University Hospitals Plymouth NHS Trust

CQC Action Plan Monitoring

December 2018

Purpose

The purpose of this report is to update the Care Quality Commission (CQC), Clinical Commissioning Group and NHS Improvement with the progress that we are making in delivering the action plan designed to address the Warning and Requirement 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 (arranged by theme/core service) and performance data that will allow us to monitor the impact of the actions that we are taking.

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

Update December 2018

Please note that due to the re-inspection of Pharmacy and Diagnostic Imaging that commenced on 11 December 2018, there is no update for these two services this month. The action plans for these two services will be refreshed on receipt of the inspection report.

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

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

Action Status	Number of Actions	Percentage of total
Completed and closed on receipt of appropriate evidence	**45**	**23**
Completed – evidence to be submitted and reviewed	**40**	**20**
In Progress	**114**	**57**
Total:	**199**	**100**

Next Update

The next planned update will be submitted by 31 January 2019.

Urgent and Emergency

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.

MUST DO: Ensure the privacy and dignity of patients is always maintained.

SHOULD DO: Consider how patients arriving by ambulance can be protected from the weather while being transferred to the department.

Planned Action

Ref	Action	Lead	Deadline
1.1 **1.10** **1.19**	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.	Stuart Windsor	31/03/2023

Update on actions

Clinical lead Dr C Bosanko, project lead Cath Atkins. Minutes of meetings and latest designs can be accessed via Peter Caton, site services for audit purposes. Three design options were presented to Project Board 14.11.18 with instruction from deputy CEO to deliver a 4th option for consideration pending submission. UHP awarded £30m for strategic rebuild announced w/c 3rd December. Next project board 12/12/18 .

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Provide sufficient equipment to monitor patients at all times.

Planned Action

Ref	Action	Lead	Deadline
1.2	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.	Stuart Windsor for Estates. Iain Yearling for equipment	1. 24/12/18 for paeds expansion. 2. Complete and closed.

Update on actions

- Paediatric expansion and reconfiguration commenced initially in car park / ambulance bay w/c 15 October. Due for completion Christmas Eve. Reconfiguration of footprint in progress and new ambulance entrance complete.
- Ortho outpatient in fracture clinic destination still to be confirmed with Service Line but in preparation, Estates and lead for minors, Charge Nurse Booth have scoped the necessary works for relocating minors; likely timescale mid January 2019.
- Uplift in ENP staffing proposed as part of business planning 2019/20 to provide ENP cover 24/7 once relocated.
- Resus expansion dependant on the move of minors to fracture clinic; designs in progress with project team but not yet finalised.
- Matron has confirmed that there is sufficient medical equipment for observation; it is the nursing staff support for the undertaking of the hourly safety rounds (SHINE tool) that can be insufficient. Point 2 therefore closed.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Ensure patients are observed, or at least have the means to call for assistance, when waiting outside X-ray.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.3	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.	Iain Yearling	31/12/2018
Update on actions			
• Fixed call bells not feasible for installation and difficult for patient use therefore not progressed. • Matron will undertake a joint SOP with the lead radiographer and Imaging Matron that will eradicate patients being left alone in the corridor outside of x ray for all those majors patients by 31/12/18. • SHINE tool to be used for all majors patients regardless of physical location (point 3) and audited via fundamentals of care remains outstanding pending Meridian programme for electronic audit. • Paper copies available until Meridian system updated – led by Cath McWhinnie.		
Assurance that actions have been addressed			
Not applicable at this stage.			

MUST DO: Ensure all equipment is serviced as required, and put in place appropriate monitoring systems to provide oversight of equipment servicing.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.4	Department Action: Revise department fundamentals of care audit to monitor equipment service dates: equipment in daily use and equipment not in daily use.	Iain Yearling	31/12/2018
Update on actions			
ED have just had a compliance visit from MEMS - pending report.			
Assurance that actions have been addressed			
Not applicable at this stage.			

MUST DO: Ensure patients have regular observations completed and documented, with easy to recognise trigger points for increased regularity of observations.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.5	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.	Iain Yearling	Quality Improvement work will be ongoing.
Update on actions			

- NEWS 2 pilot complete in ED and is now being rolled out across the Trust, currently in MAU; this is being led by the Matron for Harm Free Care.
- A3 (paper) 3rd December roll out to ED and subsequently MAU.
- Matron to provide evidence of success and demonstrate the use of the SHINE tool (safety brief).as above paper copies until Meridian updated

Assurance that actions have been addressed

Not applicable at this stage.

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.

SHOULD DO: Review the front loaded initial care (FLIC) model to ensure it provides appropriate timely decision-making and treatments.

SHOULD DO: Consider how patients arriving by ambulance can be protected from the weather while being transferred to the department.

Planned Action

Ref	Action	Lead	Deadline
1.7 1.19 & 1.22	Continue with process change as part of a recurrent PDSA improvement cycle relating to the FLIC initiative; with Service Improvement support.	David Wise	This is part of a Quality Improvement programme so is therefore ongoing

Update on actions

- FLIC continues to be activated when staffing allows and the department is not crowded.
- FLIC performance improving. As reported at 29 November, we recorded our best ever performance:
  - FLIC-d for ten days in a row.
  - Days lost due to staffing much lower in November than October.
  - 41 patients FLIC-d last Saturday – a record.
  - We exceeded our 35 pts / day target six times this month.
  - 9 other days we've exceeded 30 pts / day.
  - On Tuesday 87% patients FLIC-d within 30 mins – a record and average time to FLIC 19 mins - a record.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Urgently review nursing and medical staffing numbers to ensure there are always sufficient numbers on duty to keep patients safe.

MUST DO: Ensure the privacy and dignity of patients is always maintained.

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.

Planned Action

Ref	Action	Lead	Deadline
1.8, 1.10 & 1.11	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.	Anne Hicks/ Iain Yearling	30/04/2019

Update on actions
• Two Consultants successfully appointed further to interview on 28 November. • No applicant for paed post so this will be re-advertised January 2019; currently have 2 days per week of ST7 support from paediatric unit • Mid-grade and junior doctors at advert as a continuum with no success. • Nurse consultant re-advertised; two applicants. • Band 7 at advert 15/11/18, interview panels 03/01/19. • Paeds posts appointed plus 6 band 6 posts with phased commencement dates. Full complement expected 31/01/19. • Escalation policy agreed by Medical Director for ED to utilise appropriately and for the Trust to respond.
Assurance that actions have been addressed
Not applicable at this stage.

MUST DO: Ensure medicines are always stored securely to prevent unauthorised access.

Planned Action

Ref	Action	Lead	Deadline
1.9	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.	Iain Yearling	1. Complete 2. 31/03/2023

Update on actions

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. Review of current Meridian highlights that between Aug 2017 and Aug 2018, 8 Matrons full audits have been undertaken with 100% compliance.

Locked cage for entonox scoped pending insertion and locks placed on drug cupboard doors.

Plan for new treatment room to have external lock; need to check the requirement for inner cupboards to still be locked: access by authorised but non-clinical staff needs to be considered, e.g. cleaners. This remains pending on fracture clinic relocation. Matron to meet with Head of Pharmacy, deadline 31/12/18.

Assurance that actions have been addressed

Not applicable at this stage.

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.

Planned Action

Ref	Action	Lead	Deadline
1.12	External review completed. Take actions to address identified risks: in progress.	Anne Hicks	30/04/2019

Update on actions

- Redesign of paeds area in progress - see ref 1.1 and 1.2.
- Relocation of minors to fracture clinic pending.
- Expansion of resus pending on above works.
- Recruitment of staffing across all levels both nursing and medical ongoing see ref 1.8.
- Escalation policy to be enacted when > 18 in majors, no resus capacity, lack of critical staffing > 25 minors or significant patient safety concerns.
- Trustwide full capacity protocol in draft for Exec sign off for Winter

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Ensure the kitchen in the clinical decision unit is secure when unattended to prevent patients gaining access.

Planned Action

Ref	Action	Lead	Deadline
1.14	Reconfigure the Clinical Decision Unit to relocate the kitchen within the department; security features to be inherent in design.	Iain Yearling	Complete

Update on actions

10/10/18 - Kitchen complete.

Assurance that actions have been addressed

Reconfiguration complete.

SHOULD DO: Repair or replace the flooring in the clinical decision unit toilets/shower rooms to enable effective cleaning and minimise infection control risks.

Planned Action

Ref	Action	Lead	Deadline
1.15	Submit new works request to assess, replace or repair the floor.	Iain Yearling	Complete

Update on actions

Work now complete.

Assurance that actions have been addressed

Design agreed and available as evidence from Project Manager Cath Atkins in Estates.

SHOULD DO: Review the security arrangements for the paediatric department to prevent unauthorised entry and exit.

Planned Action

Ref	Action	Lead	Deadline
1.16	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.	Stuart Windsor Iain Yearling	31/12/2018

Update on actions

1. In progress.
2. CCTV scoped, quote approved, pending installation with extension.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Ensure children in the paediatric department do not have access to electrical sockets.

Planned Action

Ref	Action	Lead	Deadline
1.17	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.	Stuart Windsor Iain Yearling	31/12/2018

Update on actions

04/09/2018 Reminder that protective electrical socket inserts were removed as part of an NHS Estates and Facilities alert issued June 2016. "In certain circumstances, the use of plastic 13A electrical socket inserts (sold as safety accessories), can overcome the safety features designed into socket outlets".

Modular extension in progress.

Assurance that actions have been addressed

Design agreed and available as evidence from Project Manager Cath Atkins in Estates. Residual risk added to risk register.

SHOULD DO: Provide training and/or guidance to reception staff that enables them to recognise 'red flag' symptoms.

Planned Action

Ref	Action	Lead	Deadline
1.18	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.	Wendy Colley Iain Yearling	31/12/2018

Update on actions

- Charge Nurse Booth is compiling a list of red flag symptoms. This will bel laminated and placed in reception.
- Team Leader to disseminate to the team – to include in induction pack.
- Team to use Buzzers and Tannoy to escalate when necessary.
- incorporate the Minor Injury Units.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Make sure clinical waste bins are emptied before becoming over-full.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.20	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.	Wendy Colley	Complete
Update on actions			
We are utilising the facilities from CDU. It is now considered that this does not need inclusion in the Trust Escalation Policy as it is considered in the SHINE safety form. Monitoring continues as part of the Matrons Audit.			
Assurance that actions have been addressed			
To be supplied.			

SHOULD DO: Review the security arrangements for storing patient records in the clinical decision unit.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.23	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.	Iain Yearling	Complete
Update on actions			
• Dedicated ward clerk for CDU in place for timely filing and security. • Staff reminded of the need for safe placing of medical / nursing documents from Ward Manager / Matron. • Lockable notes trolley in use. • Spot monthly audit compliance to commence December 2018 and findings reported to governance pillar for any necessary actions.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Make sure incident reporting, learning and feedback is given sufficient priority to encourage improved incident reporting from staff.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.24	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.	Matt Warner and Iain Yearling	31/01/2019

	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.		

Update on actions

Project related to secretarial support for administrating governance meetings started overseen by the Service Line Support Manager and Care Group Quality Manager.
Ref streamlined review, initial discussions have taken place with the Head of Quality Governance; this needs to be revisited and progressed.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Make sure allergy information is recorded on all relevant paperwork.

Planned Action

Ref	Action	Lead	Deadline
1.25	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.	Matt Warner Ian Yearling	31/12/2018

Update on actions

This is evident in the SHINE tool.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Make sure patients waiting in the department for long periods are not left without access to drinks and food, where appropriate.

Planned Action

Ref	Action	Lead	Deadline
1.27	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.	Iain Yearling	Complete

Update on actions

Food is provided by the CDU and the housekeeper discusses who may eat / drink with the Nurse In Charge for breakfast, lunch and dinner.

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

SHOULD DO: Record patients' pain scores routinely and make sure pain relief is provided promptly when required.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.28	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.	Iain Yearling	NEWS2: 31/12/2018 Redesign: 31/03/2023
Update on actions			
NEWS2 live in ED. See 1.1 re redesign of ED.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Ensure staff working in resuscitation as part of a team wear the correct tabards to help with role identification.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.31	Internal professional standard to be written outlining the requirement to wear the correct labelled tabards to help with role identification during Trauma care.	Matt Warner	Complete
Update on actions			
An Internal professional standard is not considered necessary. Staff have been reminded of the need to wear the correct attire for their role and it is the responsibility of the resus lead to ensure that the team members are correctly identified.			
Assurance that actions have been addressed			
To be determined.			

SHOULD DO: Review how patients can be better supported to manage and support their own healthcare.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.32	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.	Anne Hicks Iain Yearling	31/01/2019
Update on actions			

Lead for Minors Nigel Booth has met the Patient Experience Manager. Weekly visits from patient advocate to department.
Assurance that actions have been addressed
Not applicable at this stage.

SHOULD DO: Consider providing nursing staff the skills required to undertake mental capacity assessments.

Planned Action

Ref	Action	Lead	Deadline
1.33	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.	Anne Hicks Ed Cox	31/12/2018

Update on actions

Trust to pursue option 1.

Assurance that actions have been addressed

Escalated to Care Group Manager and wider Care Group as an action Trustwide 20.11.18

SHOULD DO: Provide patients requiring the toilet with appropriate facilities without undue delay.

Planned Action

Ref	Action	Lead	Deadline
1.34	1. Increase in establishment across all disciplines approved. Recruit to establishment (see action 1.8). 2. Reinvigorate intentional rounding format 3. Long Term: progress the redesign of the emergency department to improve access to toilet facilities and eliminate delays (see action 1.1).	Iain Yearling	Complete

Update on actions

Patients who are in the corridor are often dressed and therefore are assisted to the toilet outside x ray. For those who require assistance the FLIC cubicle or another will be used with a commode.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Keep patients in the corridor up-to-date with their care and treatment plans.

Planned Action

Ref	Action	Lead	Deadline
1.35	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.	Iain Yearling	31/12/2018

Update on actions

Lead for Minors has met with Patient Experience Manager. Matron to meet in December.
Assurance that actions have been addressed
Not applicable at this stage.

SHOULD DO: Communicate current estimated waiting times to patients arriving at the department.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.36	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.	Jayde Fletcher	31/12/2018
Update on actions			
Feasibility to be scoped.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Look to make the environment more suitable for patients with dementia.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.37	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.	1. Iain Yearling 2. Stuart Windsor	1. Complete 2. 31/03/2019
Update on actions			
Dementia box replenished 30/9/18. Matron attends the design meetings and will ensure that dementia friendly colours etc are used.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Improve minutes and action tracking for team meetings.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
1.39	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.	Wendy Colley	Complete
Update on actions			

Project related to secretarial support for administrating governance meetings started overseen by the Service Line Support Manager and Care Group Quality Manager.
Assurance that actions have been addressed
Agenda and minutes submitted as evidence

SHOULD DO: Identify ways of obtaining feedback from the public to develop and improve services.

Planned Action

Ref	Action	Lead	Deadline
1.41	Supported by the Trust Patient Experience Manager write a local patient engagement strategy outlining approaches for seeking feedback from patients attending the department.	Iain Yearling	31/12/2018

Update on actions

New Patient Experience Manager in post w/c 8 October 2018; will engage with him to complete this action.

Assurance that actions have been addressed

Not applicable at this stage.

Medical Care

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.

Planned Action

Ref	Action	Lead	Deadline
2.1	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.	Ed Cox	Complete

Update on actions

Review process is in progress. In consultation with finance regarding funding models. The review will look at different models of care and a review of the service to see where efficiencies can be made and how we could potentially reconfigure and develop the service to meet the challenging service demands. A five year plan is being factored in. Training posts have been agreed for succession planning. Results of demand and capacity are now available which will drive the volume of staff needed and inform business planning.

Assurance that actions have been addressed

Endoscopy capacity plan and Business plan summary.

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.

Planned Action

Ref	Action	Lead	Deadline
2.2	Scope IT solution using SALUS whiteboard with use of an icon tracking completion of VTE risk assessment.	Dr Ian Higginson	Complete

Update on actions

IT solution scoped but it was subsequently agreed that Salus would no longer be pursued as a solution given the planned implementation of e-Prescribing. This will have a VTE risk assessment feature inherent in it to ensure that this is completed and the present idea is to trigger a reassessment when a patient moves ward.

