6 monthly intervals	Redacted	20/09/2018						
7.17	G	Well Led	**SHOULD DO**	Produce a published Workforce Race Equality submission which is complete and demonstrates the trust is investing in this area.	Trustwide	Director of People	WRES submission will be published on the Trust's website with narrative.	None	Achievement of this will be monitored through EDIWG.	Redacted	30/09/2018						
7.18	G	Well Led	**SHOULD DO**	Provide the board with assurance that investigations into serious incidents or complaints described in the monthly integrated performance report are leading to learning and change where this is needed.	Trustwide	Chief Nurse	Learning from incidents and complaints will be added to the Safety & Quality Committee report (Safety & Quality are a sub committee of the Board). Relevant publications, e.g. the REACT bulletins will also be added to the appendix of this report.	Not Applicable	Assurance to be gained via Safety & Quality Committee which will receive the Integrated Performance Report.	Redacted	31/10/2018						
7.19	G	Well Led	**SHOULD DO**	Give assurance that the trust board is reviewing and satisfied with the risks it is responsible for on the Board Assurance Framework.	Trustwide	Director of Corporate Business	The Board Assurance Framework (BAF) is already reviewed at every public meeting by the Trust Board. We will, however, complete the review and refresh of our BAF which began in July 2018.	Not Applicable	We will ensure that the Trust Board better understands the risks for which it is responsible and defines and oversees the actions required to mitigate them.	Redacted	31/10/2018						
7.20	X	Well Led	**SHOULD DO**	When producing the annual complaints report, look to describe changes and improvements made from complaints and concerns, and not from other areas of activity within the trust unrelated to complaints.	Trustwide	Chief Nurse	The complaints annual report this year included a range of improvements which were initiated as a result of patient feedback including complaints. Going forward Datix can now report on specific actions taken as a result of individual complaints. This will therefore not be an issue going forward	None - forms part of the Datix complaints module	The annual report will clearly describe changes and improvements made from complaints and concerns. Regular reporting of action plans and actions taken to PEC on a bi monthly basis.	Redacted	Complete	Complete	29/08/2018				

Ref No.	GYR Status	Domain (SCERW)	Requirement Notice	Area for Improvement	Core Service	Executive Lead	Planned Action(s)	Financial Impact (where relevant)	Planned Outcome and how will you ensure ongoing assurance of compliance?	Responsible Lead	Target Completion Date	Status	Actual Date Completion	Percentage Complete			
														25	50	75	100
7.21	G	Responsive	**SHOULD DO**	Look to reduce the increasing number of complaints that are reopened, often as they have not satisfied the person who has complained.	Trustwide	Chief Nurse	1. Review the current classification used to identify reopened complaints. Report those complaints where the complainant is dissatisfied with the quality and detail of the response. This will include the following two reportable categories: Failed to fully answer questions and / or Remains dissatisfied. 2. Define quality check process including a step by step guide to ensure the response letter provides an honest and accurate response, addressing all issues raised . Patient Experience & Engagement Lead to randomly review a selection of complaint responses each week for quality.	None - forms part of the Datix complaints module	Reduction in number of re-opened complaints. Regular monitoring of the number of complaints re-opened. Additional section in the Patient Experience Report to focus on re-opened complaints showing run rate of cases and reasons for reopening.	Redacted	30/11/2018						
7.22	G	Well Led	**SHOULD DO**	Review the risks around electricity supply and car parking capacity, and ensure these are reflected on the corporate risk register and the Board Assurance Framework if considered appropriate. Ensure the risks around the estate have longer-term actions described in the Board Assurance Framework.	Trustwide	Director of Corporate Business	The Corporate Risk Review Panel will review any DATIX risks associated with the electricity supply and car parking capacity as part of its meeting in October 2018. With regard to the risks associated with the Estate, this will be addressed as part of the review and refresh of our BAF referred to in action 7.19.	None	We will ensure that these risks have been appropriately recorded, reported and acted upon in accordance with the Trust's Risk Management Policy.	Redacted	30/10/2018						
