University Hospitals Plymouth NHS Trust

CQC Action Plan Monitoring

October 2018

Purpose

The purpose of this report is to provide an update the progress that we are making in delivering the action plan designed to address the Warning Notices arising from the CQC's inspection of University Hospitals Plymouth NHS Trust in April – May 2018.

The open actions in the action plan have been transferred into this action plan monitoring report which encompasses the outstanding actions and performance data that will allow us to monitor the impact of the actions that we are taking.

Next Update

The next planned update will be on 31 October 2018 for the entire CQC Action Plan.

Diagnostic Imaging

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.

Planned Action

Ref	Action	Lead	Deadline
6.1.1	Risk Owners to review and update risks on the Risk Register.	A Orrock & D Edwards	Complete
6.1.2	Updated Risk Register to be reviewed by Care Group Manager CSS and Project Director.	A Orrock & D Edwards	Complete
6.1.3	Governance Manager to review Never Event actions to establish current status of implementation. Summary report to be produced for Project Director.	A Orrock & D Edwards	Complete
6.1.4	Governance Manager to review implementation of Safer Surgery Checklist. Summary report to be produced for Project Director.	A Orrock & D Edwards	Complete
6.1.5	Governance Manager to review patient improvement action plan to establish current status of implementation. Summary report to be produced for Project Director.	A Orrock & D Edwards	Complete
6.1.6	Review status of radiation protection audit plan to establish current status of implementation. Summary report to be produced for Project Director.	A Orrock & D Edwards	Complete
6.1.7	Review all severe risks.	K Glynn, D Edwards & M Walker	Complete
6.1.8	Review all risks graded 'low'.	K Glynn	Complete

Update on actions

6.1.1/6.1.2 – Risks owners reviewed and updated their risks during August 2018 and moderate and serious risks were further reviewed by the Care Group Manager (Anna Orrock) on the 20/08/18. Total number of open risks as of 13/09/2018 was 61 and the number overdue for review was 2 risks (3%). This has been a significant improvement in our position. The total number of open risk actions is 91, of which the total number of open overdue actions is 12 (13%). These were all reviewed in detail on the 13/09/18 by the CQC programme Lead, Service Line Manager and Governance Manager. Please see current risk position report.

Imaging Open Risks and Actions (Septemt

6.1.3/6.1.4 - The Never Event action plan has been reviewed and updated. WHO checklists continue to be collected for the qualitative audit on a daily basis. Failed checklists are returned to the Governance Manager and since 15/08/18, these have been distributed to those involved in each case with a request to provide feedback. Quality compliance audit results for August 2018 were 85% for general anaesthetic cases (20 checklists, 3 of which failed) and 94.57% for non-general anaesthetic cases (129 checklists, 7 of which failed).

Key outstanding actions include implementation of the observational audit within all interventional modalities; finalisation of site marking processes within Imaging which will be included in the overarching trust site marking policy and an action plan which will be developed when the results of the SCORE survey have been collated. The REACT bulletin was shared across the Trust via the daily email on 07/09/18.

6.1.5 – Patient Improvement action plan reviewed and completion dates for some actions revised as per updates

included. Summary report provided to the Project Director and Service Line Manager on 20/09/18 and discussed during meeting on 03/10/18. Action plan was circulated to all modality leads on 24/09/18 to include any new actions and updates.


Imaging Patient Improvement Action I

6.1.6 – Radiation protection plan reviewed by Governance Manager and Radiation Physics to ensure historical actions are still relevant, duplication is removed and improvement actions from 2018 are included within the plan. A further update regarding Imaging's progress against interventional radiology actions was presented to the Radiation Safety Committee on 04/10/18 as this had been highlighted as an area of concern. The next Radiation Safety Committee is due to be held on 08/01/19 and identified modality leads will attend the Committee meeting to provide updates regarding progress against actions.

6.1.7/6.1.8 – Complete. See update under 6.1.1/6.1.2. All severe risks are within review date and have current action plans.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Make significant improvements to meeting the needs of patients in the diagnostic imaging departments in terms of timeliness of their appointments.

Planned Action

Ref	Action	Lead	Deadline
6.2.7	Implement plans to further increase scanning capacity.	D Edwards, M Walker, D King, L Barnes	Substantial improvement in WT by 26/10/2018
6.2.8	Update scanning trajectories based upon latest plans.	D Edwards, M Walker, D King, L Barnes	Substantial improvement in WT by 26/10/2018
6.2.10	Agree proposal to increase reporting capacity with Consultant Radiologists.	D Edwards	Substantial improvement in WT by 26/10/2018
6.2.11	Agree plan to provide protected access to beds for Imaging (PIU, Norfolk or Lynd,Postbridge).	D Edwards	Substantial improvement in WT by 26/10/2018
6.2.12	Secure approval for x3 additional Booking Clerk posts (FTC).	D Edwards	Substantial improvement in WT by 26/10/2018

Update on actions

6.2.7 Plans which were in place have started to deliver the additional capacity required to reduce the backlog position.

- In **CT,** the department had reduced capacity from the temporary reduction of staffing to enable training on the new scanner which was then shortly followed by a planned loss of another scanner whilst it was being upgraded. Both scanners have returned to provide their planned and additional capacity at the start of September 2018. Further capacity from a mobile van to reduce backlogs has also been realised and this is reflected in the reduction of the waiting lists; this is evident in the graph below.
- In **U/S** additional capacity has been provided with a new room, new equipment and additional Sonographer capacity through locum Sonographers. The return from maternity leave of two key members of staff will commence in November so sustainability of this reduction is expected to continue.
- In **MRI** additional scanning is continuing through a private provider and the Trust has signed off capital investment to upgrade an existing old scanner. This will provide specialist scanning once the upgrade is complete (March 2019). Weekly meetings are diarised to ensure that the project does not slip the timelines. Additional capacity is also being sought at two local sites to mitigate any loss of capacity with these projects.

6.2.8 Please see document below for current trajectories for modalities against current project positions and capacity gained/lost through them.

NEW Diagnostic trajectory 1819 UPDA

6.2.10 The Project Director has met with the Medical Director and the Radiology Consultant body to agree an 'Insourcing' arrangement with the Radiologists based upon a fee per scan payment. This arrangement has been agreed between the Trust and the consultant body and capacity is being reviewed against the expected take up from the consultants which will be shared once finalised. Additional reporting has also been secured from outsourcing companies and will form part of the capacity report for next month's report. In addition a number of other options to increase reporting capacity are being reviewed. Below in Table 2 is the current position for reporting.

6.2.11 The Project Director has met with the Service Line Manager for Surgery and Theatres to secure additional recovery capacity (beds) for radiology patients. There is an agreement to support 1-2 additional beds per day on Postbridge for radiology. The service line is now working on the patient pathway including requirements for nursing support/pre assessment etc. A proposed pathway has been suggested in conjunction with Hepatology for discussion at the Imaging performance meeting that will see Imaging patients pre-assessed by the Hepatology clinic, where they will be clerked and have blood tests to reduce delays on the day of the procedure. This will allow for the lists to begin on time, reducing the possibility of an overnight stay.