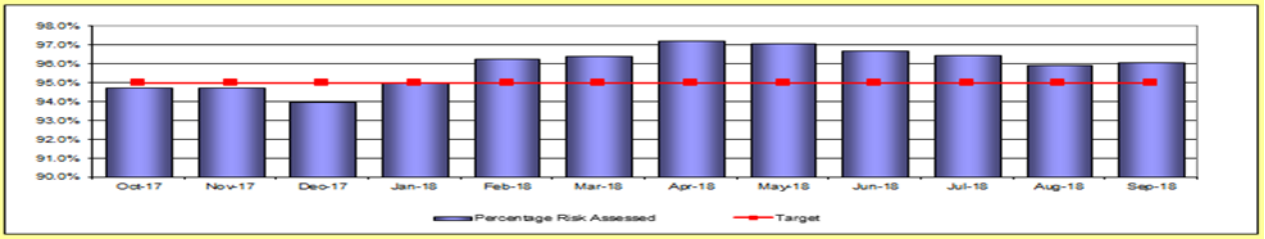
In the meantime the VTE team use the daily report on non-compliance with VTE risk assessment to look at where the worst performing areas are so that they can focus attention on them. There is also monthly monitoring via the Care Group performance reviews with service lines.

Assurance that actions have been addressed

The table below presents September 2018 data for VTE risk assessment as reported in the National Return. This shows that the target was exceeded based on current data collection methodology.

VTE Risk Assessment As Reported in National Return

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD
No of Admissions Risk Assessed	8705	8698	7668	8459	7867	8149	8304	8747	8746	8645	8368	8135	50945
No of Eligible Admissions	9186	9179	8156	8900	8171	8449	8537	9006	9042	8960	8719	8466	52730
Percentage Risk Assessed	94.8%	94.8%	94.0%	95.0%	96.3%	96.4%	97.3%	97.1%	96.7%	96.5%	96.0%	96.1%	96.6%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



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.

Planned Action

Ref	Action	Lead	Deadline
2.3	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.	Dr Ian Higginson	31/12/2018

Update on actions

1. A second test of change is planned to be conducted by the end of February 2019 – unlikely to achieve quarterly reviews.

2. Toolkit revision outstanding. Quality Manager's engagement with clinical governance leads completed related to identifying essential criteria to be covered in M&M meetings. Standardised guidance for recording locally within service lines is being drafted.

Assurance that actions have been addressed

Medical Care Group Mortality Review Report. Meeting minutes for Risk and Assurance Meeting.

SHOULD DO: Review arrangements for the safe administering of intravenous fluids for patients receiving haemodialysis.

Planned Action

Ref	Action	Lead	Deadline
2.10	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).	Hilary Cramp	31/01/2019

Update on actions

1. Completed: There is now a different way of lining and priming the machines with an extra attachment to the dialysis lines.

2. Staff training completed.

3. The proposed PGD has been drafted and submitted for review by Pharmacy. The senior pharmacist is setting up a meeting between interested parties to discuss the proposed PGD. Due date for action extended to account for this delay.

Assurance that actions have been addressed
1. Signature list of staff training – on line priming.

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.

Planned Action

Ref	Action	Lead	Deadline
2.11	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.	Ed Cox	31/12/2018

Update on actions

1. Meridian audit - draft questions have been developed for Head of Nursing review.

2. Completed: Matrons undertook a spot audit of their inpatient and outpatient areas and presented their findings into the October Service Line to Care Group performance reviews. Summary report has been written which was reviewed via the Care Group's Risk and Assurance meeting in November 2018. The report has been shared for review of recommendations with the Resuscitation Committee.

3. Annual audit outstanding. Due in February 2019.

Assurance that actions have been addressed

Summary report related to spot audit of Emergency Equipment within the Medical Care Group.

SHOULD DO: Ensure substances hazardous to health are stored in line with regulations.

Planned Action

Ref	Action	Lead	Deadline
2.13	1. Conduct awareness campaign related to safe storage of Actichlor Plus tablets (COSHH). 2. A digilock is to be fitted to an identified cupboard within the sluices of all inpatient and outpatient clinical areas for Actichlor Plus tablets to be stored. 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 cupboard'.	Ed Cox	31/03/19

Update on actions

1. Awareness campaign run via daily e-mail and vital signs- completed.

2. Following a more detailed review of different areas the ability to place a COSHH cupboard into every sluice raises wider health and safety considerations. In agreement with the Heads of Nursing for Medicine and Surgery, a revision to action point 2 has been made. The revised plan is for a digilock to be fitted to an identified cupboard within the sluices of all inpatient and outpatient clinical areas for Actichlor Plus tablets to be stored. Survey of ward areas to be undertaken to

understand volume needed. Due date for action extended to account for this delay. 3. Meridian audit question to be revised; discussions started with the Trust's Meridian administrator related to building an audit question.
Assurance that actions have been addressed
1. Evidence of awareness campaign.

SHOULD DO: Monitor, record and audit air pressure levels in positive and negative air pressure rooms in line with national guidance.

Planned Action

Ref	Action	Lead	Deadline
2.14	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.	Phil Tarbuck	31/12/2018

Update on actions

Areas visited during September and discussed with Infection Prevention & Control Team at the September 2018 Ventilation Safety Group meeting. Site visit with contractor undertaken on 03/10/2018 to discuss installation options. Quote returned on 15/10/18. Cost pressure of approximately £11K + VAT. Access restrictions due to clinical occupation will move completion date into the first or second quarter of 2019. Action progressing as planned as of 3/12/2018.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Review the suitability of Postbridge ward to accommodate inpatients and overnight.

SHOULD DO: Develop a standard operating procedure to provide guidance for staff about the safe use of escalation areas including safe staffing levels.

Planned Action

Ref	Action	Lead	Deadline
2.16 & 2.23	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.	Lee Johns	31/01/2019

	Complete risk assessment to determine suitability of Postbridge ward to accommodate inpatients during periods of operational escalation: incorporate option appraisal of not using Postbridge.		

Update on actions

Agreed via Head of Operations that the Matron for operational site team and Matron for Postbridge to be asked to work together on undertaking the risk assessment and writing the SOP (risk assessment to be integral to the SOP). To cross reference with Surgery action Ref 3.12 to include preserving the privacy and dignity of patients. Aim to review and approve through Emergency Planning Group. Due date extended to account for review and approval stages once final draft complete. SOP is being drafted.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Improve documentation to easily identify when patients were moved to a different ward and document the reasons for doing so.

Planned Action

Ref	Action	Lead	Deadline
2.17	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	Lee Johns	31/03/2019

Update on actions

Agreed via Head of Operations that the Matron for operational site team will communicate with the Salus team, review descriptors already in Salus and the hierarchy of the list of options. A meeting is being arranged between Heads of Nursing, Site Matron, and the Integration Manager and Solutions Architect.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Ensure nursing care plans are individualised and hold sufficient information to ensure safe and effective care can be delivered by all staff.

Planned Action

Ref	Action	Lead	Deadline
2.18	Nursing and Midwifery Strategic Priorities for 2018-2021 to include a review and renewal of all nursing care plan documentation.	Bev Allingham	31/03/2019

Update on actions

The latest versions of the risk assessment booklet are being shared. Discharge paperwork and discharge information to patients is being led as a project under the nursing framework and response to our patients survey, this is progressing. The rest of the documentation review is delayed due to other competing priorities. Replacement for the Matron of Clinical Standards post confirmed, start date due in early January 2019.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Review clinical guidelines on the trust intranet to ensure they are all current and reflect the most up-to-date national guidance.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
2.20	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.	Dr Ian Higginson	31/01/2019
Update on actions			
The Care Group Director has e-mailed all service line clinical leads requesting that clinical guidelines are brought up to date or to confirm those to be decommissioned and archived. Updated position presented to attendees at the Care Group's Directors, Managers & Matrons meeting. The Care Group Manager is actively chasing via the Service Line Managers. Further reminders sent during December to relevant services via the quality manager for medicine.			
Assurance that actions have been addressed			
There are **23** expired clinical guidelines as of 13 December which is an improvement on last month's position.			

SHOULD DO: Improve documentation from treatment escalation plans to ensure these are completed to demonstrate patients' choices are considered.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
2.22	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).	Sian Dennison Dr Ian Higginson	31/03/2019
Update on actions			
Trust wide TEP audit completed in October 2018 and presented at the End of Life Committee November 2018. Outcome of Committee to be communicated to the Care Groups and Service Lines with the next actions to take in order to monitor the percentage achievement related to accurate completion of TEP forms.			
Assurance that actions have been addressed			
Not applicable at this stage.			

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.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
2.25	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.	1. Bev Allingham 2. Caroline Dawe	1. 31/12/2018 2. 31/03/2019
Update on actions			
Training options are currently being explored.			
Assurance that actions have been addressed			
Not applicable at this time.			

Surgery

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.

SHOULD DO: Continue to improve theatre utilisation and reduce the number of theatres cancelled.

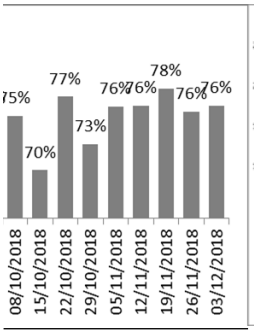
Planned Action

Ref	Action	Lead	Deadline
3.1.2 3.13	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 Line Managers at the Care Group Board meetings.	Jemma Edge	31/03/2019

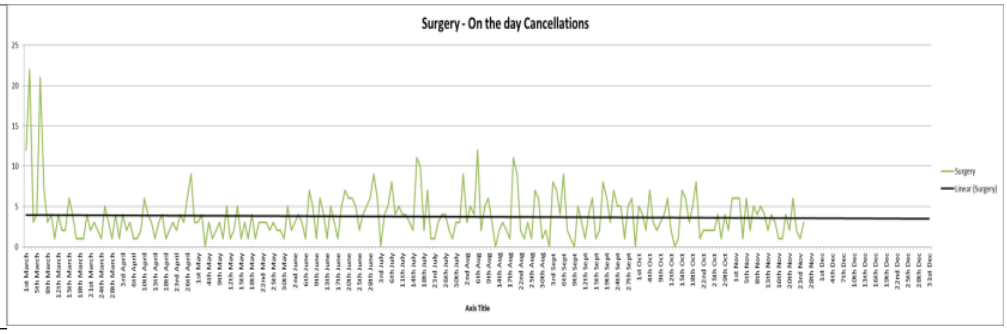
Update on actions

The 85% Target continues to be compromised by the non-elective admissions to the hospital which is leading to on the day cancellations.

Previous Month



Cancellations



Cancelled Operations actions

- New Operations Manager post
- Oversight of Cardiac cancellations
- New SOP for starting theatres on time

Specialties position

Project Workstream	Service Line	17/18 Data: Baseline cases per list	17/18 Data: Average income per case	YTD Price Variance	YTD Volume Variance	YTD Total Variance
Original Targeted Service Lines						
Freedom Specialties						
	ENT	2.20	£1,470	-£ 37,938	£ 17,130	(£ 20,808)
	General Surgery	2.20	£1,753	£ 9,179	£ 74,920	£ 84,099
	Maxillo Facial Surgery	2.40	£1,054	£ 45,170	£ 7,169	£ 52,339
	Plastic Surgery	2.70	£1,182	-£ 141,174	£ 244,440	£ 103,266
	Oesophago-Gastric Surgery	1.30	£2,916	-£ 100,053	£ 151,628	£ 51,575
	Urology	2.00	£1,778	£ 40,717	£ 141,338	£ 182,054
						£ 452,525
Non-Freedom Specialties						
	Breast Surgery	2.00	£2,140	£ 29,871	-£ 58,852	(£ 28,980)
	Colorectal Surgery	1.60	£2,750	-£ 27,833	£ 160,041	£ 132,208
	Gynaecology	2.10	£1,501	£ 90,267	£ 33,401	£ 123,668
	Ophthalmology	4.50	£782	£ 204,541	-£ 32,474	£ 172,067
	Orthodontics	2.80	£620	-£ 921	-£ 5,831	(£ 6,751)
	Orthopaedics	1.80	£3,287	£ 258,104	-£ 154,798	£ 103,306
	Restorative Dentistry	2.60	£586	£ 106	-£ 3,515	(£ 3,409)
	Vascular Surgery	1.60	£2,528	-£ 118,995	-£ 18,710	(£ 137,705)
	In Scope Total			**£ 251,041**	**£555,887**	**£ 1,259,453**
Non Targeted Service Lines						
	Cardiac Surgery	0.80	£11,451	£ 137,178	-£ 513,007	**(£ 375,829)**
	Cardiology	2.20	£2,136	-£ 266,393	£ 95,820	(£ 170,573)
	Dermatology	3.90	£739	-£ 146,838	£ 182,813	£ 35,975
	Neuropathology	2.70	£1,357	£ 11,483	-£ 9,633	£ 1,850
	Neurosurgery	0.90	£6,166	-£ 613,856	£ 394,793	(£ 219,063)
	PAC	8.30	£659	-£ 1,925	£ 2,767	£ 841
	Pain Management	1.40	£2,306	-£ 27,078	£ 14,758	(£ 12,321)
	Thoracic Surgery	1.50	£5,752	-£ 65,963	-£ 267,449	(£ 333,413)
	Thyroid Surgery	1.30	£2,325	£ 8,446	£ 7,325	£ 15,771

Assurance that actions have been addressed

Project performance is monitored via a bi weekly steering group

Operational performance is monitored via Weekly Performance meeting. Exception reporting where opportunity is

assessed as significant.

Cancellations are monitored. Ensure all decisions to cancel are escalated to Care Group level.

Distribute data to service lines.

Additional project support added.

SHOULD DO: Ensure cross infection processes are followed in all ward and theatre areas.

Planned Action

Ref	Action	Lead	Deadline
3.3	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.	HoN Surgery	Complete

Update on actions

Cardiothoracic Theatres: Improvements evident in Cardiac Theatres implemented by Senior Sister and Matron. Action plan in place and to be a regular item on theatre governance agenda until satisfactory completion. Good leadership demonstrated by Senior Sister and Matron to embed this.

Moorgate: Combined Observation of Care feedback completed and found to be satisfactory.

Assurance that actions have been addressed

Combined Observation of Care feedback and Service Line Balanced Scorecard for Moorgate.

SHOULD DO: Ensure products deemed as hazardous to health are locked away and not accessible to patients.

Planned Action

Ref	Action	Lead	Deadline
3.4	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.	HoN Surgery	31/03/2019

Update on actions

Ward Audit 26/09/2018 Included in Chart Below; Outpatient areas added 07/12/2018

Ward/Clinic	Bleach tablets secured	COSHH cupboard in sluice	Lock to existing cupboard in sluice needed?	COMMENTS
Stannon	YES	YES	NO	
Sharp	NO	YES	NO	COSH cupboard has lock, on audit twice it had been checked and it was locked
Shaugh	YES	YES	NO	
Sonehouse	NO	NO	YES	
Wolf	YES	NO	YES	Currently stored in unlocked cupboard in locked cleaning room
SAU	NO	NO	YES	Stored in unlocked high cupboard in sluice
Crownhill	NO	NO	YES	Stored in unlocked high cupboard in sluice
Clearbrook	NO	NO	YES	
Torrington ICU	NO	NO	YES	
Torrington HDU				NO SLUICE
Penrose Main Sluice	NO	NO	YES	
Penrose Link Sluice	NO	NO	NO	Shelving only in sluice
Pencarrow	NO	NO	NO	There is already a locked cupboard in pencarrow sluice which contains patient toiletries
Moorgate	NO	YES	NO	This is a problem - cupboards are metal - proably better if they lock in COSHH cupboard
Lynher	NO	NO	YES	Stored in unlocked high cupboard in sluice
Orthopaedic Outpatients	YES	YES	NO	Sluice locked with digi and COSH locked in sluice
ENT Outpatients	YES	NO	NO	secured in locked cupboard in sluice
Max Fax	YES	NO	NO	Locked COSHH in locked cupboard
Chestnut	YES	YES	NO	Secured in locked COSHH in sluice
Main OPD	YES	YES	NO	Secured in locked COSHH in sluice
REI	YES	NO	NO	Digi locked room with locked cupboards
Erme	NO	YES	YES	COSHH cupboard lock broken - could have lock added to white cupboard in sluice
Fal	NO	YES	YES	COSHH in sluice not locked - could have a digi on white cupboard
Postbridge	NO	YES	NO	Cupboards not suitable for digi - would need to either use lock on coshh or replace cupboards

Audit now includes Outpatient areas to understand in conjunction with Medicine the total number of digilocks that we will need to procure to cover the trust.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Improve compliance with 95% of venous thromboembolism (VTE) (blood clot) assessments being carried out for patients in line with national guidance.