7.23	X	Well Led	**SHOULD DO**	Resolve the issues for the infection prevention and control team around signing-off data for NHS England.	Trustwide	Chief Nurse	There were significant IT issues in April which meant we had problems logging onto the This was largely due to the introduction of a new system by our IT department which resulted in us signing off our April data later than the required date of the 15th May. Unfortunately the problems persisted into May. Despite this the May data was signed off before the June 15th deadline and the issue has now been resolved.	Not Applicable	Not Applicable	Redacted	Complete	Complete	15/06/2018				
7.24	G	Well Led	**SHOULD DO**	Consider what improvements can be made to reduce the risks from the three-stage safeguarding system for adults in the light of the far better system used for children. Bring this risk to the corporate risk register for monitoring and improvement.	Trustwide	Chief Nurse	1. A review of Safeguarding Adults processes within the Trust and the results of this will be available in Mid September 2018. The outcome will be considered and changes made to process to ensure risk is reduced. 2. This has been placed on the Trust risk register and review of the recording system will be complete by the end of September following the wider review of safeguarding adult systems.	Moderate	New system to be in place end October 2018 reported via Safeguarding Steering Group and change in policy to reflect this.	Redacted	01/11/2018						
7.25	G	Well Led	**SHOULD DO**	Add the issue around it being possible to access and incorrectly update the wrong patient medical record to the risk register for monitoring and improvement.	Trustwide	Director of Planning and Site Services	Datix Risk recorded - ID: 6323 with Simeon Brundell (Clinical Safety Officer) and Paul Copleston (Head of IM&T Software Development, Integration and Clinical Systems Management) as the actioning officers. ICM has warning notices in 2 places already. Upgrade added a further measure to alert requester to ensure that they have selected the correct patient. Plan to add a double check to the request form which will send alerts to the Clinical Safety Officer.	None	Clinical Safety Officer and Head of IM&T Software Development, Integration and Clinical Systems Management regularly to progress the actions. This is also expected to be picked up in the revised Clinical Reference Group when it is established with a Chief Clinical Information Officer (CCIO) in post (about to be appointed).	Redacted	01/11/2018	Implementation					
7.26	G	Well Led	**SHOULD DO**	Raise awareness with staff of how patient feedback is used to improve services.	Trustwide	Chief Nurse	New ward and department noticeboards to include a section which identifies actions taken to improve.	Awaiting confirmation of funding for noticeboards	Noticeboards on each ward and department.	Redacted	30/10/2018	Draft noticeboard in place. Awaiting funding confirmation					
7.27	G	Well Led	**SHOULD DO**	Demonstrate that actions have been taken when learning from patient death and how these actions have improved practice and reduced the risk of events happening again.	Trustwide	Medical Director	The Learning from Deaths report will include specific examples where actions have been taken to improve practice or cross referenced to the appropriate improvement program.	Not Applicable	Assurance to be gained from the Learning from Deaths report to Trust Board.	Redacted	30/11/2018						
7.28	G	Well Led	**SHOULD DO**	Provide consistency in the quality and effectiveness of the mortality and morbidity reviews at service line or speciality level. Ensure in doing so that any concerns within national indicators are investigated and explained.	Trustwide	Medical Director	The Mortality Review Group will now look at HSMR & SHMI by Service Line in a run chart format; this is the same data that is available on the Service Line dashboards. The Group have agreed a set of principles when reviewing the data that will require a response from the Care Group / Service Line if: 1. The Service Line Lower Confidence Limits show us as an outlier compared with similar services. This is consistent with the Service Line dashboards. 2. 5 consecutive data points are showing a negative trend. 3. Mortality alerts received in relation to any patient group. The Care Groups will be requested to attend the Mortality Review Group (period to be defined) to update the Group on: • What we have learned, both good and what needs improvement; and • What action has been taken.	Not Applicable	Updated report to Mortality Review Group.	Redacted	31/10/2018						
Use of Resources																	