6.2.12 At the time of this report financial approval has been agreed to support 3 WTE additional posts. Recruitment will start as of W/C 24/09/18 with an estimated timeline of 8-12 weeks. In the interim other opportunities are being sought internally to support the Admin teams. Further to the above, discussions have been held with the Outpatient Appointment Centre (OAC) with regards to support for the Admin teams and an agreement has been reached that will see the booking of Plain Film radiographs to be managed by the OAC. The 3 WTE posts will be recruited directly into the OAC along with another 0.93 WTE from the Service Line budget. The staff who currently undertake this role will remain within the Service Line and will be redeployed to the benefit of the remaining modalities. Following a workforce review it was agreed that the redistribution of CT Colonography booking would be beneficial for the performance of the CT service and the CTC service and would share the operational pressures more evenly across the Admin team.

Performance against the 7 day 2ww cancer standard in MRI, CT and Ultrasound has steadily improved with the increased capacity over the past 10 weeks. A detailed review of demand was undertaken and the capacity allocated for 2ww patients in CT has been increased from October. Adjustments have also been made to the sub-specialist MRI capacity which will also provide a further upturn in 2WW MRI scanning performance and reduction of the 2WW waiting list.

Table 1: 2WW Waiting List

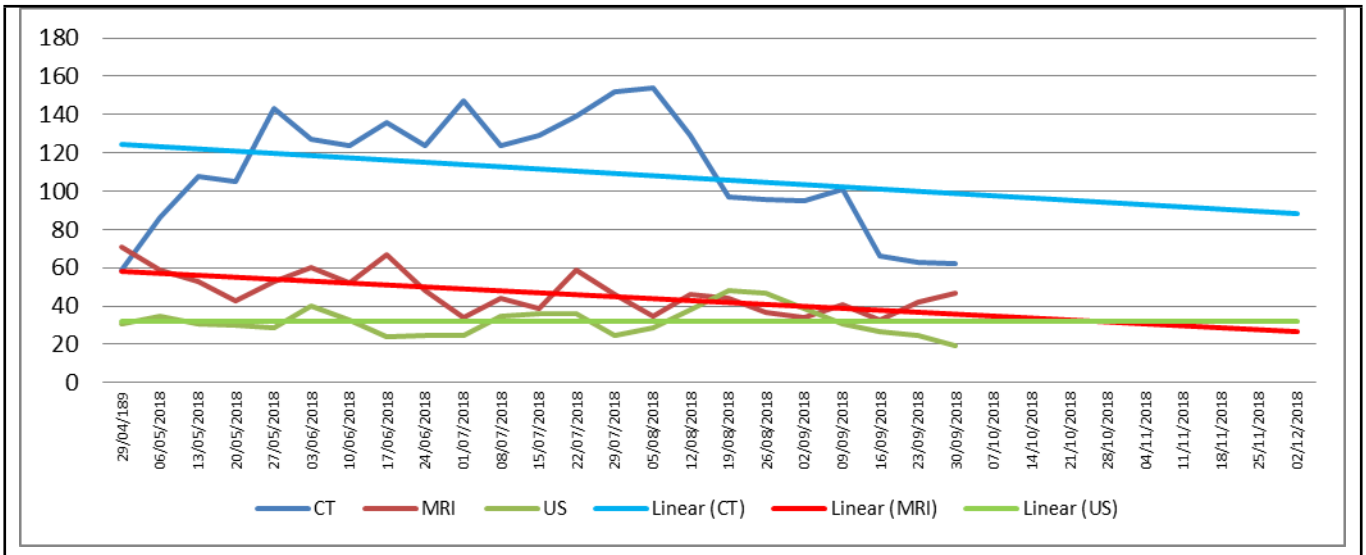
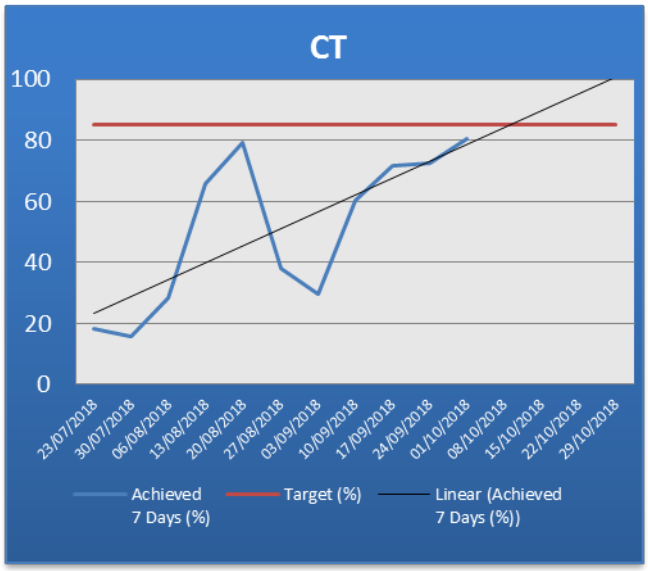
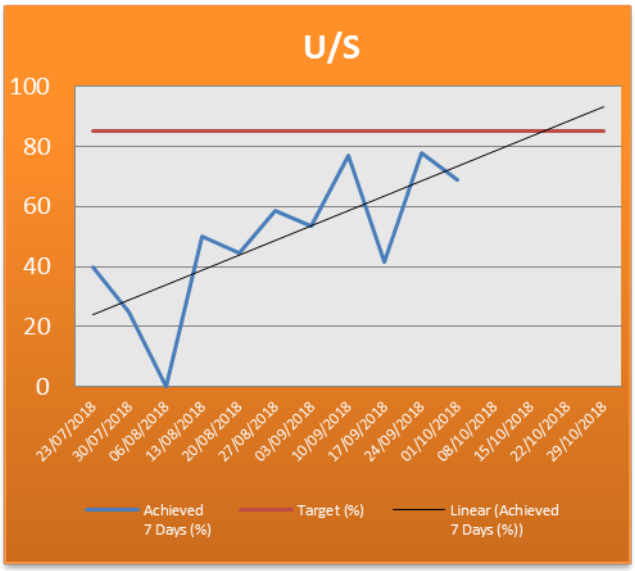