Planned Action

Ref	Action	Lead	Deadline
3.5	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.	Richard Struthers	31/03/2019

Update on actions

Safety Thermometer Data for September 2018 and October 2018 Included in the charts below demonstrates that compliance reduced from 90% in September to 82% in October. The unacceptable variability in compliance has been referred to the trust VTE CNS for specialist advice regarding how to take this forward, it is noted that the data does not suggest a corresponding issue with VTE prophylaxis prescribing.

September 2018

Ward	September 2018 Safety Thermometer No Pts/Risk Assessed	Percentage
Stannon	10 patients 10 risk assessed	100%
Sharp	27 patients 27 risk assessed	100%
Shaugh	33 patients 33 risk assessed	100%
Stonehouse	31 patients 28 risk assessed	90%
Wolf	28 patients 22 risk assessed	79%
SAU	20 patients 17 risk assessed	85%
Crownhill	24 patients 16 risk assessed	67%

Clearbrook	26 patients 18 risk assessed	70%
Torrington CICU	4 patients 4 risk assessed	100%
Torrington HDU	4 patients 4 risk assessed	100%
Lynher	29 patients 29 risk assessed	100%
Moorgate	24 patients 18 risk assessed	75%
Penrose	10 patients 10 risk assessed	100%
Pencarrow	10 patients 10 risk assessed	100%

October 2018

Ward	Number of Patients	VTE Risk Assessment Documented	Percentage Risk Assessed	Prophylaxis Prescribed	Prophylaxis Not Prescribed	Prophylaxis Not Applicable
Crownhill	26	26	100%	24	0	2
Moorgate	24	15	63%	23	1	0
Clearbrook	25	20	80%	21	1	3
SAU	25	22	88%	21	2	2
Torrington	7	7	100%	7	0	0
Torrington HDU	6	6	100%	6	0	0
Stannon	18	13	72%	15	0	3
Lynher	30	25	83%	25	5	0
Sharp	29	23	79%	27	0	2
Penrose	13	8	62%	12	0	0
Wolf	28	28	100%	28	0	0
Stonehouse	31	26	84%	26	2	3
Shaugh	31	21	68%	31	0	0
Pencarrow	6	6	100%	6	0	0
Recovery	1	1	100%	1	0	0
	300	247	82%	273	11	15

The document below provides a summary of the data on the Performance Dashboards:

Copy of VTE (2).xlsx

Overall service lines have shown a pleasing improvement since Spring 2018. Review by the Care Group Director has identified that Cardiac Surgery requires support to improve and Orthopaedics Surgery require support to improve and understand the variability in compliance. The medium term solution to address VTE Risk Assessment Compliance is the implementation of the e-prescribing system.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Improve compliance with the WHO checklist in the specialities where the 95% compliance target was not being achieved.

Planned Action

Ref	Action	Lead	Deadline
3.6	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.	Jemma Edge	31/03/2019

Update on actions

Chart below details August WHO Compliance Data:

Service Line	WHO- GA	WHO-La	Latest Data if <95% or compliant (13/11/2018)
Anaesthetics	N/A	No Data	N/A
Thoracic Surgery	86%	75%	GA 90% / LA 80%
Vascular Surgery	88%	100%	GA 91%
Cardiac Surgery	93%	No Data	Compliant
Colorectal	98%	100%	Compliant
Critical Care	N/A	N/A	Compliant
Restorative Dentistry	100%	100%	N/A
Max Fax	100%	No Data	Compliant
Orthodontics	100%	No Data	N/A
Dermatology	N/A	N/A	N/A
ENT/Audiology	99%	100%	Compliant
General Surgery	97%	100%	Compliant
Upper GI	94%	100%	GA 93%
HPB	N/A		Compliant
Majpr Trauma Centre	N/A	N/A	N/A
Neurosurgery	94%	100%	LA 94%
Opthalmology	100%	98%	Compliant
Chronic Pain Services	N/A	N/A	N/A
Plastic Surgery	94%	96%	Compliant
Theatres Central	N/A	N/A	N/A
Orthopaedics	96%	100%	Compliant
Fracture Clinic	N/A	N/A	N/A
Rheumatology	N/A	N/A	N/A
Urology	98%	100%	LA 75%

Analysis ongoing to understand variability in compliance.

Assurance that actions have been addressed

Monitor progress via Clinical Governance framework.

SHOULD DO: Continue to improve staffing levels and ensure they match the acuity of patients on all wards.

Planned Action

Ref	Action	Lead	Deadline
3.7	Corporate Establishment review in progress. The Surgical Care Group will interrogate leavers exit interview data and monitor via Clinical Governance Meetings.	HoN Surgery	31/03/2019

Update on actions

Conducted Establishment review as part of Trust Process. Executive Directors implemented a 14 point action plan for the short to medium term time line to improve staffing. Establishment reviews nearing completion. Winter recruitment plan is in process. Work continues to raise awareness of the need for exit interviews with Theatres confirming that a process

has been implemented. Band 6 review and 14 Point Plan in progress.

Assurance that actions have been addressed

Monitor compliance with the 14 point programme.

SHOULD DO: Improve appraisal levels so that they achieve the trust's target.

Planned Action

Ref	Action	Lead	Deadline
3.8	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.	Jemma Edge	31/03/2019

Update on actions

Care Group Manager meeting with Cluster Managers to identify if there are any other means of supporting this improvement work.

Service Line	Staff Count "In Date"	%	Total Staff due to be appraised
216 Cardiothoracic & Vascular Surgery Summary	147	85.47%	172
216 Colorectal Surgery Summary	44	88.00%	50
216 Critical Care Summary	170	87.18%	195
216 Dental & Max Fax Summary	37	100.00%	37
216 Dermatology Summary	23	92.00%	25
216 ENT & Audiology Summary	47	90.38%	52
216 General and Upper GI Surgery Summary	68	86.08%	79
216 Neurosurgery Summary	37	86.05%	43
216 Ophthalmology Summary	62	91.18%	68
216 Pain Services Summary	11	78.57%	14
216 Plastic Surgery Summary	43	89.58%	48
216 Surgery SL Man Costs Summary	15	71.43%	21
216 Theatres Central Summary	398	85.96%	463
216 Trauma & Orthopaedics and Rheumatology Summary	157	86.74%	181
216 Urology Summary	21	84.00%	25
216 Oesophago-Gastric Surgery Summary	4	80.00%	5
Grand Total	4561	87.61%	5206

Assurance that actions have been addressed

Heat map assessment process completed; need to ensure individual action plans are in place.

SHOULD DO: Ensure all areas used in times of escalation protect patient's dignity and meet their needs.

Planned Action

Ref	Action	Lead	Deadline
3.12	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.	Head of Operations	31/01/2019

Update on actions

This is a Corporate Issue and feeds into the work on discharge and patient flow. The Winter plan needs to consider assessment of fitness for patients prior to use. Ensure SOP in place for opening of escalation areas. SOP in progress for Postbridge.

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

SHOULD DO: Improve the number of risks on the risk register actioned within the agreed timescales.

Planned Action

Ref	Action	Lead	Deadline
3.14	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.	Jemma Edge	31/03/2019

Update on actions

Progress Chart below:

Month	**% Action Plans Outstanding** (Data obtained from monthly Risk Management Performance Report)
May 2018	40%
June 2018	33%
July 2018	40%
August 2018	43%
September 2018	44%
October 2018	44%

No percentage improvement despite prompts to individuals and support. All Action owners identified and escalated to relevant Service Line Managers and Service Line Cluster Managers to manage. Risk and Incident Manager updating dashboards so this information is readily available without needing to open each individual risk.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Standardise the format of minutes of mortality and morbidity meetings to ensure effective sharing of information.

Planned Action

Ref	Action	Lead	Deadline
3.15	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.	Richard Struthers	31/03/2019

	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 that the key learnings are shared.		

Update on actions

Governance Leads Meeting - Agreed learning which should be shared with other Service Lines or Trust Wide from Morbidity and Mortality Meetings would be a standard item on the Governance Leads Meeting Agenda to retain some flexibility for Service Lines to record the Morbidity and Mortality meetings in their preferred format. 03/10/2018 Updated template for Governance Leads Meeting Agenda approved at Care Group Governance Meeting. General Surgery Mortality Review at Governance Leads meeting 20/11/2018.

Further discussion with the Service Line Governance Leads on 20/11/2018 focussing on the current HSMR figures. It is clear that there are some data quality issues which the Performance Information Team are aware of and may in part be attributable to the use of Salus. Performance Information are enlisting NHSI support in addressing this. In particular Cardiac Surgery and Intensive Care are subject to national audit which suggest that they perform well while having HSMR levels >200.

Service Line Leads have raised concerns around the current process including screening before referral to ensure that the case is attributed to the correct Service and timeliness of requesting notes. These will be raised by the Care Group Director with the Head of Quality Governance.

Assurance that actions have been addressed

Not applicable at this stage.

Maternity

MUST DO: Ensure all staff in maternity have in date mandatory training, including emergency procedures and safeguarding.

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

Planned Action

Ref	Action	Lead	Deadline
4.1 Mat 5.1 OP	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.	Ali Cowls Richard Maguire	30/11/2018

Update on actions

- Livewell to assist with “making every conversation count” training.
- Mandatory pool training – currently at 85% compliant. Need band 7 coordinators who can also formally assess the competencies of the staff. There is a process for all new staff joining the unit and the mitigation is that there is always someone trained in evacuation on duty.
- Undertake training at start of each rotation to CDS for midwives.
- Mandatory training can now be separated out for midwives and Medics.

Assurance that actions have been addressed

Not applicable at this stage.

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.

Planned Action

Ref	Action	Lead	Deadline
4.3.2	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.	Sheralyn Neasham	Complete

Update on actions

1. Matrons for inpatients have updated checklist.

2. Historically handovers were only undertaken between Maternity Care Assistants but they are now involved in the main handover so that the shift coordinator is aware of any equipment issues. Handover sheet revised. New spreadsheet will be signed to evidence the conversation has occurred.

3. Separate Matron’s Maternity audit created – HCA room checks, equipment checklist, grab boxes. 6 monthly audit to be presented at CEC as a standard agenda item.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Review the systems and processes for the safe management of medicines, including replenishment and storage, both within the hospital and in community.

Planned Action

Ref	Action	Lead	Deadline
4.4	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.	Sheralyn Neasham / Charlotte Wilton	30/11/2018

Update on actions

- Induction process for midwives attending Home birth.
- Lead for Homebirth Team to empty and replenish the Homebirth boxes. Photograph how box should be stocked and design new checklist to reflect the requirement.
- Enhanced Observation room cabinet has been added to the CD checking book. Twice daily check to be conducted. This will form part of the Matrons audit.
- Stationary cupboard and equipment cupboards are being altered on CDS. All medical equipment will be stored separately from the stationary. Ongoing work to move equipment and stationary.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Ensure the process for approval to work under Patient Group Directions are consistent with trust policy and national guidance.

Planned Action

Ref	Action	Lead	Deadline
4.5	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.	Ceri Staples	Complete

Update on actions

- Band 7 Midwife (CS) leading on PGDs in department.
- Emails have been sent to all midwives with the PGD policy attached.
- Pharmacy hold the signature bank of the number of midwives who have completed E-learning and signed for competency. Plan for individual signature bank for each drug on PGD list.
- PGD competency can be added to CEC agenda to assure actions are being addressed.
- Lesson plan to evidence PGD discussion/inclusion during MMT week.
- PGD E-learning now approved and in place for completion end December 2018.

Assurance that actions have been addressed

- New education package for midwives via E-learning.
- PROMPT lesson plan.
- Communication to midwives re: PGDs and signature bank for pharmacy.

MUST DO: Consistently achieve internal targets for the use and completion of the WHO safety checklist.

Planned Action

Ref	Action	Lead	Deadline
4.6	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.	Gill Nicholson	31/10/2018

Update on actions

- 92% compliance. Email sent to the theatre team involved when WHO checklist is recorded as "failed" for feedback as to why. This will provide an audit trail.
- WHO checklist failure audits from Maternity theatres to be tabled every 6 months at CEC.

Assurance that actions have been addressed

Not applicable at this stage.

MUST DO: Ensure patient information is protected in clinical areas and records are amalgamated and stored securely following discharge from the service.

Planned Action

Ref	Action	Lead	Deadline
4.7	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.	Ali Cowls	Complete

Update on actions

Backlog has been cleared and there are daily walk arounds for the department. The importance of completing paperwork in a timely way has been communicated to Midwifery teams. Weekly audit now completed. Storage has been reviewed and lockable notes trolleys are now in place for the Antenatal Clinic area.

Assurance that actions have been addressed

To be reviewed.

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.

Planned Action

Ref	Action	Lead	Deadline
4.10	1. Review of all guidelines 6 months prior to expiry. 2. Historic and rolling review of version control to be revisited to align	Dr Joanne Page	31/03/2019

	with review schedule.		

Update on actions

The department is notified when guideline/policy document is within 6 months of expiry date. Audit, Assurance and Effectiveness team provide monthly update on the status of guidelines.

Assurance that actions have been addressed

Not applicable at this stage.

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.

Planned Action

Ref	Action	Lead	Deadline
4.11	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.	Sheralyn Neasham Charlotte Wilton	Complete

Update on actions

1. & 2. Room has been re-named on white board and on room door. MMT week also now refers as "Enhanced Observation Room". Midwives do not provide care for critically ill women. Communications to all staff via Theme of the week and inclusion in the Mandatory Multi-disciplinary training sessions.

3. Incorporate the training on the monitor as part of the rotation to CDS. Utilise the ORE/Ward Manager at the start of rotation to assist in the updating of staff at the start of their rotation. Staff have a check list to sign off that they are competent to do. There is a plan for introduction of "return to CDS" induction for staff rotating back to the area.

4. Guideline and observation charts updated to reflect the changes.

Assurance that actions have been addressed

To be reviewed.

MUST DO: Ensure Modified Early Obstetric Warning Score (MEOWS) charts are used consistently and escalation occurs in accordance with policy.

Planned Action

Ref	Action	Lead	Deadline
4.12	Audit MEOWS charts of inpatients every 6 months.	Sheralyn Neasham	Complete

Update on actions

Added to the audit routine schedule; first audit completed and presented as part of audit schedule at monthly Clinical Effectiveness Committee.

Assurance that actions have been addressed

MEOWs audit now on audit schedule. Plan for addition to Meridian to facilitate ease of recording.

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.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.13	1. Implement LMS agreement for Pan-Devon Definition of Serious Incidents within Maternity. 2. Backlog to be cleared.	Sue Wilkins Helen Harling	30/11/2018
Update on actions			
There has been a Pan-Devon agreement on the classification of serious incidents which has resulted in the cooling babies incidents to now become reportable on STEIS. Rachel Sturley is lead observation for the LMS.			
Assurance that actions have been addressed			
Not applicable at this stage.			

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.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.14	1. Joint review of handover by Maternity Matron and Service Line Director. 2. Electronic or paper capture of handover to be commenced.	Peter Scott Sheralyn Neasham	31/01/2019
Update on actions			
New handover sheet developed to ensure that all high risk patients and outliers are discussed as well as priority of patients. Matron to compile Survey Monkey re: staff shift start and finish times.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Continue with the plans already initiated for a midwifery-led service to comply with national guidance.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.16	Continue to raise awareness through the LMS, Board Reporting and the Risk Register of inequality with the backdrop of the financial position.	Sue Wilkins	Ongoing
Update on actions			
There have been 11 business cases submitted over the last 7 years for a midwifery-led unit that have been rejected. This will go through the investment panel again.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Expand the use of clinical audit and other improvement tools to proactively measure service delivery.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.17	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.	Tim Hookway Lauren Graham	Complete
Update on actions			
1. 0.4wte band 6 Audit Midwife in post and will liaise with Consultant Obstetrician regarding allocation of audit to junior doctors. 2. Audit schedule in place with rolling presentation to Monthly Maternity Governance Meeting (CEC).			
Assurance that actions have been addressed			
To be submitted.			