Ref No.	GYR Status	Domain (SCERW)	Requirement Notice	Area for Improvement	Core Service	Executive Lead	Planned Action(s)	Financial Impact (where relevant)	Planned Outcome and how will you ensure ongoing assurance of compliance?	Responsible Lead	Target Completion Date	Status	Actual Date Completion	Percentage Complete			
														25	50	75	100
8.1	G	Use of Resources	Area for improvement	The trust is not meeting its constitutional performance targets.	Trustwide - Use of Resources	Chief Operating Officer	See 7.4	See 7.4	See 7.4	Redacted	See 7.4	See 7.4					
8.2	G	Use of Resources	Area for improvement	Investigating trends and themes of re-admissions at a specialty level in order to reduce re-admissions where possible is an on-going work stream.	Trustwide - Use of Resources	Chief Operating Officer	1. Increase the prominence of re-admission performance in Service Line performance dashboards and Care Group performance meetings. 2. Review Service Lines with worst performance and complete specific action plan in these areas.	Reduce contract reductions for readmissions. Potential cost implications for local Service Line actions.	Target to improve Trust performance to the peer median as per the Model Hospital with improvement from 7.95% to 7.5%. To be monitored at Care Group Review meetings.	Redacted	31/07/2019						
8.3	G	Use of Resources	Area for improvement	Reviewing the drivers of non-elective pre-procedure bed days and reducing these where possible, is an on-going piece of work for the trust.	Trustwide - Use of Resources	Chief Operating Officer	1. Increase the prominence of re-admission performance in Service Line performance dashboards and Care Group performance meetings. 2. Review Service Lines with worst performance and complete specific action plan in these areas.	Potential cost implications for local Service Line actions. Overall improvements will improve patient flow.	Target to improve Trust performance to the peer median as per the Model Hospital with improvement from 7.95% to 7.5%. To be monitored at Care Group Review meetings.	Redacted	31/07/2019						
8.4	G	Use of Resources	Area for improvement	The trust is part of an NHS Improvement deep dive review of its high Medical Costs.	Trustwide - Use of Resources	Medical Director	Detailed work plan already completed under the Medical Workforce Productivity Programme with a number of actions identified. Additional efficiency programmes detailed below will also improve Medical Productivity.	Reduction in Medical Workforce costs.	Target to improve DDC time in Job plans to peer median as per the Model Hospital with improvement from 72% to 77%. To be monitored at monthly TME for Productivity and Improvement.	Redacted	30/04/2019						
8.5	G	Use of Resources	Area for improvement	The trust in the process of embedding the results of a number of internal and external reviews of efficiency opportunities.	Trustwide - Use of Resources	Chief Operating Officer	Detailed programmes already in place for Urgent Care flow improvement, Outpatients productivity and Theatre Productivity. These are supplemented by the Trust's GIRFT response and deep dives on outlying areas identified by Model Hospital.	Improved productivity will lead to financial improvement	Improve Outpatients utilisation to 90%. Improve Theatre utilisation to 85%. Reduce urgent care admission and length of stay. To be monitored at monthly TME for Productivity and Improvement.	Redacted	30/04/2019						
8.6	G	Use of Resources	Area for improvement	There is scope to review the trust's medicines cost to establish if the high costs are warranted by the tertiary level services it provides.	Trustwide - Use of Resources	Director of Finance	Initial report describing high medicines costs completed. Further investigation required once immediate improvements to Pharmacy services has been completed.	Potential cost savings.	To be monitored at monthly TME for Productivity and Improvement	Redacted	31/07/2019						
8.7	G	Use of Resources	Area for improvement	Opportunities exist to recurrently reduce the trust's energy costs.	Trustwide - Use of Resources	Director of Planning and Site Services	Continue efforts to drive down consumption (kWh / m2) to mitigate the impact of continuing to add high demand equipment onto the site – continuing to access SALIX funding to implement invest to save schemes such as the low energy lighting. 1. Connect the low temperature take-off from the CHP into the Trust Phase I hot water system to improve efficiency. 2. Deliver the DCHW low energy lighting replacement scheme. 3. Deliver the MSCP low energy lighting replacement scheme. 4. Develop the business case for the replacement of lighting throughout all Outpatient Departments	Loan funding to be received offset by cost savings.	Target to improve on £0.05/kWh Updates are scheduled in to the Financial Improvement Group.	Redacted	1. 31/12/2018 2. 31/03/2019 3. 31/03/2019 4. TBA - early 2019						