Table 2: 7 Day 2WW Performance





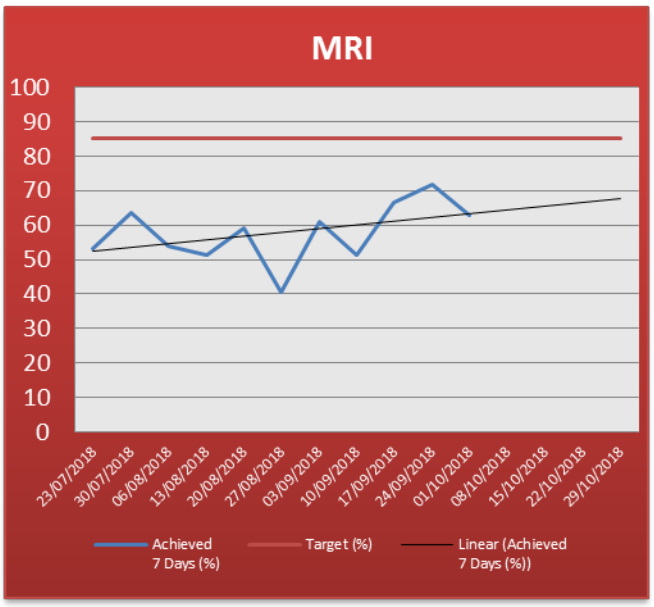
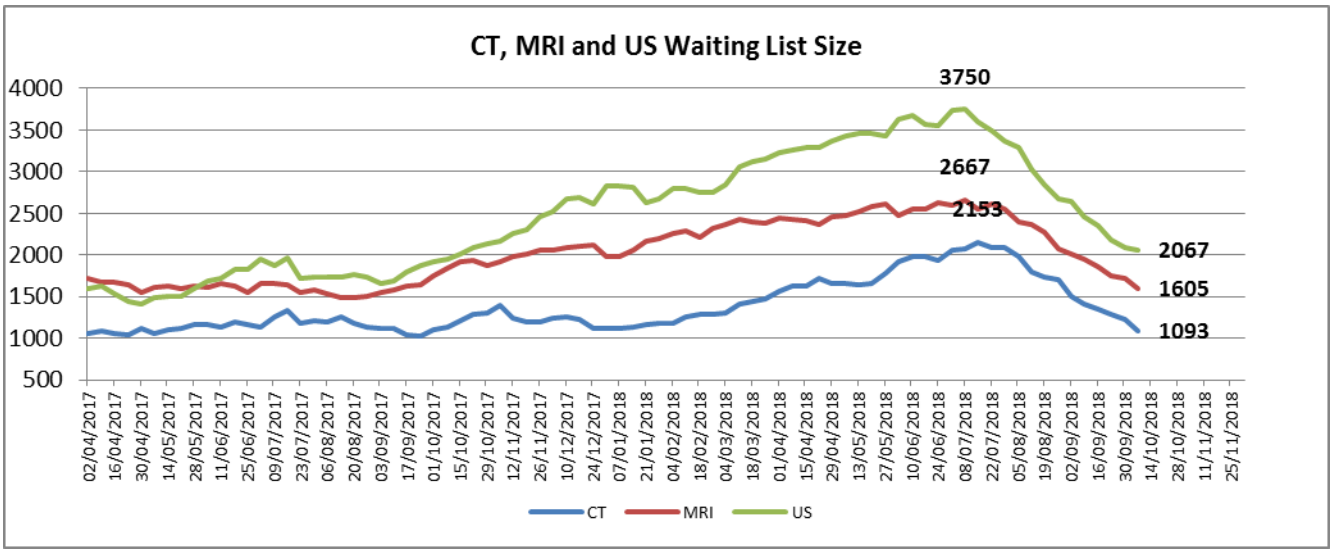
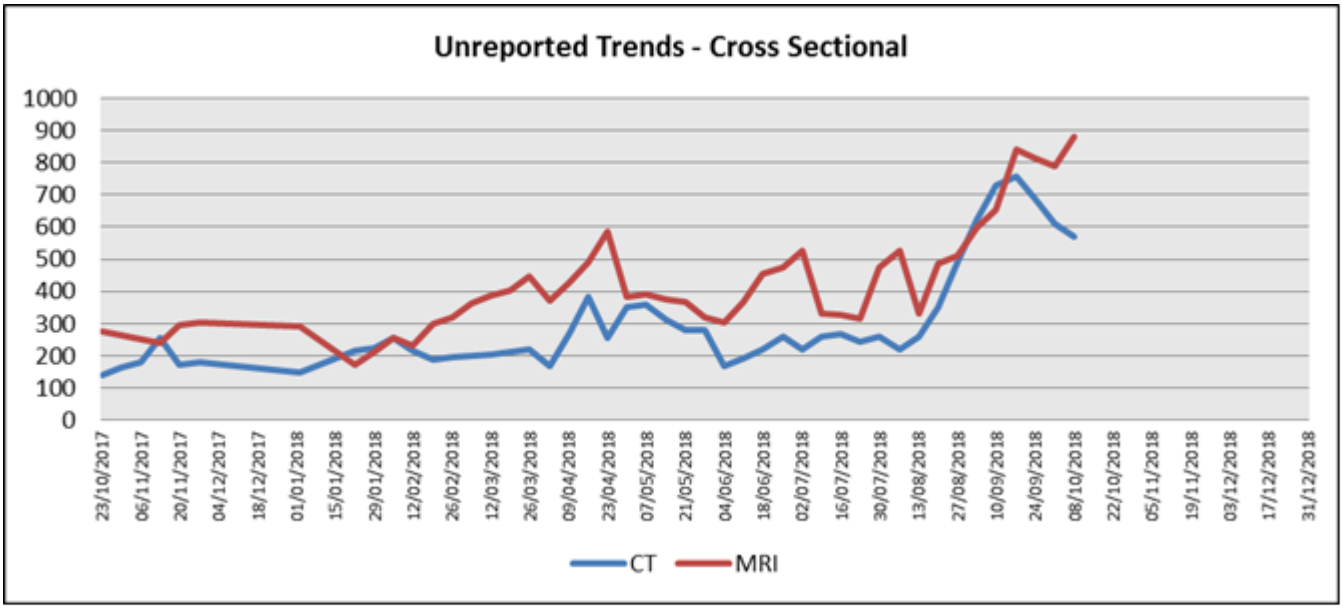