SHOULD DO: Evaluate the roster to identify if midwifery staff shortages are disparate across the service and disproportionally affect one part of the pregnancy.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.18	Rosters will be reviewed and, if required, staff will be re-allocated to balance areas.	Sheralyn Neasham / Charlotte Wilton	31/10/2018
Update on actions			
Communication to staff re change to recording on MAPs for daytime escalation of specialist midwives. Added to audit schedule for Maternity and Obstetrics Governance meeting (CEC).			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: A risk assessment for the safe storage of medical gases should always be available to staff.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.19	Risk assessment to be completed and shared with staff.	Tracey Sargent	31/10/2018
Update on actions			
Matron met with Paul Commander from Estates. Cupboard cleared of homebirth equipment and entonox gas cylinders and has been reassessed. Matron is liaising with the Health and Safety Team regarding moving spare O2 cylinders for resuscitaires to outside gas storage facility. The Homebirth team lead has drafted a SOP for carriage of entonox to homebirth.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Review the process for ensuring hazardous chemicals are consistently locked away and not accessible to unauthorised persons.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.20	Review the process for ensuring hazardous chemicals are consistently locked away and not accessible to unauthorised persons.	Sheralyn Neasham	Complete
Update on actions			
COSHH cabinets are now available in all clinical areas.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Consider how to increase information technology in the community, and specifically access by community midwives to maternity guidance and blood results.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
4.21	Business case for the solution to be repeated and placed on Risk Register if not financially or physically achievable.	Ali Cowls Charlotte Wilton	Complete
Update on actions			
IT access for community staff is on the Risk Register: Risk Register ID `6296 - Evolution Maternity System – Unsupported software by supplier DXC - Moderate Risk. Risk Register ID 4033 – Inconsistent access to patient information via ICT systems - Moderate Risk. Business case has been re-submitted.			
Assurance that actions have been addressed			
Not applicable at this stage.			

Outpatients

SHOULD DO: Make sure all staff working in clinical outpatient areas are 'bare below the elbow' in line with best practice and trust policy.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
5.4	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.	Rachael Buller	31/12/2018
Update on actions			
DAAF audits have been completed during November and initial first review indicates that only one area had staff at time identified as not being bare below elbows. This was actioned at the time of assessment and escalated to the Unit Manager and Matron. As this is only a yearly audit it is important that we continue with development of monthly outpatient department audit and this question will form part of that audit. Paper copy sent to Meridian for implementation as a test audit Monday 3rd December. Once this is on Meridian we will undertake trials/tests in 4-5 areas to ensure that this is fit for purpose and then the expectation will be that this audit is undertaken a minimum of once per month with results to form part of the governance structure at 1-1s.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Take steps to provide sufficient seating and outpatient waiting areas facilities for patients attending appointments.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
5.5	Service lines to review their waiting areas and submit plans to provide sufficient seating to OPD Board.	Rachael Buller	31/12/2018
Update on actions			
Information has been requested from Service Lines and will be co-ordinated in a document for submission to OPD Performance and Governance Meeting in January 2019. Care Groups and Service Lines remain in charge of managing the risk and managing/requesting works.			
Assurance that actions have been addressed			
Not applicable at this stage.			

SHOULD DO: Make sure patient notes are stored securely when not in use in outpatient clinics.			
Planned Action			
Ref	**Action**	**Lead**	**Deadline**
5.6	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	Rachael Buller	31/12/2018

	undertaken to gain a better understanding of what is audited and what can be audited in future and increase regularity if possible.		

Update on actions

TADAFF and DAFF currently auditing. Yearly audits being undertaken by Health Records and monitored through Health Records Board. Requested addition to Meridian in monthly outpatient department audit. Email to be sent out via daily email. Posters have been distributed to all OPD areas.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Ensure that learning from any serious incidents is embedded within the relevant department and the wider organisation.

Planned Action

Ref	Action	Lead	Deadline
5.7	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.	Rachael Buller	31/12/2018

Update on actions

This is already being managed within Service Lines and Care Groups so assurance can be given that issues are being dealt with but OPD Board want to be able to have oversight. A location review has therefore been requested to be able to pull information from Datix; this is currently underway.

Request submitted for Dashboard and with Risk Team to undertake; they are currently working on this development.

Assurance that actions have been addressed

Agenda item and discussion at OPD Performance and Governance meetings.

SHOULD DO: Keep patients informed of delays in outpatient clinics making sure staff communicate effectively with patients with disabilities and sensory loss.

Planned Action

Ref	Action	Lead	Deadline
5.8	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.	Rachael Buller/Kerry Richardson	31/12/2018

Update on actions

This is on the agenda for OPD forum on 10th December and also forms part of the Fundamentals of Care audit that all OPD areas should be completing. Service Lines/Heads of Departments should have awareness of their results and be putting in place action plans to rectify any deficits.

Communication boxes are in the development stage and will include things such as:

- Hospital communication book
- Hospital Passports and add-ons for example autism, mental health, epilepsy, learning disabilities, carers
- A small portable hearing loop
- Getting to know me book – laminated

- Laminated A-Z Makaton signs
- Laminated A-Z BSL Signs
- Dyslexia sheets
- Instructions for SignLive
- Magnifying sheet
- How to guides for staff for access to braile and large print etc
- Details on the red bag scheme
- Accessible information standard
- Checklist for staff

This will be taken to the Derriford User Group, meeting with matrons, ward sisters, outpatient forum etc. with some sample boxes in early February for comments before we agree the planned roll out.

Assurance that actions have been addressed

Not applicable at this stage.

Trust Wide

Referral to Treatment

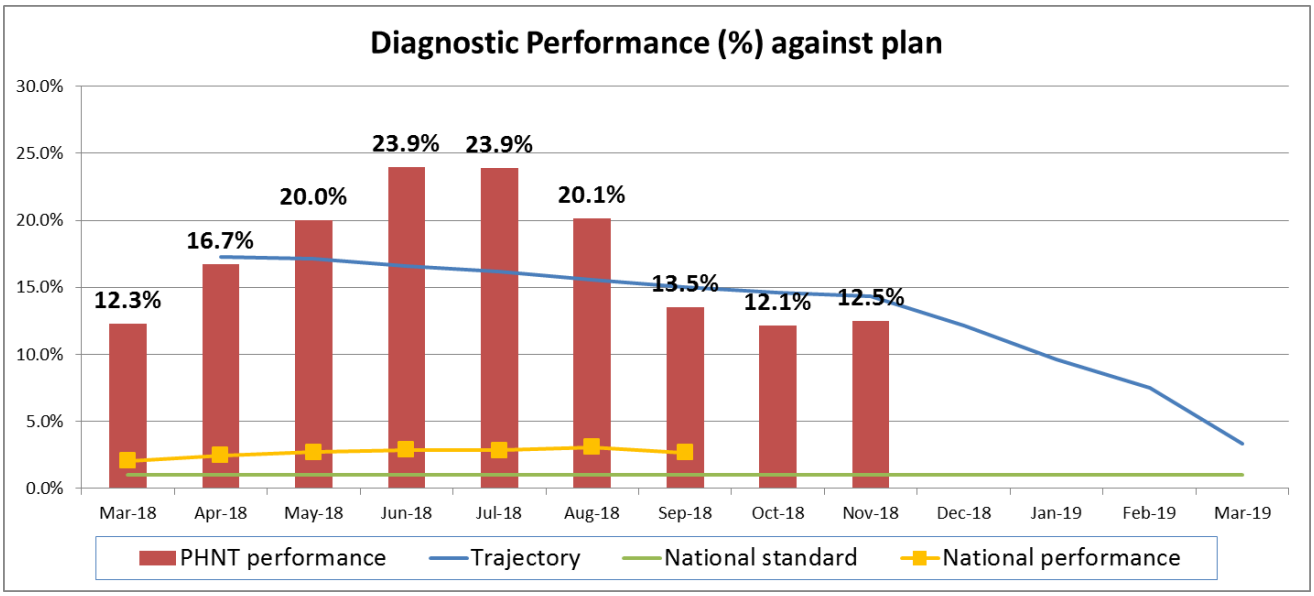
MUST DO: Make significant improvements to meeting the needs of patients in the diagnostic imaging departments in terms of timeliness of their appointments.

Planned Action

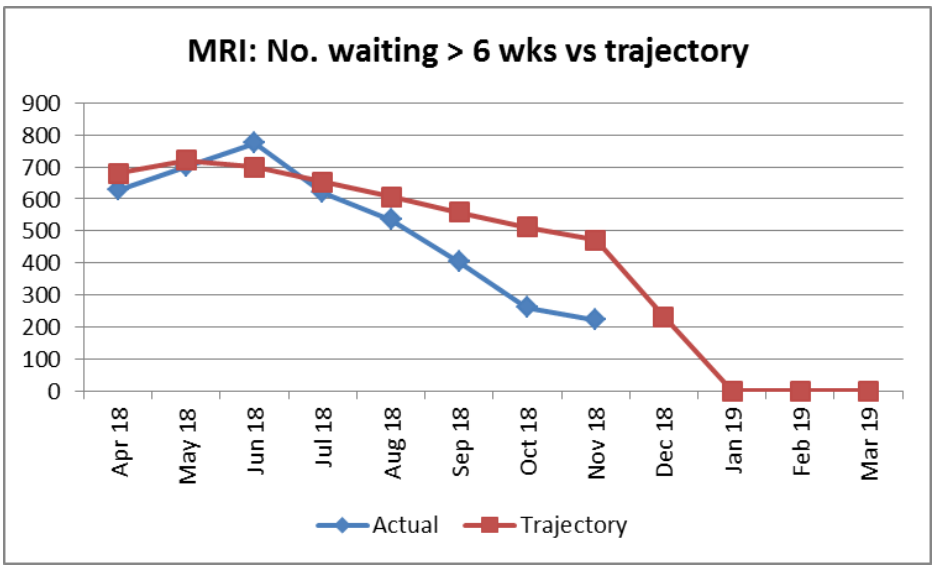
Ref	Action	Lead	Deadline
6.2.1 Imaging	Ensure achievement of the improvement trajectory as agreed with NHSI. Reduce DMO1 reportable tests > 6 week waits to 3.4% by March 2019 (detailed action plan in place)	Jacqui Beer	31/03/2019

Update on actions

Graph 1: Shows achievement of DM01 waiting times against agreed NHSI trajectory



Graph 2: Shows achievement of DM01 for MRI only against trajectory

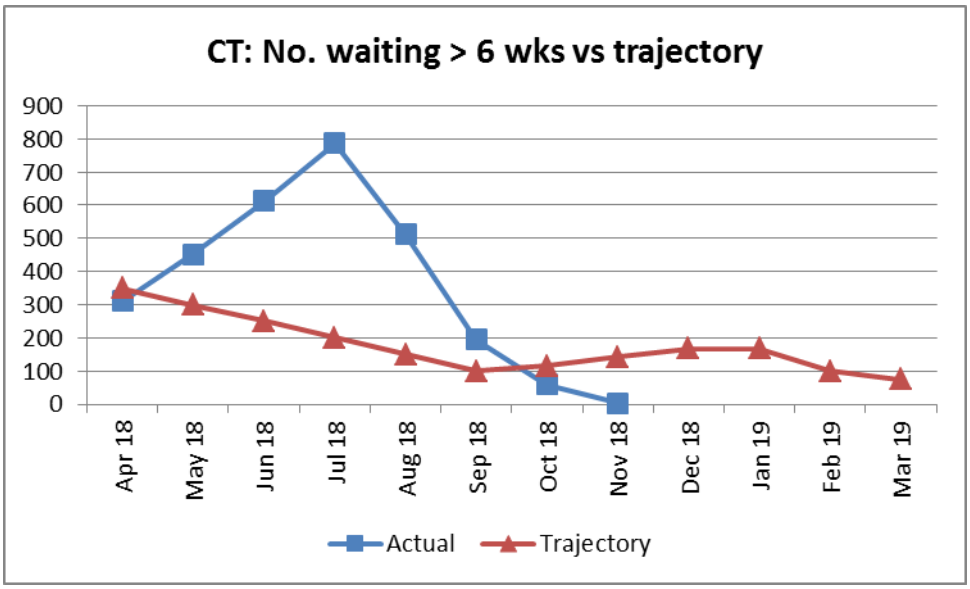


Key actions to increase MRI capacity in 2018/19:

1) Increase mobile capacity via "Interim" pad – COMPLETE Aug 2018

2) Increase scanning at peripheral sites (Care UK & DDRC) – DDRC plan now changed to on site "Oak Tree Pad" – COMPLETE: start date 8/10/18. Care UK - *expected start date 7th Jan 2019*.

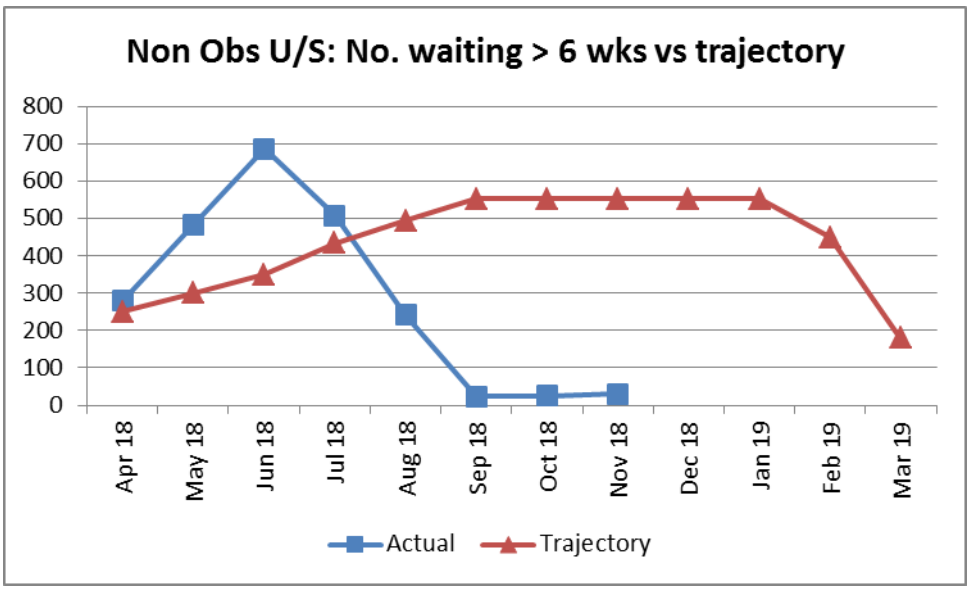
Graph 3: Shows achievement of DM01 for CT only against trajectory



Key actions to increase CT capacity in 2018/19:

1) "Lightspeed" refurbishment – COMPLETE Aug 2018
2) Increase mobile capacity via "Interim" pad – COMPLETE Aug 2018
3) Utilise Alliance PET/CT scanner for routine CT outpatient scanning – COMPLETE: start date 7/11/18

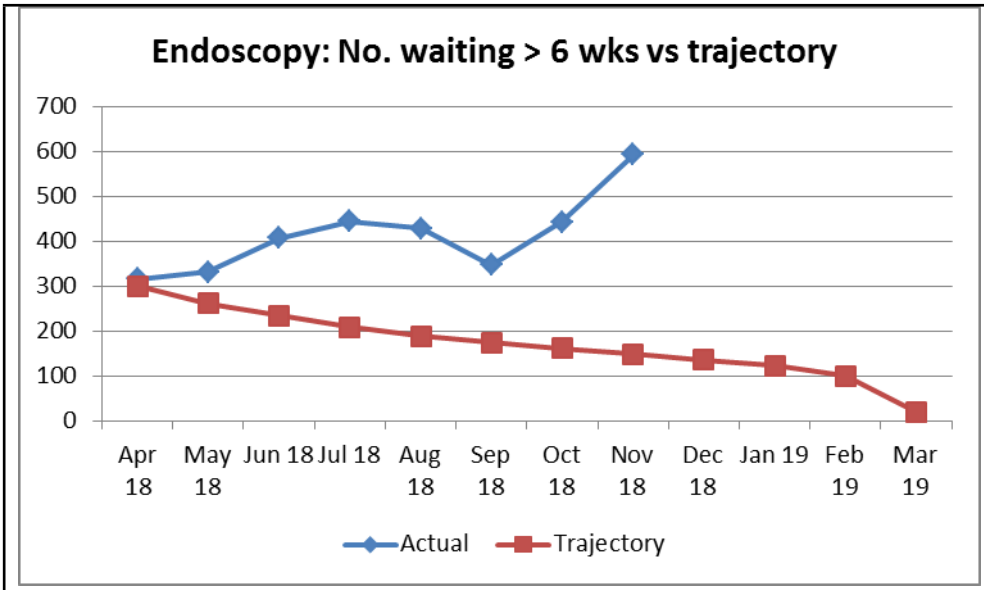
Graph 4: Shows achievement of DM01 for Non Obs Ultrasound only against trajectory



Key actions to increase Non Obs Ultrasound capacity in 2018/19:

1) Development of new scanning room on Acute Assessment Unit – COMPLETE July 2018
2) Staff 3 additional sessions on SAU in the afternoons – COMPLETE: started Oct 2018

Graph 5: Shows achievement of DM01 for Endoscopies only against trajectory



Key actions to increase Endoscopy capacity in 2018/19:

1) Recruitment to fill 6 WTE nursing vacancies – position improved down to 2.5wte vacant – nurses being trained – should be fully operational Feb/Mar 2019.
2) "Insource" additional capacity at weekends – started – extending through to March 2019.
3) Demand & Capacity exercise to be revisited due to increase in 2ww referrals – work is complete and results show the capacity gap remains through to the financial year end.
4) NEW ACTION: Initial meeting with Four Eyes took place on 11th Dec 2018 – plan is to work with them on improving productivity within the Endoscopy suite ASAP – timescales TBC.

Assurance that actions have been addressed

Graph 1 shows that the DM01 standard performance is ahead of trajectory [12.5% versus plan of 14.3%] as at Month 8.

MRI – actions progressing well. Graph 2 demonstrates reduction in the number of waiters > 6 weeks is ahead of trajectory as at November 2018 and more capacity comes online from January 2019.

CT - actions progressing well. Graph 3 demonstrates the number of waiters > 6 weeks as at November 2018 is significantly (-784) reduced compared to July 2018 and ahead of trajectory by 140.

Non Obs Ultrasound – actions complete. Graph 4 demonstrates reduction in the number of waiters > 6 weeks is significantly ahead of trajectory as at November 2018.

Endoscopy – despite recruitment progress and confirmation of "in-sourcing" through to March 2019, the capacity gap remains such that c. 400 6 week breaches are currently forecast for the end of March 2019 position. Consequently, a dialogue with Four Eyes has commenced to use their expertise to help improve our productivity and thus gain more capacity internally.

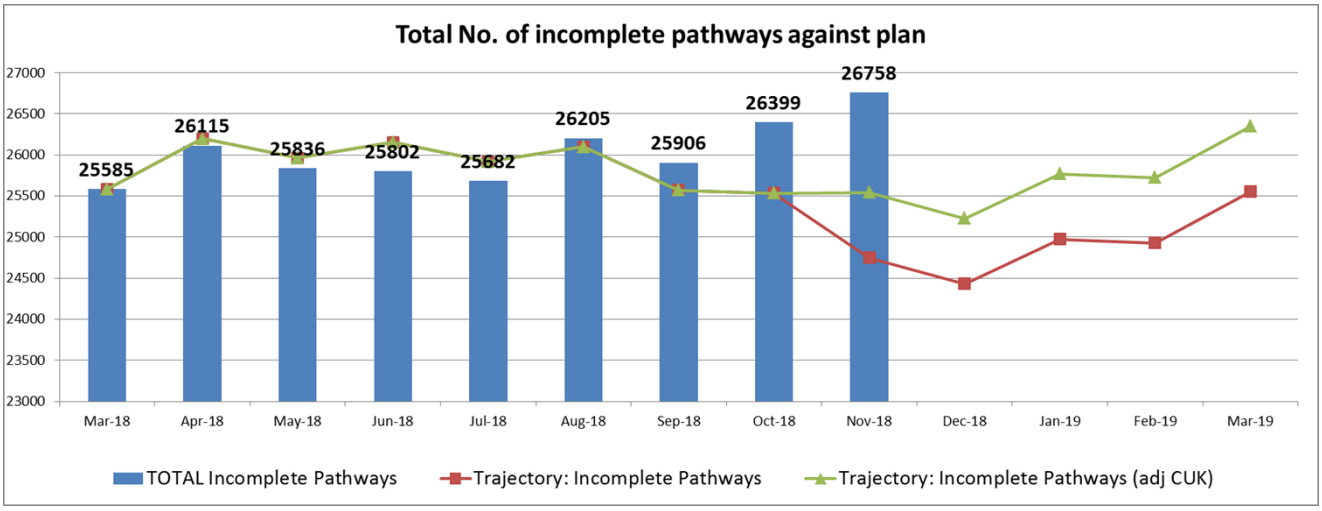
MUST DO: Ensure referral to treatment time for incomplete pathways are improved and improve the cancer waiting times for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.
MUST DO: Bring the current outpatient referral to treatment time target into line with targets.

Planned Action

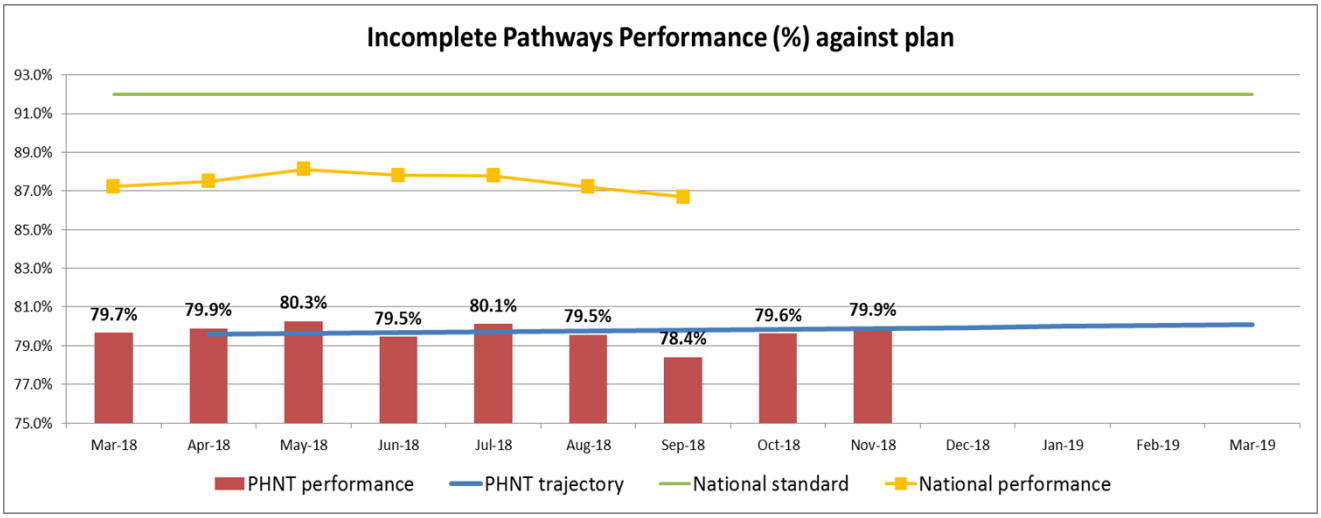
Ref	Action	Lead	Deadline
3.1.1 Surgery 5.2 OP	Ensure achievement of the improvement trajectory as agreed with NHSI. Maintain incomplete pathways and reduce 52 week waits by 50% compared to March 2018 position in line with national planning guidance and commissioned levels of activity	Jacqui Beer	31/03/2019

Update on actions

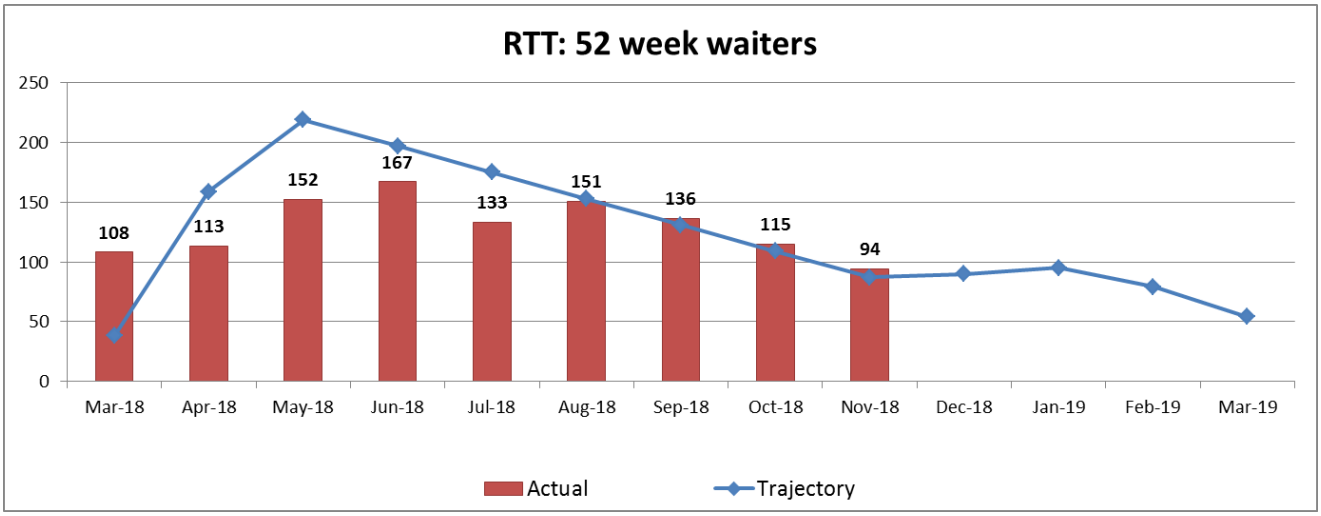
Graph 1: Shows the number of RTT incomplete pathways against trajectory



Graph 2: Shows RTT performance (% within 18 weeks) against trajectory



Graph 3: Shows the number of RTT 52 week waiters against trajectory



Status of Key projects relating to maintenance of RTT standards

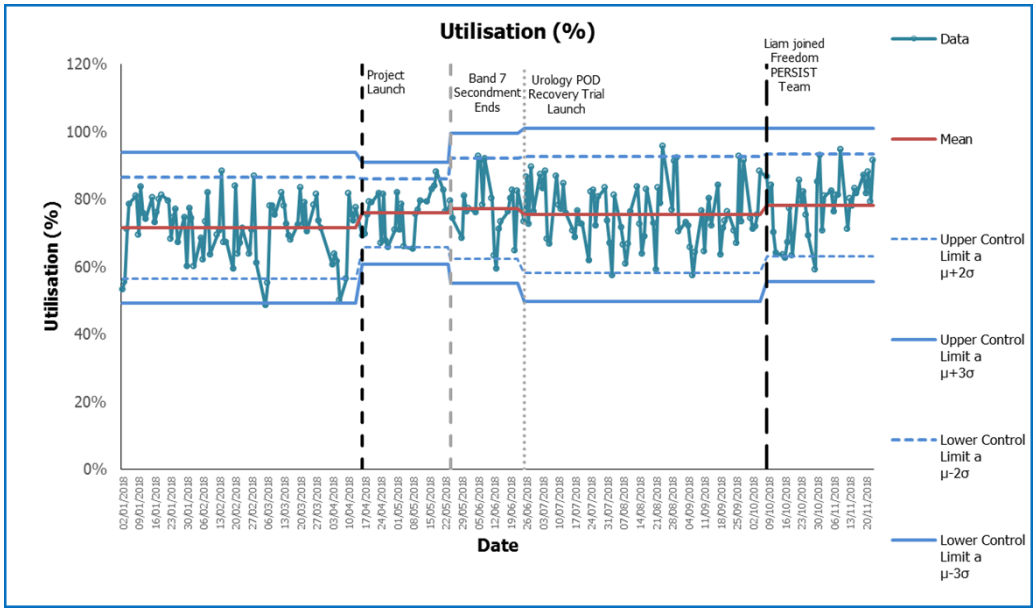
1. Outpatient Productivity Programme

TME OPPROD 111218 v2.pptx

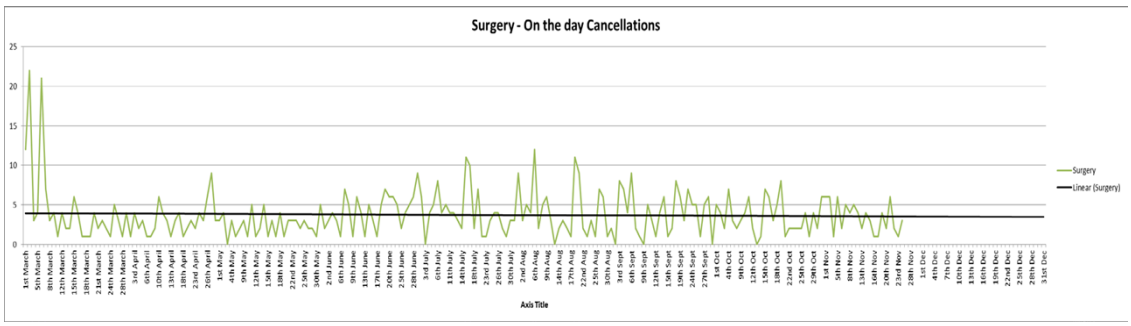
2. Theatre Productivity Programme (PERSIST)

The 85% Target continues to be compromised by the non-elective admissions to the hospital which is leading to on the day cancellations.

Utilisation in Freedom Theatres



Cancellations.



Freedom Specialties (Area of most Opportunity)

Specialty	Theatre Utilisation (Based on Touchtime)				
	Baseline	Target	Weekly	Monthly	YTD
ENT	69%	79%	69%	62%	71%
General Surgery	68%	79%	120%	70%	70%
Maxillo Facial Surgery	67%	79%	61%	74%	71%
Ophthalmology	93%	97%	92%	91%	91%
Orthodontics	80%	84%	63%	64%	74%
Plastic Surgery	71%	80%	73%	71%	71%
Restorative Dentistry	60%	74%	82%	68%	65%
Urology	67%	77%	76%	77%	73%

3. Development of new partnership working with Care UK

Project was signed off by the Trust Board at the end of August 2018. The transfer of patients onto UHP's waiting list and the new activity schedule commenced in November.

4. Development of 3rd Cath Lab

Cath Lab Nov 18 update.pptx

5. Consultant recruitment in Medical Specialties

Update on planned recruitment:

- 11th respiratory consultant starting September 2018 - STARTED but 10th leaving in November so will be going out to advert to fill that vacancy. Two further new posts have now been agreed but won't see benefit until Summer 2019.
- Recruitment drive from Spain to allow for additional General Internal Medicine support releasing current consultants to OP and IP activity - On plan. Two started in November – progressing with induction – expect benefits will be realised in New Year.
- Permission being sought for 12th Cardiologist – Agreed (locum currently in post, 7 interviews for substantive post take place in December).
- Additional acute medical consultants out to advert to help with weekend working (urgent care activity) – Delays with Royal College but progressing – expect to go out to advert imminently.
- Diabetes consultant post out to advert as an additional post to support community working which has already shown a reduction in acute demand - Interviews Dec 2018 – appointed.
- Permission sought for 2 Gastroenterology posts which will go to advert in October 18 and allow the specialty to return to baseline establishment. 2 applicants – interviews January 2019.
- Hepatology - 6th consultant agreed due to drop in hours for health reasons from existing consultant body. Post recruited to – start date Jan 2019.
- Neurology – new consultant started Sep 18.
- HCE – new consultant - started beginning of Nov 2018.
- Nephrology have successfully recruited to vacancies securing activity levels – Complete.

6. Improved administrative functions in specified Service Lines

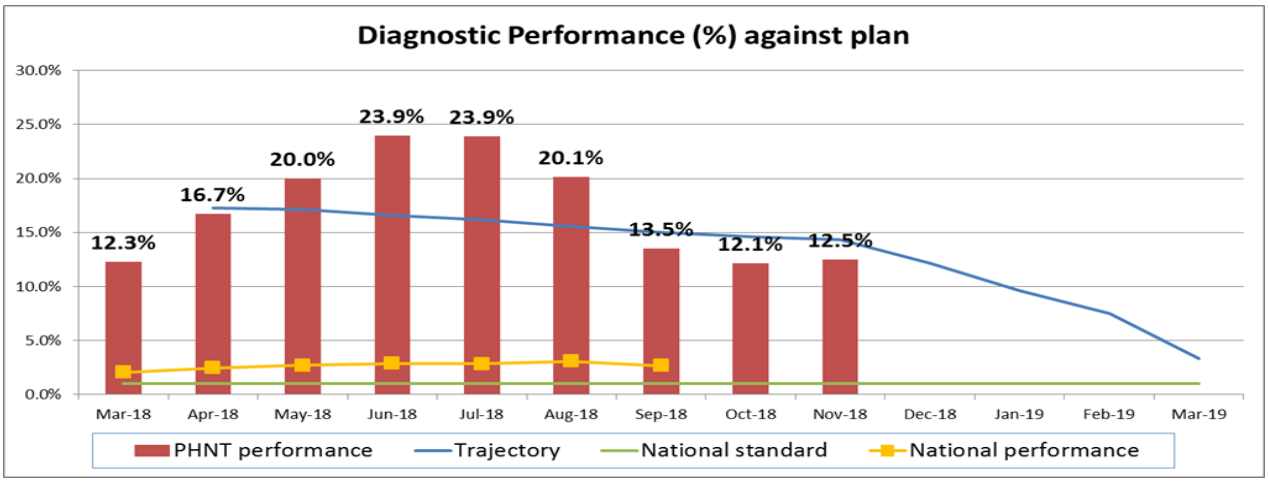
Work progressing well in Cardiology & Thoracic medicine.