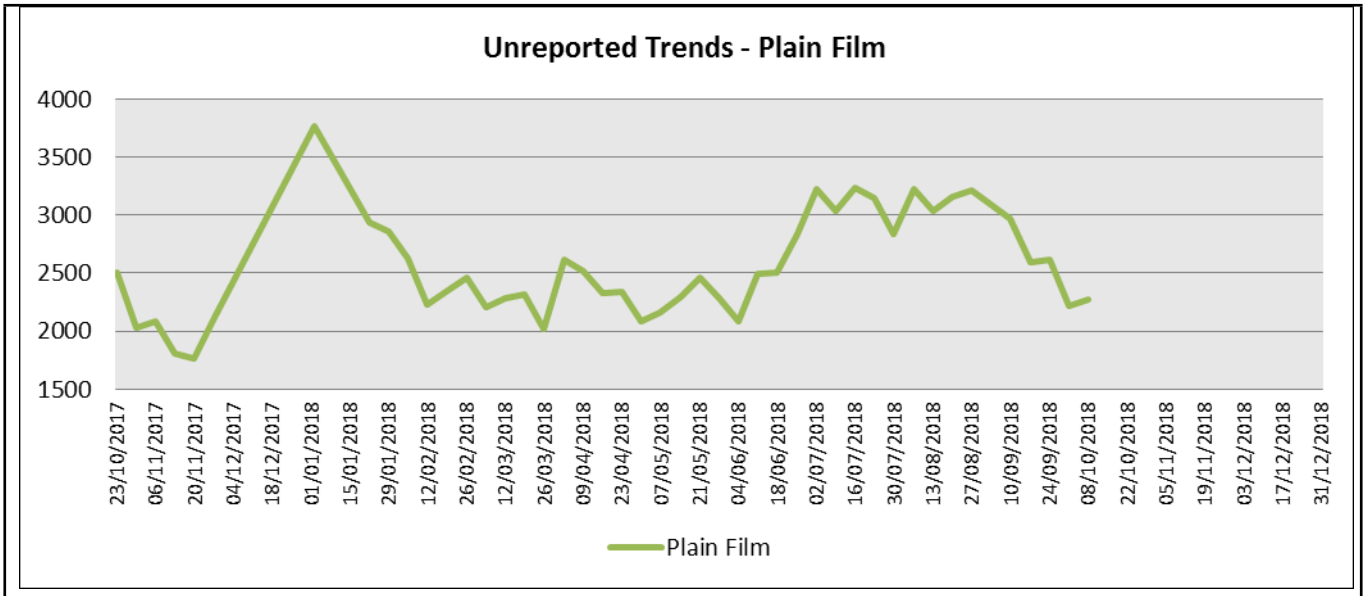
Table 3:Waiting List – All Urgencies



The increase in volume of Imaging acquisition has created an additional reporting requirement as illustrated in Table 4. The Service Line is exploring a number of potential opportunities to manage this including outsourcing to third party providers, an insourcing agreement with UPHT Radiologists and more innovative solutions such as home reporting workstations. The Service Line is developing a detailed reporting trajectory which will be included in the next update.

Table 4: Reporting position.





Assurance that actions have been addressed

All identified actions have commenced.

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.

Planned Action

Ref	Action	Lead	Deadline
6.3.2	Service Line Manager & Superintendent Radiographer to identify proposals to address the shortfall identified via the self-assessment of capacity versus responsibilities.	M Walker & Di Nicholson	28/09/2018

Update on actions

A questionnaire has been sent to all Radiographic leads within the department for a self-assessment of what they currently have within their weekly timetable to deliver their non-clinical tasks and an ask of what would be realistic to have within their timetables. Replies have been received and a report is being drafted. An email has been sent to the South West Radiology Managers to gain a wider understanding of other hospitals capacity for their leads. Both Mark Walker and Di Nicholson visited Royal Cornwall Hospital on the 1st October to discuss their approach to rotas and job descriptions for their leads. This will help inform our approach to allocating non clinical time for Radiographers.

Assurance that actions have been addressed

Self Assessments completed, emails to other providers to ask of their Leads time has been completed and a visit to RCHT has been undertaken.

MUST DO: Support and improve the culture and wellbeing for the diagnostic imaging staff.

Planned Action

Ref	Action	Lead	Deadline
6.4	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.	M Walker	26/10/2018

	- Ensure regular senior management Walkabouts. - Implement 'SCORE' in Interventional Radiology. - Ensure that musculoskeletal risks are on the risk register and are being adequately managed		

Update on actions

Imaging CQC Plan.xls

The Service Line Manager (SLM) and HR Business Partner have reinstated the fortnightly meetings with leads and have a new agenda which can be seen below. The SLM has linked with the Organisational Development Facilitator and there are dates in the diary for October, November and December for the facilitator to meet with the leads of the department. Sessions on Coaching and Difficult conversations, Promoting Positive Manager Behaviour and Leadership have been identified as the key topics to start with.

Imaging Service Line performance review a

Staff Communication boards have now been put up in 11 areas within the department. These have been updated with recent information and data. Senior Manager walk arounds have commenced and an 'aid memoire' of these saved for reflection and to capture any actions from these discussions. A copy of the most recent can be found below. The SCORE survey was sent out to the department in late August and we are awaiting returns before an analysis can be undertaken by the lead for the survey. This is expected to be completed with actions identified by the end of October 18.

Leadership Walkaround 14-09-18

There are currently two risks on the risk register which relate to the potential for musculoskeletal injuries to occur within the workplace. One of these relates to the MRI modality and the second to the Interventional Radiology modality (specifically rooms 5 and 6). Within MRI all possible controls have been put in place to minimise the risk of injury to staff and incidents continue to be monitored however, there is an additional action to procure new scanners with undockable tables and this is due to be completed in May 2019. The risk for rooms 5 and 6 within Interventional Radiology has been graded as residual from 11/09/18. An intoprone manual handling device was purchased to help with moving patients and staff within this area have received training during CME sessions. Staff will continue to receive annual update training and incidents relating to manual handling will be monitored.

The next steps are to assess with modality leads, if there is a risk of musculoskeletal injuries within the other areas of the Imaging service. If appropriate, these will be added to the risk register with appropriate actions plans by 12/10/2018.

Assurance that actions have been addressed

Not applicable at this stage.

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.

Planned Action

Ref	Action	Lead	Deadline
6.5.2	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.	M Walker, K Glynn & Imaging Project Manager	Complete
6.5.3	Assess/update risk and assign prioritisation for replacement.	M Walker, K Glynn & Imaging Project Manager	Complete

Update on actions

6.5.2 - The Service Line has an itinerary of all equipment which is RAG rated as per age and vulnerability. This has been shared with the Capital Steering Group in previous meetings. Due to the amount of equipment requiring replacement the Service Line has appointed a substantive member of staff into a Project and Equipment Manager role and they will be joining the department on the 29/10/18. The expectation will be for the post holder to further review the replacement list and pull together the projects of the equipment replacement programme working closely with the service line to achieve this. In recent weeks the Trust Board has signed off the replacement of an existing old MRI Van owned by UHP which will be upgraded and retuned in a modular build in March 2019. This was the oldest MRI scanner at the hospital which will now be replaced and provide further resilience to our MRI capacity.

6.5.3 – All risks relating to the replacement of equipment were reviewed and updated with the Service Line Manager in August 2018. There is a risk relating to the overall backlog of imaging equipment replacement however, the revised replacement plan has been attached to the risk register. Progress with the replacement of equipment is expected to improve when the newly appointed Imaging Project Manager joins the service on 29/10/2018. There is one serious risk which relates to the replacement of x-ray equipment in rooms 3 and 4 and this is highlighted as very high risk on the equipment replacement plan and has been highlighted as a priority.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Make sure all patients of child-bearing age have the appropriate pregnancy checks recorded.

Planned Action

Ref	Action	Lead	Deadline
6.6	1.Assess and deliver any training & communication needs. 2.Audit compliance and take appropriate action.	Di Nicholson	28/09/2018

Update on actions

A PowerPoint training package produced by Medical Physics on protocol I2 and form F2 was circulated to all radiologists and radiographers in imaging. A record check has been carried out to ensure that all staff have acknowledged the training information. Lead radiographers have been communicated with to ensure that staff in their areas follow the correct practice regarding the use of the pregnancy form in their areas. An audit sample has been obtained and the results are being collated.