G - Cardiology Clinical Administration

G - Thoracic Medicine Clinical Administration

7. Reduction of diagnostic waiting times

Graph below shows how performance against the national diagnostic waiting times standard is improving and ahead of trajectory as at the end of November 2018.



8. Demand management – roll out more Advice & Guidance schemes as per CQUIN

Action plan attached.

A&G Action Plan vOct18.xls

Assurance that actions have been addressed

Graph 1 demonstrates that the number of incomplete pathways is now higher than the trajectory. The main reasons for the increase include:

- Above planned level of referrals in October and November 2018 (60% of increase are 2 week waits).
- Ophthalmology: lack of junior doctors in first 6 months of financial year – now recruited.
- Neurosurgery: demand higher than capacity – plan to recruit 1 or 2 new Consultants.
- Neurology: new consultant recruited as per business plan but another leaving has meant no increase in capacity. Further CNS posts have been approved and are being recruited to.

Graph 1 demonstrates that although the number of patients waiting has increased (Graph1) the same level of performance is being achieved in terms of length of wait.

Graph 3 demonstrates that the number of 52 week waiters is close to trajectory. The number of 52 week breaches has reduced by 73 patients since June 2018.

Update on actions in previous section shows progress to date.

MUST DO: Bring the current cancer wait targets, especially for two-week wait and 62-day pathways into line with targets.

Planned Action

Ref	Action	Lead	Deadline
3.1.1 Surgery 5.3	To achieve the 62 day standard trajectory as agree with NHSI and achieve the 2ww standard. (detailed action plan in place)	Sian Dennison (62 day)/Jacqui Beer (2ww)	31/03/2019

OP			

Update on actions

2 week waits

Detailed action plan for 2 week wait recovery attached:

2WW Project Plan and Task Lists.xlsx

Table 1: Shows 2 week wait performance for last 12 months

Cancer standard	TARGET	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
2 week wait standard	93%	92.6%	92.6%	94.3%	89.5%	88.5%	90.0%	90.6%	92.3%	94.8%	95.4%	95.4%	95.4%
2 week wait standard: Breast Symptomatic	93%	21.7%	21.9%	84.8%	80.0%	51.0%	89.1%	84.1%	88.0%	96.9%	92.2%	98.2%	97.5%

The action plan has delivered in terms of improved performance. Table 1 shows that the Trust has achieved the 2 week wait standard in from August onwards.

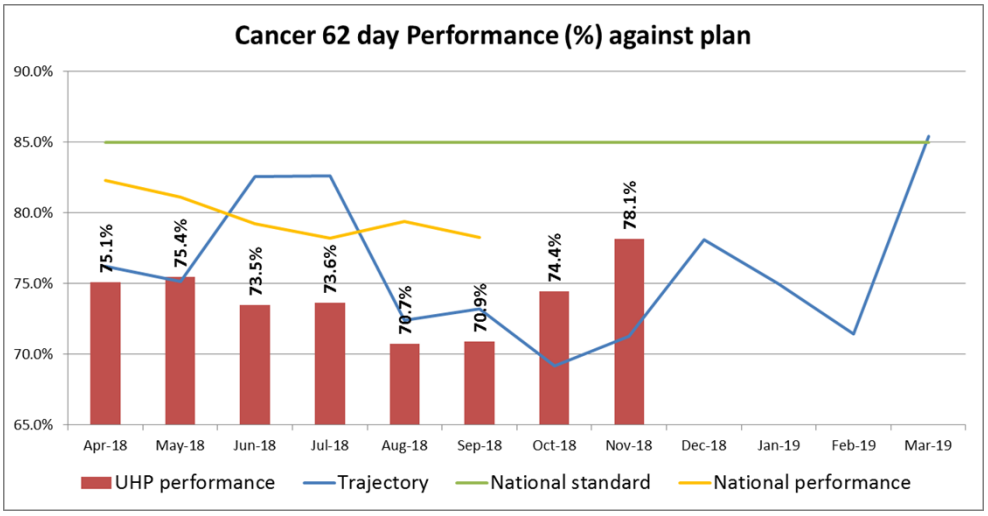
The 2 week wait standard for Breast Symptomatic patients has been a challenge over the last 12 months predominantly due to staffing issues within the specialty but recent performance has improved dramatically; the standard was achieved in August 2018, marginally missed in September 2018 (there were 7 breaches of the standard all of which were patient choice delays) and achieved again in October and November 2018. Position is monitored daily to ensure adequate capacity is available.

62 day standard

62 Day Remedial Cancer Action Plan to improve 62 day performance and reduce backlog and 104 day breaches:

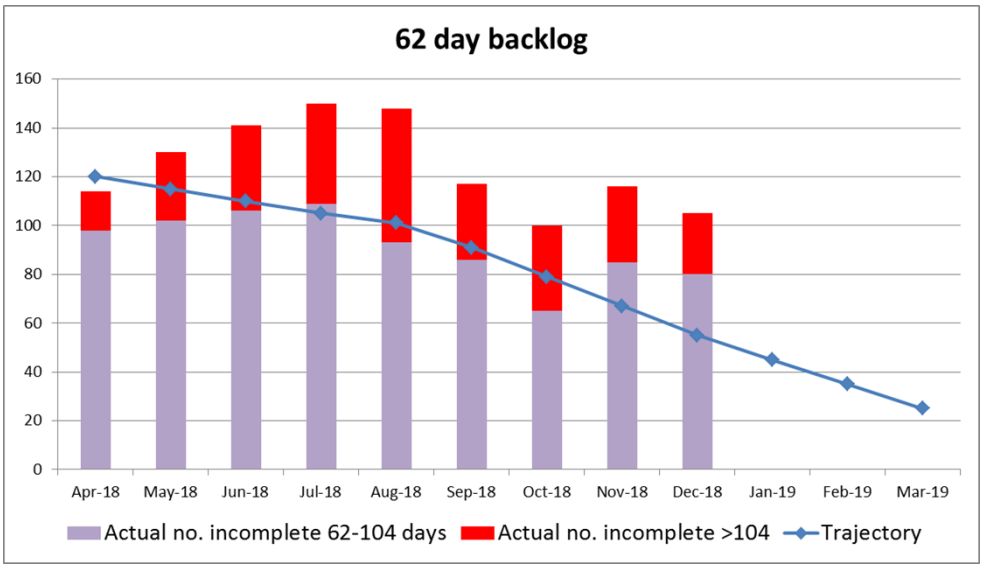
Cancer Plan Template November 2

Graph 1: Shows 62 day performance for this year to date against trajectory.



Graph 2: Shows 62 day backlog of incomplete pathways against trajectory.

(Note: Position as at 11th Dec 2018)



Assurance that actions have been addressed

Action plans demonstrate progress of detailed cancer site tasks.

Plans are monitored fortnightly at the Trust Management Executive Meeting.

The backlog of incomplete pathways reduced from August to the end of October (see Graph 2) but started to increase again in November due to capacity shortfalls and an increase in tertiary referrals. As at the 11th December the position has improved again but it should be noted that the Trust is approximately 50 patients behind trajectory. Further actions are being developed to return to the trajectory as soon as possible. Operational pressures and staffing issues remain the key challenges combined with the continual growth in demand; 2 week wait demand is 17% higher than the previous year.

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.

Planned Action

Ref	Action	Lead	Deadline
7.3 TW	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.	Kevin Baber	31/03/2019

Update on actions

CCG have been contacted to discuss the action. There is a renewed focus at system level to support performance and to find alternative provision to support UHP position where possible.

The Trust attends the monthly Devon wide STP cancer group to address operational and strategic issues to improve cancer pathways and work with primary care to ensure a unified approach.

Assurance that actions have been addressed

Limited assurance at this point as other providers also struggling with constitutional standards.

Equipment

MUST DO: Ensure all equipment is serviced as required, and put in place appropriate monitoring systems to provide oversight of equipment servicing.

Planned Action

Ref	Action	Lead	Deadline
1.4 U&E 4.3.1 Mat	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.	Jonathan Applebee	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.

Update on actions

Go live date for e-Quip database has been delayed until January 2019 due to synchronising availability of supplier training resources, on-site training accommodation and UHP IM&T resources. The RFID project is on schedule for implementation in the first quarter of 2019.

Additional Technical Inspector recruitment has been delayed pending successful award of contract, date unknown. We are exploring other funding possibilities.

Assurance that actions have been addressed

Not applicable at this stage.

Sepsis

MUST DO: Ensure patients presenting with possible sepsis are recognised, started on a treatment pathway and administered antibiotics within 60 minutes.

SHOULD DO: Ensure awareness of the sepsis care bundle is rolled out to all inpatient wards and departments.

SHOULD DO: Undertake sepsis audits on all wards where sepsis might occur.

Planned Action

Ref	Action	Lead	Deadline
1.6 U&E 2.21 Med 3.9 Surgery	1. Quality Improvement programme agreed with the CCG in place; concentrating on admission and assessment areas. 2. Continuous prospective audit of all cases presenting with severe sepsis in ED with recurrent PDSA of interventions to improve to 90%. 3. Educational programme - Turbo teaching, posters; investigate any case where severe sepsis has resulted in severe decline or death. 4. NEWS2 will go live in MAU areas as of September 2018, and remaining inpatient areas by December 2018 to increase likelihood of sepsis identifications	Paul McArdle	31/03/2019 Quality Improvement programme will be ongoing.

Update on actions

1. Sepsis action plan is in place. Sepsis screening tool incorporated into NEWS observation booklet to raise the profile of sepsis screening.
2. Audits currently taking place using data to drive improvement accepting that this is a new process which requires embedding across the organisation.
3. Ongoing – Sepsis nursing team is leading education. Report of training uptake for NEWS2 in progress to define areas requiring support. Training in NEWS 2 for all ward areas publicised and wards submitting training assurance figures. This will be used to drive assurance process and to achieve standardised implementation and escalation.
4. NEWS2 is live in the Emergency Department and has been rolled out across the whole of MAU; we are in the process of finishing training for Tamar staff. On plan for December roll out continuing into new year, to align with Sepsis CQUIN requirements.

Assurance that actions have been addressed

Not applicable at this stage.

DoLS

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.
MUST DO: Ensure Deprivation of Liberty Safeguards are applied for in accordance with legal requirements.

Planned Action

Ref	Action	Lead	Deadline
7.2 TW 2.4 Med	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. 8. Medicine Care Group to develop action once corporate process review and surveillance systems are approved and in place by the corporate lead.	Alison O'Neill and Angela Hill	Action 7 01/10/2018 Action 8 31/03/2019

Update on actions

- There is still a need to appoint a medical lead for the Trust for MCA. This has been raised with Executive leads via the Steering Group and placed on the Trust risk register; it is being reviewed.
- Executive review is taking place to ensure that there is medical oversight and liaison within the Trust.

Assurance that actions have been addressed

Further time is needed to audit and offer assurance that improvements have been embedded into practice. It is expected that further audit will be completed by January 2019.

Mandatory Training

SHOULD DO (Urgent & Emergency): Ensure all staff are up-to-date with mandatory and safeguarding training.

MUST DO (Medicine): Improve training compliance for medical staff undertaking mental capacity assessment.

SHOULD DO (Medicine): Review the level of child protection training and compliance for staff providing care and treatment for young adults under the age of 18 years.

SHOULD DO (Medicine): Improve training compliance with Mental Capacity Act and Deprivation of Liberty Safeguards.

SHOULD DO (Medicine): Improve compliance with mandatory training for medical staff to meet the trust target.

SHOULD DO (Surgery): Improve mandatory and safeguarding training levels so that they achieve the trust's target.

SHOULD DO (Surgery): Improve mental capacity and deprivation of liberty training levels for medical staff and nursing staff so they achieve the trust's target.

MUST DO (Maternity): 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.

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

Planned Action

Ref	Action	Lead	Deadline
1.13 2.5 2.8 2.9 2.12 3.2 3.10 4.2 5.1	To be defined – please see update below.	TBC	31/03/2019

Update on actions

There are nine separate 'Must Do' Requirement Notices or 'Should Do' recommendations related to mandatory training. Whilst initial actions had originally been identified, on reflection, a piece of work has now been initiated by the Quality Managers to develop a unified and pragmatic way forward to address these. This has commenced with identifying the causes of non attendance at training, their individual repercussions and the controls in place at that point in the chain of events. A number of further actions have been identified together with a confidence rating which has helped to identify the likely success this will give against different staff groups. The revised actions are in the process of development and agreement and will be reflected in future updates on delivery of the action plan.

Assurance that actions have been addressed

Not applicable at this stage.

Other Trustwide Actions

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.

Planned Action

Ref	Action	Lead	Deadline
7.1.2	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	Kevin Baber	Embedded within Care group review process by 30/11/2018.

	review. Key themes to be reviewed and followed up.		
7.1.4	Explore the introduction of an independent raising concerns mechanism (Speak in Confidence) for staff concerns.	Claire Underdown	30/11/2018
7.1.5	Introduce a 360 degree appraisal process as part of leadership development.	Claire Underdown	31/03/2019
7.1.6	Promote a top 20% Staff survey response rate.	Claire Underdown	31/12/2018

Update on actions

7.1.2 **E**mail sent to Care Groups w/c 22 October. Performance Review now contains a section asking about staff engagement activity in Care Groups and the emerging themes. Work continues in Pathology, Imaging and Pharmacy as specific priority areas. Pulse survey in place in Pharmacy and IM and T as a trial before implementing Trustwide in January.

7.1.4 Independent concerns mechanism investigated but not being taken forward as not fit for purpose. Alternative route within Guardian webpage still being explored.

7.1.5 360 constructed based on NHSI 360 process has been tested with changes now taking place. Will be trialled with Trust Board prior to 31 December 2018.

7.1.6 Staff survey has been promoted widely in the organisation and has now closed.

Assurance that actions have been addressed

7.1.1 All staff email sent on 24/9/18 from Ann James.

7.1.3 Publicised in Vital Signs 19/10/18 and Daily Email 22/10/18.

7.1.6 National reporting data from Picker.

SHOULD DO: Demonstrate in the board papers the open and professional challenge we were told happened.

Planned Action

Ref	Action	Lead	Deadline
7.8	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.	Gill Hunt	Complete

Update on actions

Invitations to Board members to raise questions on any item are minuted. 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. The Director of Corporate Business is reviewing all minutes to provide a further perspective on ensuring that any challenges are appropriately recorded.

Assurance that actions have been addressed

- Trust Board minutes.
- Safety & Quality Committee minutes.
- Audit Committee minutes.
- Finance & Investment Committee minutes.

- HR&OD Committee minutes.

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.

Planned Action

Ref	Action	Lead	Deadline
7.9	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.	Bill Chapman	31/10/2018

Update on actions

Checklist now in place. FPP appointment and recheck template has been updated taking into account the CQC feedback and to be used going forward including this year's annual recheck process (checks now underway).

Assurance that actions have been addressed

Not applicable at this stage.

MUST 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.

Planned Action

Ref	Action	Lead	Deadline
7.11	On production of the Quality Account we will ensure that key metrics are included that demonstrate whether we have met the targeted objective.	Steve Mumford	30/06/2019

Update on actions

Action not due until 2019.

Assurance that actions have been addressed

Not applicable at this stage.

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.

Planned Action

Ref	Action	Lead	Deadline
7.12	We will commission an external review of our governance arrangements to independently test the robustness of assurance from Care Groups to the Trust Board.	Lee Budge Greg Dix	31/12/2018

Update on actions

Following discussion with NHSI in July 2018, they agreed to undertake a more detailed review of the Trust's current recovery action plans and other documents overseeing improvement of performance. This included consideration of our governance arrangements which led to a number of recommendations for improvement. These have been captured as part of an overarching action plan for improvement. The work in this area is ongoing.

Assurance that actions have been addressed

- Monthly Integrated Delivery Meetings (IDMs) with NHS Improvement.
- NHSI Action Plan.

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.

Planned Action

Ref	Action	Lead	Deadline
7.13	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.	Bill Chapman	31/10/2019

Update on actions

The rollout of doctors rostering is now in phase 1 with sickness and annual leave now complete and many areas now with full rostering. Full action plan overseen by Rostering Board however, medicine and key carter areas scheduled to be completed by October 2019 (as per deadline).

Assurance that actions have been addressed

Not applicable at this stage.

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.

Planned Action

Ref	Action	Lead	Deadline
7.15	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.	Lisa White / Bev Allingham	Complete

Update on actions

1. Leadership training has been updated to specifically outline the experience of BME staff and the Trust's zero tolerance stance. Action complete.
2. Leaflets have been produced for staff. These were approved by the Security Strategy Group on 5th December and have been circulated to relevant staff areas.
3. Training continues to be rolled out to staff in patient / visitor areas. Head of HR Operations and PI Lead have met to discuss BME experience so that this can be considered through the training of BME staff. A mechanism has been put in place for feedback to the Head of HR Operations if negative themes are identified from BME staff during training.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Look again at the work plan for the Equality, Diversity and inclusivity group to ensure its objectives and achievable and realistic.

Planned Action

Ref	Action	Lead	Deadline
7.16	Review EDIWG Work Plan to ensure that objectives are achievable and reporting timeframes realistic.	Lisa White / Bev Allingham	Complete

Update on actions

The work plan and objectives were reviewed in November's EDIWG meeting.

Assurance that actions have been addressed

To be submitted.

SHOULD DO: Produce a published Workforce Race Equality submission which is complete and demonstrates the trust is investing in this area.

Planned Action

Ref	Action	Lead	Deadline
7.17	WRES submission will be published on the Trust's website with narrative.	Lisa White / Bev Allingham	30/09/2018

Update on actions

This action was delayed due to WRES data quality issues that were identified and not finalised with NHS England until 24th September 2018. The completed template with narrative (content consistent with the revised action plan, linked with action Ref 7.16) will be presented to the HR&OD Committee on 20th December 2018, for approval to publish on the Trust's website.

Assurance that actions have been addressed

Not applicable at this stage.

SHOULD DO: Give assurance that the trust board is reviewing and satisfied with the risks it is responsible for on the Board Assurance Framework.

Planned Action

Ref	Action	Lead	Deadline
7.19	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.	Lee Budge	Complete

Update on actions

The outcome of a review of our Board Assurance Framework and the role of the Board and Committees in using this effectively was reported to the Audit Committee on 22nd October 2018. Subsequently, the BAF has been updated and was reported to the Trust Board on 30th November 2018.

Assurance that actions have been addressed

- Presentation to Audit Committee on 22nd October 2018.
- Audit Committee minutes.
- Trust Board agenda and minutes for 30th November 2018.

SHOULD DO: Look to reduce the increasing number of complaints that are reopened, often as they have not satisfied the person who has complained.

Planned Action

Ref	Action	Lead	Deadline
7.21	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.	Mark Griffiths	Complete

Update on actions

1. Revised reporting structure that shows the required data fields. This will includes five reporting categories such as the following two reportable categories: Failed to fully answer questions and / or Remains dissatisfied. All information is collated in a monthly report. This information is reviewed for quality and causes of reopening. This information is then shared up and down, starting at the Quality, Governance and Learning meeting; the Quality Managers in attendance feed back to the relevant service lines for action and learning.
2. The current quality process has been improved to ensure the standard of responses develops. This includes refresher training in the Complaints Team of expected standards. A plain English user guide for all staff involved in responding to complaints has been developed to refer to when completing responses. A quality sample of responses are reviewed by the Patient Engagement Lead; findings are discussed with the Complaints Team for learning and improvement.

We are in the process of developing the standard of reporting to demonstrate the number of re-opened complaints to the Board and to Quality Governance and Learning Group.

Assurance that actions have been addressed

Meeting minutes or email communications where complaints issues have been escalated are available if required. Copies of generated reports and associated actions can be made available.

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.

Planned Action

Ref	Action	Lead	Deadline
7.22	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.	Lee Budge	Complete

Update on actions

The Risk Review Panel reviewed all risks recorded on DATIX which relate to electricity supply and car parking on 10th December 2018. There are no serious risks recorded on DATIX, however, there are a number of car parking related risks which have been recorded as 'moderate' or 'low' for which further assurance is being sought from the Emergency Planning Officer on the business continuity arrangements should the electricity supply fail in critical areas of the hospital. At this stage there is no requirement to include this in the BAF but this will be reviewed on an ongoing basis.

Assurance that actions have been addressed

- Corporate Risk Register
- Risk Review Panel Minutes on 25th October, 19th November and 10th December.

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.

Planned Action

Ref	Action	Lead	Deadline
7.25	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.	Paul Copleston	Complete

Update on actions

Paul Copleston, Suzanne Stones, Simeon Brundell and Mac Armstrong met on the 28th September and agreed the following plan:

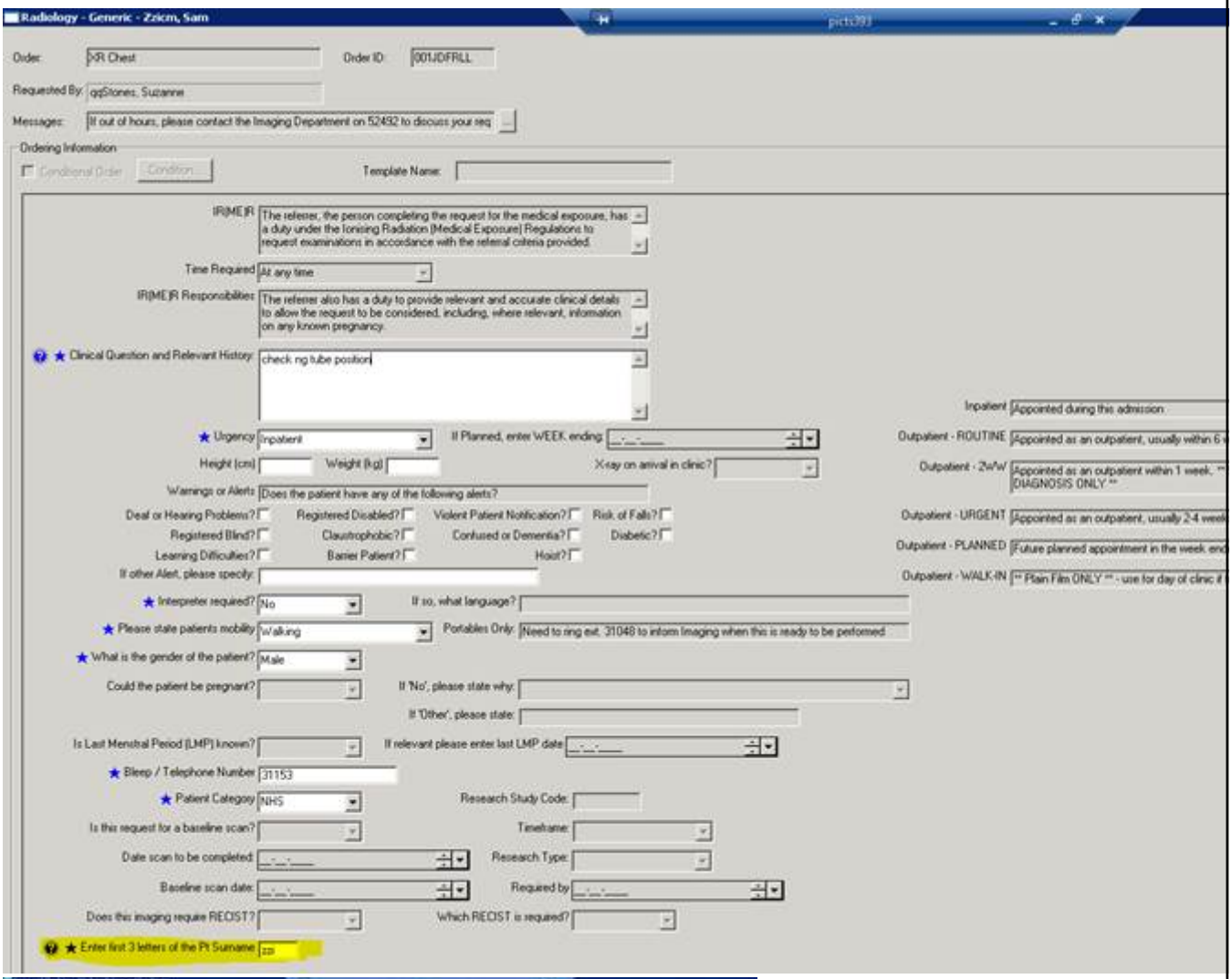
In Test iCM:

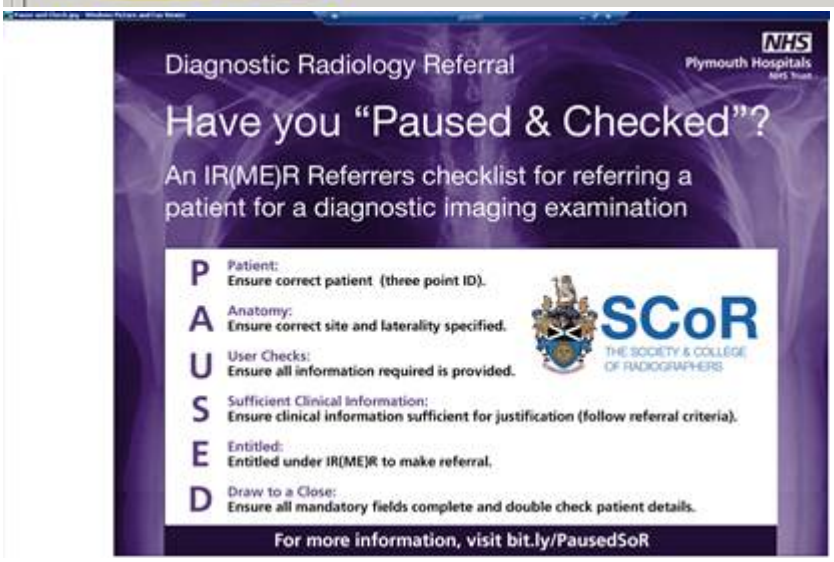
1. Create new field in iCM (RAD – PT Check) – completed.
2. Add tool tip explaining use – adding the PAUSED slide (Radiation Protection patient check info) – completed – evidence below.
3. Place at the bottom of the request form, next to the submission button – completed – evidence below.
4. Block the new data item from reaching CRIS (Integration Team) – completed.
5. Test – completed.
6. Create report of exceptions - completed.
7. Once report available (01/11/18):

In Live iCM:

1. Create new field in iCM (RAD – PT Check) – completed.
2. Add tool tip explaining use – adding the PAUSED slide (Radiation Protection patient check info).
3. Place at the bottom of the request form, next to the submission button.
4. Block the new data item from reaching CRIS.
5. Simeon to communicate change to users – completed 07/11/18.
6. Write to any that do not comply.
7. Escalate non-compliance to the Medical Director.
8. Monitor weekly.
9. Review.

10. Add data item to all forms.





ACTUAL TIMESCALES :

Report availability to monitor users. 1st November 2018

Communications to Users. Early November 2018

Pilot/Test/Review. Early November2018

Go Live. 15th November 2018.

Assurance that actions have been addressed
Continual monitoring of the implemented solution and Clinical Safety Officer addressing anomalies with individual referrers.

SHOULD DO: Raise awareness with staff of how patient feedback is used to improve services.

Planned Action			
Ref	**Action**	**Lead**	**Deadline**
7.26	New ward and department noticeboards to include a section which identifies actions taken to improve.	Jayne Glynn	30/10/2018

Update on actions
New noticeboards have now been finalised and agreed with the Heads of Nursing, Deputy Chief Nurse and Chief Nurse. Costed through Significant Signs for production and installation of 42 boards across the hospital - £7,399.52. Current proposal is for each ward to fund from individual budgets. Awaiting exact image specifications from supplier to organise a sample board for review.

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

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.

Planned Action			
Ref	**Action**	**Lead**	**Deadline**
7.27	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.	Steve Mumford	Complete and closed

Update on actions
The Quarter 2 Learning from Deaths report which will be submitted to Trust Board in November has been updated to include specific examples of the actions taken in response to work identified.

Assurance that actions have been addressed
November 2018 Quarter 2 Learning from Death report.

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.

Planned Action			
Ref	**Action**	**Lead**	**Deadline**
7.28	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	Steve Mumford	Complete

	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.		

Update on actions
Service Line HSMR and SHMI data is reviewed at Mortality Review Group. Care Groups receive regular reports on Mortality from the Service Lines.
Assurance that actions have been addressed
Mortality Review Group minutes and Care Group governance meeting minutes.

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.

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.

Planned Action

Ref	Action	Lead	Deadline
8.2	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.	Jacqui Beer	31/07/2019

Update on actions

Monthly information relating to readmissions and pre-op LOS for both elective and non-elective admissions is included within the Service Line dashboards however a review will be undertaken to ensure the methodology matches that used in Model Hospital.

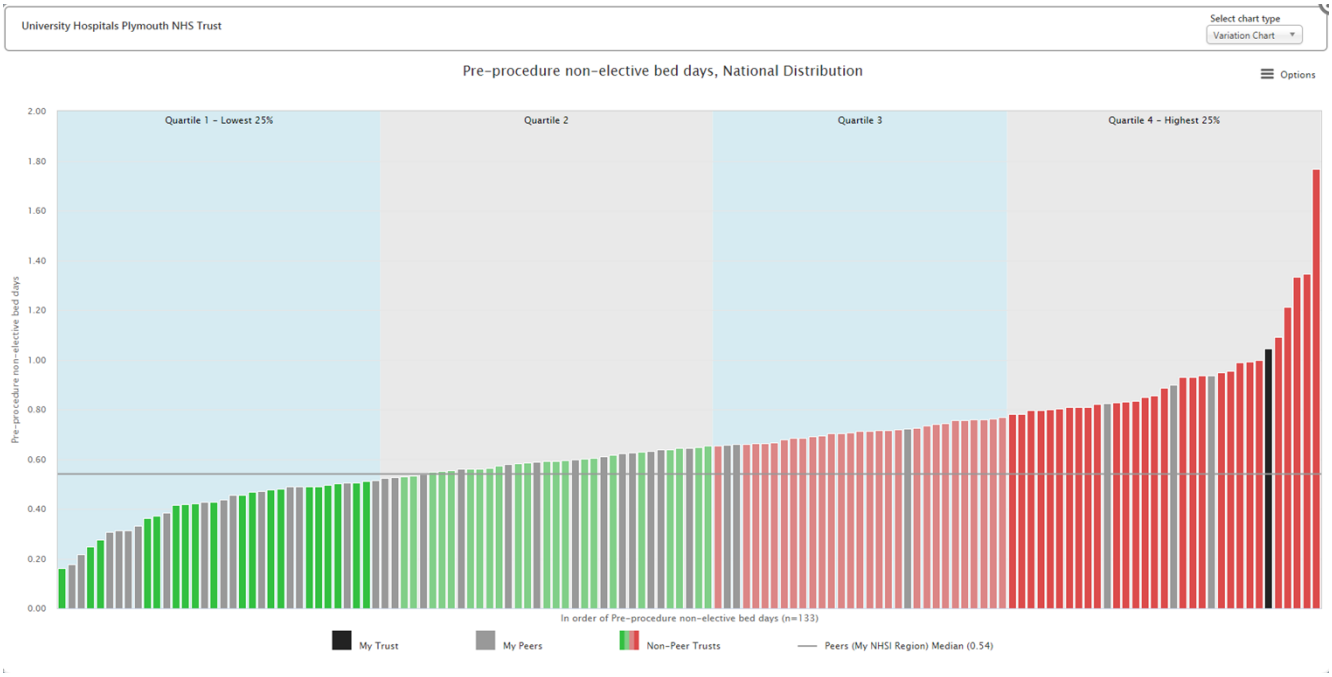
Analysis of worst performing specialties has now been completed.

Pre-op LOS for non-elective admissions

Current performance benchmarked Quarter 2 2018/19 (source: Model Hospital): In Quartile 4.