The audit has demonstrated that further work is required to clarify the use of the form and the recording of LMP information on CRIS in the plain film department. Work is ongoing to clarify the current policy documentation which will include screen shots demonstrating how LMP should be recorded on CRIS and scenarios detailing how the policy and form apply. Staff meetings are being utilised to talk through the documentation with the staff to ensure compliance with the process.

There is a further work stream looking at LMP forms and policy in use elsewhere in the region; once this information is collated a decision will be made regarding broadening the use of the LMP form in low dose examinations. Feedback from junior staff indicates they favour use of the form for all exams where the LMP requires consideration.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Progress the e-referral system implementation to reduce risks to patient safety, particularly around unnecessary exposure, and incorrect referrals.

Planned Action

Ref	Action	Lead	Deadline
6.7	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.	A Blofield A Orrock	30/09/2018

Update on actions

The entire Trust risk register has been reviewed and a report containing details of IT and e-referral risks provided to the Project Director on 23/08/18.

The Project Director commissioned Service Improvement to undertake a process map of the current ordering process (paper referrals) together with the ordering of Imaging via ICM in the Emergency Department. This process mapping process has been completed and will be written up following discussion with key leads. Once this is complete representatives from both departments will be asked to agree recommendations and any mitigating actions.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO (Outpatients): Make sure all staff within the outpatient departments have undertaken mandatory training updates in line with trust policy.

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.

Planned Action

Ref	Action	Lead	Deadline
5.1 OP 6.8 Imaging	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.	M Walker	26/10/2018

Update on actions

The Service line continues to send out email reminders to leads of areas where dates are either out of date or proactively reminding leads to book in advance. The service line has also created a specific dashboard to individualise specific matrixes on performance which will be shared with leads week commencing 22/10 18. One to one meetings with leads have an adjusted agenda to discuss further monthly positions and formulate plans if required.

The table below shows the position as at 07/10/18:

	July	Aug
Trust Update	93.5%	92.1%

BLS	81.8%	87.3%
Manual Handling	91.3%	90.4%

- For Trust update: 280 staff with 23 required to be booked.
- For BLS : 271 staff with 35 required of which 22 are booked in the next 2 months.
- For Manual Handling: 280 staff with 33 required of which 28 are booked.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Complete paperwork associated with infection prevention and control and that it is appropriately countersigned by a senior radiographer.

Planned Action

Ref	Action	Lead	Deadline
6.9	1.Review and address existence and suitability of SOP. 2.Assess and deliver any training & communication needs. 3.Audit compliance and take appropriate action.	Di Nicholson	28/09/2018

Update on actions

A review of the cleanliness audit templates in the imaging x-ray rooms has been completed. To ensure there is a consistent approach all cleanliness audits have "audit completed by" added to the templates. The fortnightly matrons cleanliness audit has had a question added ("check that the equipment cleanliness sheet is completed") to ensure and record compliance. The matrons audit is currently being piloted and will go onto Meridian shortly to ensure consistent audit is undertaken throughout Imaging and Therapies. The new audit format has been produced by Therapies to be more appropriate for outpatient areas including imaging which provide improved assurance with regarding to cleanliness and infection control matters. It will replace the full matrons audit template in these areas which is a ward based assessment tool. Areas continue to use the existing tool to report audit results until the matrons audit is available. Awaiting confirmation from Therapies that the matrons audit has replaced the current Trust mini audit templates on Meridian.

Matron Mini Audit - Pilot B highlighted for

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Improve compliance with audits such as the hip fracture audit and the trauma audit.

Planned Action

Ref	Action	Lead	Deadline
6.10	This is assessed as part of ISAS accreditation and is not considered to be an issue. Evidence to be provided.	R Lavis & ISAS Lead	26/10/2018

Update on actions

Dr Lavis and Dr Wotton (ISAS Lead) have reviewed the previous audits. An action plan will be developed from both. Repeat audits are being arranged. We will also correlate with TARN/Peninsula Trauma Network data with regard to Trauma.

Assurance that actions have been addressed
Not applicable at this stage.

SHOULD DO: Ensure that all staff receive, annually, an up to date appraisal.

Planned Action

Ref	Action	Lead	Deadline
6.11	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.	R Lavis	Complete

Update on actions

Appraisals - email reminders are sent out to leads and organised accordingly. An entry on the current position has been added to the new dashboard that will be shared with the leads to monitor performance and status. Current performance as at 07/10/18 is **96.5% compliance.**

Job Plans – Job planning complete at SLCD and consultant level, 30/9/18.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Improve privacy and dignity for patients in the diagnostic imaging department. Particularly in plain film X-ray, MRI and nuclear medicine.

Planned Action

Ref	Action	Lead	Deadline
6.12	Undertake privacy & dignity assessment and develop an Action Plan.	Di Nicholson & K Richardson	28/09/2018

Update on actions

An audit template was designed to consider privacy and dignity in all areas on imaging. Special consideration being given to waiting areas, design of the area, male/female, privacy, bed patients, areas where procedures were being undertaken.

Privacy and Dignity Audit.docx

Following the audit an action plan has been drawn up which will be discussed at the forthcoming clinical governance meeting. Actions will then be worked up and implemented.

Privacy and Dignity Action Plan Imaging.d

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Ensure that targets set in diagnostic imaging are achievable, realistic, and encourage the service to improve.

Planned Action

Ref	Action	Lead	Deadline
6.13	Agree KPI's and Performance Standards.	D Edwards, M Walker & M Hollow	28/09/2018

Update on actions

Both the Service Line Manager and the Clinical Director have met with the Deputy Head of Performance to discuss internal professional standards on scan and report timings for in patients. Dashboards are being adjusted accordingly and once completed they will be monitored. The provisional KPI's are as follows:

- Very urgent category 5 scans will be scanned within 1 hour and reported within 1 hour
- Urgent category 3 scans will be scanned within 12 hours and reported within 2 hours
- Routine category 1 scans will be scanned within 24 hours and reported within 4 hours.

Assurance that actions have been addressed

Not applicable at this stage.

Pharmacy

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.

Planned Action

Ref	Action	Lead	Deadline
7.4.1	Complete Gap Analysis against Royal Pharmaceutical Society Hospital Pharmacy Standards to identify and manage unrecognised areas of risk.	Sally Mayell	Complete
7.4.2	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.	Sally Mayell	Complete

Update on actions

7.4.1: The Gap Analysis has been completed as a collaborative work-stream involving the Interim Chief Pharmacist, Senior Clinical Pharmacists, Pharmacy Service Line Manager, Senior Nurse, Lead Governance Manager, Lead Service Improvement Manager and Senior HR Manager. Additionally the pharmacy team as a collective have supported the sourcing of evidence and development of future actions to develop continuous improvement and assurance.

The Gap analysis was undertaken using the Royal Pharmaceutical Society's Professional Standards (RPS) for Hospital Pharmacy and is now complete. RPS Standards for Hospital Pharmacy are now being use as a 'continuous development' and assurance tool to inform the Medicines Utilisation and Assurance Committee, Safety and Quality Committee, Pharmacy Board and Trust Board.

7.4.2: Risk identification and mitigation is now supported by the RPS Standards – informing and managing the Risk Register. Risk will be discussed at Medicines Utilisation and Assurance Committee, Safety and Quality Committee, Pharmacy Board and Trust Board.

Assurance that actions have been addressed

Table 1. Screen Shot of front page of RPS Hospital Standards – Gap Analysis

Key: RED – Gap identified, Yellow – Actions in process, Green – Assurance complete (as of x date)

Please note that red does not indicate Risk Level.

Project Element		GYR Status			Prog. Need Date	Planned Date	Closed Date	Resp. Initials	Remarks
		Current	Last	Trend					
Standard 1: Putting Patients First									
1.1	Patient focused services	Y	R	⇧	28-Sep-18	28-Sep-18		SM	Risk Register entry 5852
1.2	Information about medicines	Y	R	⇧	28-Sep-18	28-Sep-18		SM	Risk Register entry 5852
1.3	Support with effective medicines use	Y	R	⇧	28-Sep-18	28-Sep-18		SM	Risk Register entry 5852
Standard 2: Episode of Care									
2.1	At pre-admisison, on admission or at first contact	Y	Y	⇔	28-Sep-18	28-Sep-18		SM	
2.2	Care of the patient	Y	Y	⇔	28-Sep-18	28-Sep-18		SM	
2.3	Patients' outcomes	Y	Y	⇔	28-Sep-18	28-Sep-18		SM	
Standard 3: Integrated Transfer of Care									
3.1	Patient needs	Y		⇔	28-Sep-18	28-Sep-18		SM	
3.2	Professional responsibilities	Y		⇔	28-Sep-18	28-Sep-18		SM	
Standard 4: Medicines governance									
4.1	Effective management of medicines	Y	R	⇧	28-Sep-18	28-Sep-18		Smu	Risk Register entry 6318, 6235
4.2	Support for other health and social care staff	Y	Y	⇔	28-Sep-18	28-Sep-18		SMu	
4.3	Digital technology& informatics to support medicines use	R		⇩	28-Sep-18	28-Sep-18		SM	FMD Risk Register Entry
4.4	Safe systems of care	R	R	⇩	28-Sep-18	28-Sep-18		SMu	
4.5	Safety culture	Y	R	⇧	28-Sep-18	28-Sep-18		SMu	
Standard 5: Efficient supply of medicines									
5.1	Medicines procurement	Y	Y	⇔	28-Sep-18	28-Sep-18		NH	
5.2	Distribution, storage and unused medicines	Y	Y	⇔	28-Sep-18	28-Sep-18		NH	
5.3	Prepared or manufactured unlicensed medicines	R	Y	⇩	28-Sep-18	28-Sep-18		NH	
5.4	Dispensing	R	Y	⇩	28-Sep-18	28-Sep-18		NH	
Standard 6: Leadership									
6.1	Professionalism and professional leadership	Y		⇔	28-Sep-18	28-Sep-18		SM	
6.2	Strategic leadership	Y		⇔	28-Sep-18	28-Sep-18		SM	
6.3	Operational leadership	R		⇩	28-Sep-18	28-Sep-18		SM	Not actively involving patients currently. Risk Register Entry 6318
6.4	Clinical leadership	R		⇩	28-Sep-18	28-Sep-18		SM	
Standard 7: Systems governance & financial management									
7.1	Systems governance	Y	Y	⇔	28-Sep-18	28-Sep-18		KT	
7.2	Financial governance	Y	Y	⇔	28-Sep-18	28-Sep-18		KT	
Standard 8: Workforce									
8.1	Strategic workforce development	R		⇩	28-Sep-18	28-Sep-18		SM	
8.2	Workforce planning	R		⇩	28-Sep-18	28-Sep-18		SM	Risk Register entry 5852
8.3	Workforce quality assurance	Y		⇔	28-Sep-18	28-Sep-18		SM	

An example entry for a red rating (Gap Identified)

Project Element	Key Requirements	Current	Last	Assurance / evidence required	Action required
4.3)	Digital technology& informatics to support medicines us ◀	R			Element Responsibility:
a	Pharmacy services utilize digital systems (including automation) to underpin and transform the delivery of medicines optimisation/pharmaceutical care services.	Y		Pharmacy robot introduced approx 2008, business case to update. EMIS (Ascribe) stock control EPMA - implementation starting Feb 2019 Pharm outcomes - information sharing SALUS tracker FMD	Align to NHS digital transforming Pharmacy services with Technology Program
b	The pharmacy leadership and workforce have the necessary skills in clinical informatics to maximise the use of systems to support optimisation and transformation of medicines use.	Y		Funded posts for pharmacists and technicians to support IT systems	Review leadership skills as part of ongoing appraisal process
c	Information generated through digital systems is used to optimise care with medicines and to support benchmarking and performance management (accommodating information governance and privacy issues).	R			Introduction of EPMA
d	Pharmacy informatics leaders ensure that digital systems comply with required standards and enable interoperability.	G		Example from EPMA set up (business case)	
e	Processes are in place to ensure that any system content relating to medicines is appropriately governed and backed up. This includes looking for and managing unintended consequences of content changes or updates.	R		Example from EPMA set up (business case)	Confirm what the pharmacy specific governance arrangements are
f	The pharmacy team is directly involved with the procurement, implementation, operation and development of electronic prescribing and medicines administration systems.	G		EPMA, Edischarge - pharmacy are key members of the project team.	

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.

Planned Action

Ref	Action	Lead	Deadline
7.5.4	Implement a series of leadership and team development days planned to support staff.	Sally Mayell	Ongoing
7.5.6	Recruit to current vacancies as identified in establishment review.	Sally Mayell	30/04/2019
7.5.7	Conduct a workforce review in line with the planned pharmacy integration with Livewell.	Sally Mayell	01/04/2019

Update on actions

7.5.4: Leadership Development Days – delivered over a single day.
Attendance achieved 76% (n=23). Content for the day included:

- Personal disclosure from Interim Chief Pharmacist on personal drivers / motivations for achieving the best she can for the patient.
- Defining 'leadership'.
- Purpose.
- 'Perception is real'.
- What pharmacy needs is… hope… consistency.
- Clear expectations of behaviour, aligning to organisational values and HR policy.

Further actions/follow-up:

- Individuals attendance on combined leadership academy and post-graduate pharmacy course.
- Monthly in-house CPD for leadership team lead by Interim Chief Pharmacist, supported by OD team.

Team Development Days – delivered as a single day.
7 days delivered so far with 93% (n= 140) attendance and included:

- Personal disclosure from Interim Chief Pharmacist – personal drivers.
- Learning about each other.
- Civility.
- Human factors.
- Team building exercise.
- Clear expectations of behaviour, aligning to organisational values and HR policy.

Further actions/follow/up:

- Rolling programme of development sessions for all staff, to include development of shared purpose, mission and vision.

Additional actions underpinning the cultural change programme:
Adoption of an Organisational Development Change Strategy (transformational and collaborative approach to improvement programme) focussing on capabilities within the team including:

- Commitment and trust.
- Co-ordination and team work.
- Competence – technical and leadership.
- Open communications.
- Creativity and capacity for constructive conflict.
- Learning .

…with an emphasis on the importance of shared purpose, developing a strong culture, bottom-up change rather than utilising extrinsic incentives as motivators for change. Generating an environment where employees can self-motivate (intrinsic motivation), through leadership support, self-determination and empowerment.

Trust

Trust is essential for patient safety and underpins all that we need to achieve in pharmacy throughout our improvement programme, and to ensure sustainability for the future.

Reciprocity of trust plays an important role in the building of trusting relationships – pharmacy leadership are developing an environment where leadership exhibit trustworthy behaviours and exhibit trust in employees, and so enabling reciprocal effect through development of the antecedents of trust, ability, benevolence, integrity and predictability.

Re-establishing trust in pharmacy will contribute to improved wellbeing of employees, improved performance, reduction in costs associated with increased productivity, less wastage and lower staff turnover.

Building early credibility in the change process through quick-win activities

Quick-wins were identified through 1:1 meetings with the Interim Chief Pharmacist and team meetings and included:

- Enabling employees to volunteer to attend mental health first aider training to support wellbeing of peers within the department.
- Removal of artefacts which are not aligned to core values of the organisation.
- Introduce an open-door policy.
- Enabling change through empowerment and trust of employees through 'small change leads to big improvements' (Kaizen Philosophy).
- Opportunities for every member of the team to meet with interim Chief Pharmacist 1:1.

7.5.6: Recruitment to Pharmacist Vacancies

2018	Establishment WTE	Vacancies WTE
May	25.8	13.32
August	33.05	6.07

Plan to go to advert week commencing 15th October:

-**Training and Education** – system post. Uplifted to deliver training and education across secondary and primary care, to include general practice, care homes and community hospitals. Responsibilities include developing a sustainable pipeline of pharmacy resource. High level of confidence to recruit to this post.

-**Deputy Medication Safety Officer.**

Outstanding vacant posts:

-Formulary and Medicines Information

-Neurology.

2 WTE Pre-registration Pharmacists (remain vacant for 2018/2019). Reduced to 4 (from 6) pre-registration posts for the year 2018/2019 to accommodate onboarding of large numbers of new staff.

Latest clinical staff – incoming

Paediatric pharmacist commencing 15th October.

Hepatology Specialist Pharmacist – anticipated start date 29th October.

7.5.7: Workforce review/system stakeholder analysis will commence in December 2018 with a plan to submit business case by end of 2018/19 financial year. Early work streams are forming – first review in haematology and oncology – SWOT analysis, PESTLE, Local and National drivers etc. to inform business planning and strategy.

Assurance that actions have been addressed

7.5.4: Pulse-Survey planned for October 2018 ahead of NHS Staff Survey 2018.

Snapshot Received feedback:

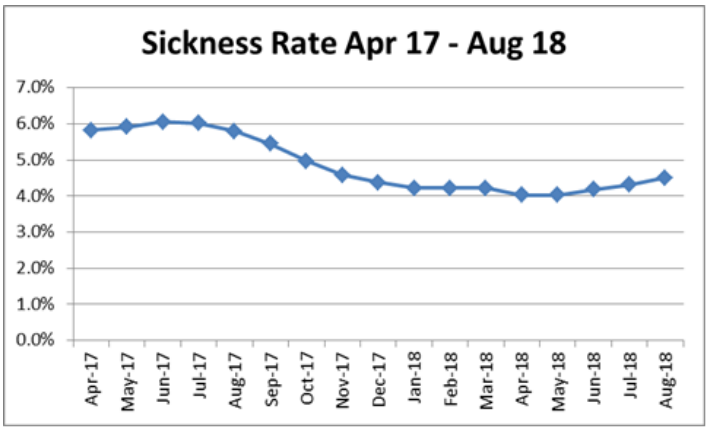
"…a boost in morale, I have fallen back in love with my job...I was considering handing in my notice to leave, I have been given confidence that this department can and will be a wonderful place to work...I have been shown that you don't need to be a mean or nasty person to get to the top step in this department. I thought that my management style was a dying breed… I have been shown this is not the case. [Without the change] I'm not confident I would still be in my position, the department or even the Trust today!" Pharmacy employee

"I have worked in pharmacy for 15 years, I am only realising now how bad things have been here in regard to culture. I have been led to believe that the way the culture was in the past was normal…for the first time we have a voice. I have been allowed to lead my area of the department the way I would like them led and it's proving a fantastic working environment… [the change] has made me realise that we are all one big team within the pharmacy and here to support each other…I found the leadership development days fantastic… into perspective how a good leader should behave… our new leader was open and honest why all of us were there… I felt trusted… I am excited about my future within pharmacy… for the first time in a long time I feel valued." Pharmacy employee

It is appreciated that the above is not representative of the whole team, and that cultural shift will take time to fully achieve, nonetheless early progress has been achieved with some employees forming a 'guiding coalition' for change, and others as expected a little behind on the change curve. It is fully recognised that to ensure sustainability of cultural change momentum must be maintained therefore requiring ongoing investment in time and resource to support employees through the change, with periodic evaluation of progress.

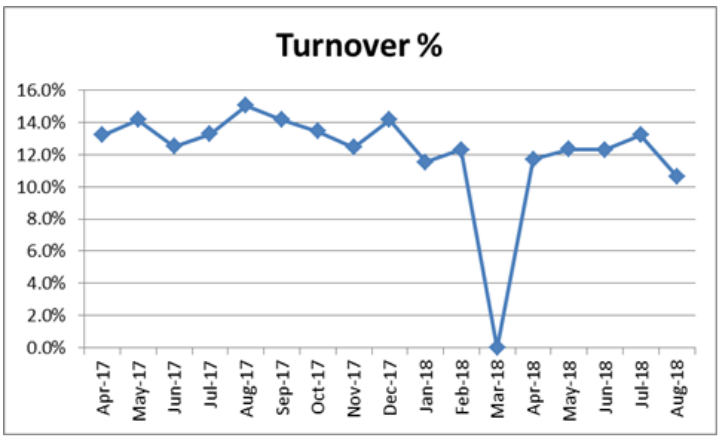
Other Metrics.

Absenteeism: Early measurements show initial reduction in sickness rates falling to the lowest over a 12 month period in April and May of this year, at 4%. June and July show a gradual increase to 4.2 and 4.3% respectively. During significant change programme a spike in sickness might be expected as a reaction to change, or other more formal processes which underpin the conduct and performance improvement work stream.



Staff Retention: No significant difference can be identified in the early phase of improvement for overall pharmacy staff retention. However, our pharmacist turnover has slowed with only two members of the team leaving – one for promotion elsewhere in the county, the second to attend medical school.

The expectation is to see an improved staff retention score over the next 12 months. However, early increase may be explained by the change programme not suiting all employees in relation to their personal values and behaviours not aligning to those desired by the Trust. During any large change programme there may be natural attrition – this will be kept under review.



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.

Planned Action

Ref	Action	Lead	Deadline
7.6.1	To implement a system to monitor TTAs returned to pharmacy containing critical medicines.	Sally Mayell	Complete
7.6.2	Any critical medicine that is returned without a valid reason will be escalated.	Sally Mayell	Complete
7.6.3	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.	Sally Mayell	28/02/2019
7.6.4	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.	Lin Nicholls	26/10/2018
7.6.5	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.	Sam Sheridan	30/11/2018

Update on actions

7.6.1, 7.6.2, 7.6.3: A system to safeguard against discharge without critical medication was developed in collaboration between pharmacy and nursing personnel. A pilot has been completed over a two week period to capture patients who were discharged without critical medicines. One patient was discharged without antimicrobials – this was captured within 24hours of discharge with medication sent to patient post-discharge.

Aligned to the daily controlled drug check, a 'sweep' of the ward for TTA's is conducted to ensure that no medications remain in hospital following discharge. To safety-net Pharmacy has a process in place should TTA medicines be returned to pharmacy without the local check for appropriateness at ward level.

The process is currently being rolled out through the organisation.

EPMA is delayed until February 2019; incorporating additional safety measures here will support safe discharge.

Completed Action – to maintain continuous review of process for assurance and learning.

7.6.4: A review of the discharge process is underway between the lead in pharmacy for supply and a senior nurse.

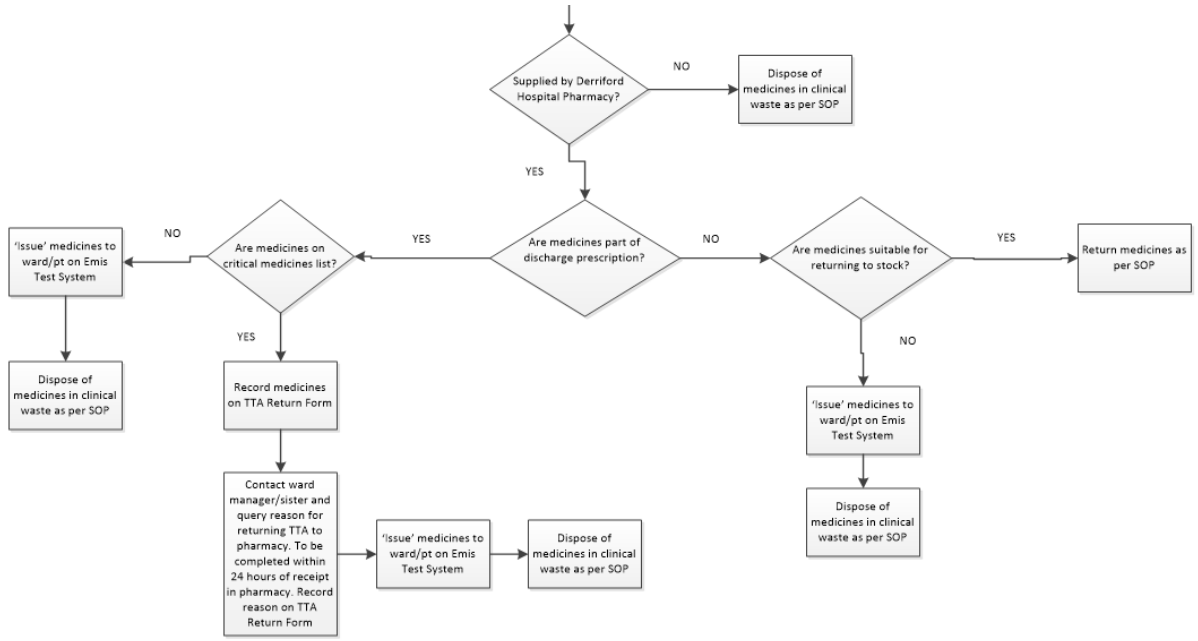
This project is aligning to a broader improvement project reviewing the discharge process as a whole.

7.6.5: We are currently scoping out the automation of confirmation of addition to the follow up waiting list letter through our electronic outcome system. Advice is awaited from our ICT integration team, however initial correspondence indicates that this will not be too problematic. A reminder to send confirmation letters to those being added manually will be sent shortly. The content of these letters is currently under review.

The Chair of the Ward Admin Forum (who sits in the Patient Access Team) is working constantly to ensure that Ward Administrators follow the correct process in relation to the booking of follow-ups. This will be reiterated at, and reminder sent out after the next forum in October.

The Director of Corporate Business is also reviewing ward admin support and processes at a higher corporate level to ensure that the ward admin function is fit for purpose. A forum will be set up to reiterate roles and responsibilities.

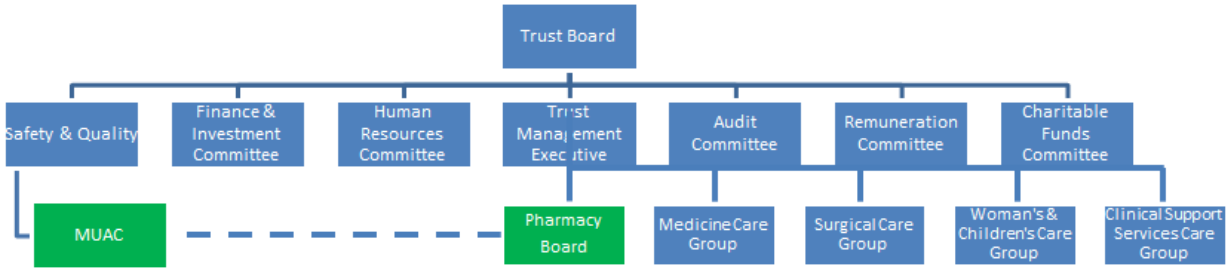
Assurance that actions have been addressed
Screen shot of pharmacy flow chart for TTA's returned to pharmacy



MUST DO: Ensure effective governance within the pharmacy service to provide a high quality and safe service.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
7.7.1	Undertake a review of the current pharmacy governance framework and make recommendations to Trust Management Executive for a revised structure.	Sally Mayell	Complete
7.7.2	Additional review and redesign of the Medicines Utilisation and Assurance Committee (MUAC) with recommendation to Safety and Quality Board for revised reporting.	Sally Mayell	Complete

Update on actions
It has been agreed that MUAC will report to Safety and Quality Committee and Pharmacy Board will report to Trust Management Executive.

Assurance that actions have been addressed
New Governance reporting Structure for Pharmacy:



SHOULD DO: Improve documentation of when liquid medicines are opened to ensure they are not administered when they have expired.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
2.19	1. Review Medicines Management Policy to ensure that liquid medicines are included. 2. Ensure that liquid medicines are part of the medicines management audit.	Sally Mayell	30/11/2018
Update on actions			
Policy change will be ratified at MUAC with communication Trust-wide post ratification in October.			
Assurance that actions have been addressed			
Not applicable at this stage.			