National median = 0.65

Trust value = 1.05



Specialties selected for deep dive review are as follows:

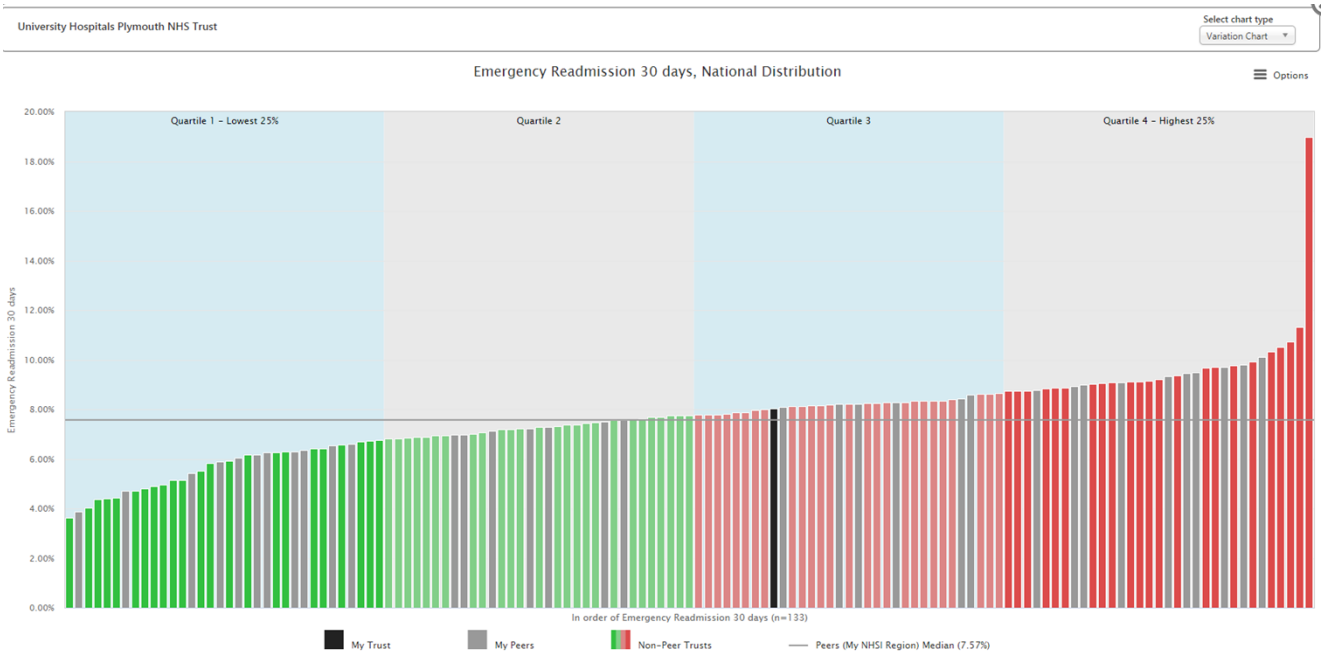
Geriatric medicine
General medicine
Respiratory medicine
Cardiology
Trauma & orthopaedics
Clinical oncology (previously radiotherapy)
Gastroenterology

Emergency readmissions within 30 days

Current performance benchmarked Quarter 2 2018/19 (source: Model Hospital): In Quartile 3

National median = 7.76%

Trust value = 8.03%



Specialties selected for deep dive review are as follows:

Specialty
Colorectal Surgery
ENT
Nephrology
Plastic Surgery
Neonatology
Paediatrics
Gynaecology
Clinical oncology (previously radiotherapy)

Next step is to organise meetings with relevant service line teams and discuss data to identify remedial actions. We expect this work to be completed by the end of February 2019.

Assurance that actions have been addressed

Attached is an example of a Service Line dashboard which includes metrics for Readmissions within 30 days and Pre-op LOS (see tabs named “Effective” for Readmissions and “GIRFT & Model Hosp” for Pre-op LOS.

Colorectal Surgery.xlsx

AREA FOR IMPROVEMENT: The trust is part of an NHS Improvement deep dive review of its high Medical Costs.

Planned Action

Ref	Action	Lead	Deadline
8.4	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.	Peter Rowe	30/04/2019

Update on actions

The Workstream has a regular update at the Trust Management Executive for Improvement and Productivity. The update for November is attached.

The update includes the Job Planning Dash Board that monitors progress and gives an update on specific actions being taken. The Job Plan review chamber has now been established and has had two meetings. Actions coming from this meeting to review specific additional NHS responsibilities are being taken but so far significant improvement has not yet been achieved. The overall programme is being reviewed by the Putting People First Programme to see if it can enhance the delivery of improvements in this area. This is scheduled for December 2018.

Draft TOR Job Planning Chamber Se

TME Medical Workforce Slides 301

Assurance that actions have been addressed

Assurance that progress is being monitored only – improvements not yet evidenced.

AREA FOR IMPROVEMENT: The trust in the process of embedding the results of a number of internal and external reviews of efficiency opportunities.

Planned Action

Ref	Action	Lead	Deadline
8.5	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.	Theatres Utilisation- Jemma Edge OP Utilisation -Jacqui Beer Urgent Care - Jo Beer GIRFT and Model Hospital - Laura Langsford	30/04/2019

Update on actions

Progress reports supplied to the TME for productivity and Improvement.

Improvements evidenced in Outpatient Metrics and some progress in Theatres and GIRFT.

 18.12.11 TME presentation.pptx	 TME GIRFT Financial Update 11122018.do	 TME OPPROD 111218.pptx

Assurance that actions have been addressed

Further improvement required to meet targets.

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.

Planned Action

Ref	Action	Lead	Deadline
8.6	Initial report describing high medicines costs completed. Further investigation required once immediate improvements to Pharmacy services has been completed.	Laura Langsford	31/07/2019

Update on actions

This action has yet to progress as urgent pharmacy action plan is completed. However it has now been agreed that this item will be picked up on the next Pharmacy Board meeting agenda to start the process of review.

Assurance that actions have been addressed

Not applicable at this stage.

AREA FOR IMPROVEMENT: Opportunities exist to recurrently reduce the trust's energy costs.

Planned Action

Ref	Action	Lead	Deadline
8.7	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.	Stuart Windsor	1. 31/12/2018 2. 31/03/2019 3. 31/03/2019 4. TBA - early 2019

Update on actions

1. Works commenced.

2. Works completed ahead of schedule.

3. Business case submitted to SALIX and internal approval complete.

4. Business case sent to NHS Improvement for £1m investment under the £46 m Public Dividend Fund to implement 'energy-efficient' LED lighting. Bid submitted on 30 November and Full Business Case approved by the Board. Now awaiting outcome.

Assurance that actions have been addressed

2. Lighting has been installed and is operational. Terms of SALIX funding completed and loan draw down in progress.

Actions Completed and Closed

Ref	Core Service	Requirement	Action Taken
7.27	Trustwide	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.	The Quarter 2 Learning from Deaths report which will be submitted to Trust Board in November has been updated to include specific examples of the actions taken in response to work identified.

Actions Completed and evidence to be submitted

Ref	Core Service	Requirement	Action Taken
1.14	Urgent and Emergency	Ensure the kitchen in the clinical decision unit is secure when unattended to prevent patients gaining access.	Clinical Decision Unit reconfigured to relocate the kitchen.
1.15	Urgent and Emergency	Repair or replace the flooring in the clinical decision unit toilets/shower rooms to enable effective cleaning and minimise infection control risks.	Work completed.
1.20	Urgent and Emergency	Make sure clinical waste bins are emptied before becoming over-full.	We are utilising the facilities from CDU and monitoring continues as part of the Matrons Audit.
1.23	Urgent and Emergency	Review the security arrangements for storing patient records in the clinical decision unit.	Dedicated ward clerk for CDU in place for timely filing and security. Staff reminded of the need for safe placing of medical / nursing documents from Ward Manager / Matron. Lockable notes trolley in use. Spot monthly audit compliance to commence December 2018.
1.27	Urgent and Emergency	Make sure patients waiting in the department for long periods are not left without access to drinks and food, where appropriate.	Food is provided by the CDU and the housekeeper discusses who may eat / drink with the Nurse In Charge for breakfast, lunch and dinner.
1.29	Urgent and Emergency	Continue to participate in relevant audits to monitor and improve patient outcomes through consistent compliance with national standards.	Participation in national and local audit programmes continues and outputs feed via service line governance process.
1.31	Urgent and Emergency	Ensure staff working in resuscitation as part of a team wear the correct tabards to help with role identification.	Staff have been reminded of the need to wear the correct attire for their role and it is the responsibility of the resus lead to ensure that the team members are correctly identified.
1.34	Urgent and Emergency	Provide patients requiring the toilet with appropriate facilities without undue delay.	Patients who are in the corridor are often dressed and therefore are assisted to the toilet outside x ray. For those who require assistance the FLIC cubicle or another will be used with a commode.
1.39	Urgent and Emergency	Improve minutes and action tracking for team meetings.	Adopted the Medical Care Group's branded suite of meetings' templates and meetings' standard operating procedure (part of governance tool kit).
2.1	Medical Care	Ensure nursing staffing levels meet the nursing establishment on the endoscopy unit to enable planned investigations can be	Results of demand and capacity are now available which will drive the volume of staff needed and inform business planning.

Ref	Core Service	Requirement	Action Taken
		carried out and not to hamper service improvement projects.	
2.2	Medical Care	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.	E-Prescribing will have a VTE risk assessment feature inherent in it to ensure that this is completed and the present idea is to trigger a reassessment when a patient moves ward. In the meantime the VTE team use the daily report on non-compliance with VTE risk assessment to look at where the worst performing areas are so that they can focus attention on them. There is also monthly monitoring via the Care Group performance reviews with service lines.
3.3	Surgery	Ensure cross infection processes are followed in all ward and theatre areas.	Cardiothoracic Theatres: Monthly monitoring of action plan continues via Theatre Governance meetings for Cardiothoracic Theatres. Moorgate: Combined Observation of Care feedback completed and found to be satisfactory.
4.3.2	Maternity	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.	Matrons for inpatients have updated checklist. Maternity Care Assistants are now involved in the main handover and separate Matron's Maternity audit created which is to be presented at CEC as a standard agenda item.
4.5	Maternity	Ensure the process for approval to work under Patient Group Directions are consistent with trust policy and national guidance.	Band 7 Midwife (CS) leading on PGDs in department. Emails have been sent to all midwives with the PGD policy attached. PGD competency can be added to CEC agenda to assure actions are being addressed. Lesson plan to evidence PGD discussion/inclusion during MMT week. PGD E-learning now approved and in place for completion end December 2018.
4.7	Maternity	Ensure patient information is protected in clinical areas and records are amalgamated and stored securely following discharge from the service.	Backlog has been cleared and there are daily walk arounds for the department. The importance of completing paperwork in a timely way has been communicated to Midwifery teams. Weekly audit now completed. Storage has been reviewed and lockable notes trolleys are now in place for the Antenatal Clinic area.
4.8	Maternity	Review governance, risk management, and performance processes to ensure threats and defects in the service are visible and escalated appropriately.	Appointed Care Group Quality Manager to ensure that risks are considered outside of Care Group Management Team for appropriate check and challenge.
4.11	Maternity	Ensure all nurses and midwives delivering care within the high dependency unit have been assessed as competent to care for the critically ill woman.	Room has been re-named on white board and on room door. MMT week also now refers as "Enhanced Observation Room". Communications to all staff via Theme of the week and inclusion in the Mandatory Multi-disciplinary training sessions. Staff have a check list to sign off that they are competent to do. Guideline and observation charts updated to reflect the changes.
4.12	Maternity	Ensure Modified Early Obstetric Warning Score (MEOWS) charts	Added to the audit routine schedule; first audit completed and presented as part of

Ref	Core Service	Requirement	Action Taken
		are used consistently and escalation occurs in accordance with policy.	audit schedule at monthly Clinical Effectiveness Committee.
4.17	Maternity	Expand the use of clinical audit and other improvement tools to proactively measure service delivery.	0.4wte band 6 Audit Midwife in post and will liaise with Consultant Obstetrician regarding allocation of audit to junior doctors. Audit schedule in place with rolling presentation to Monthly Maternity Governance Meeting (CEC).
4.20	Maternity	Review the process for ensuring hazardous chemicals are consistently locked away and not accessible to unauthorised persons.	COSHH cabinets are now available in all clinical areas.
4.21	Maternity	Consider how to increase information technology in the community, and specifically access by community midwives to maternity guidance and blood results.	IT access for community staff is on the Risk Register: Business case has been re-submitted.
5.1 and 6.8	Diagnostic Imaging	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. Make sure all staff within the outpatient departments have undertaken mandatory training updates in line with trust policy.	The Service Line has sent 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 was 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. Further reminders have been sent out through November with an additional list for Manual Handling actioned and supported by the Trust. This should be more reflected in December's position.
6.4	Diagnostic Imaging	Support and improve the culture and wellbeing for the diagnostic imaging staff.	Reinstated HR Leadership Meetings, actions to support the development of Senior Leads, implementation of Communication Board, regular senior management Walkabout, implementation of 'SCORE' in Interventional Radiology and ensured that musculoskeletal risks are on the risk register and are being adequately managed
6.13	Diagnostic Imaging	Ensure that targets set in diagnostic imaging are achievable, realistic, and encourage the service to improve.	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 inpatients. Dashboards are being adjusted accordingly and once completed they will be monitored.
7.4.1	Pharmacy	Address and resolve the issue of unrecognised or unaddressed risks in the pharmacy teams connected with patient safety, staff pressures, performance, and governance failings.	Gap Analysis against Royal Pharmaceutical Society Hospital Pharmacy Standards completed.
7.4.2	Pharmacy	Address and resolve the issue of unrecognised or unaddressed risks in the pharmacy teams connected with patient safety, staff pressures, performance, and governance failings.	Risk identification and mitigation is now supported by the RPS Standards.

Ref	Core Service	Requirement	Action Taken
7.5.5	Pharmacy	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.	Conducted a gap analysis of current establishment.
7.6.1	Pharmacy	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.	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. 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.
7.6.2	Pharmacy	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.	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. 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.
7.7.1	Pharmacy	Ensure effective governance within the pharmacy service to provide a high quality and safe service.	Review of the current pharmacy governance framework completed.
7.7.2	Pharmacy	Ensure effective governance within the pharmacy service to provide a high quality and safe service.	Revised reporting route for MUAC agreed.
7.8	Trustwide	Demonstrate in the board papers the open and professional challenge we were told happened.	Invitations to Board members to raise questions on any item are minuted. 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.
7.10	Trustwide	Update the policies and procedures relating to criminal record checks to ensure they are current and referring to the current processes.	Policies have been updated.
7.15	Trustwide	Demonstrate that progress is made on reducing the disproportionate level of violence and aggression from	Leadership training has been updated to specifically outline the experience of BME staff and the Trust's zero tolerance stance. Leaflets have been produced for staff

Ref	Core Service	Requirement	Action Taken
		patients and the public to staff identifying as from a Black and minority ethnic background.	and have been circulated to relevant staff areas. Training continues to be rolled out to staff in patient / visitor areas. A mechanism has been put in place for feedback to the Head of HR Operations if negative themes are identified from BME staff during training.
7.16	Trustwide	Look again at the work plan for the Equality, Diversity and inclusivity group to ensure its objectives and achievable and realistic.	The work plan and objectives were reviewed in November's EDIWG meeting.
7.19	Trustwide	Give assurance that the trust board is reviewing and satisfied with the risks it is responsible for on the Board Assurance Framework.	The outcome of a review of our Board Assurance Framework and the role of the Board and Committees in using this effectively was reported to the Audit Committee on 22nd October 2018. Subsequently, the BAF has been updated and was reported to the Trust Board on 30th November 2018.
7.21	Trustwide	Look to reduce the increasing number of complaints that are reopened, often as they have not satisfied the person who has complained.	Revised reporting structure implemented. All information is collated in a monthly report which is reviewed for quality and causes of reopening. This information is then shared up and down, starting at the Quality, Governance and Learning meeting; the Quality Managers in attendance feed back to the relevant service lines for action and learning. The current quality process has been improved to ensure the standard of responses develops. We are in the process of developing the standard of reporting to demonstrate the number of re-opened complaints to the Board and to Quality Governance and Learning Group.
7.22	Trustwide	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.	The Risk Review Panel reviewed all risks recorded on DATIX which relate to electricity supply and car parking on 10th December 2018. There are no serious risks recorded on DATIX, however, there are a number of car parking related risks which have been recorded as 'moderate' or 'low' for which further assurance is being sought from the Emergency Planning Officer on the business continuity arrangements should the electricity supply fail in critical areas of the hospital. At this stage there is no requirement to include this in the BAF but this will be reviewed on an ongoing basis.
7.25	Trustwide	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.	ICM has warning notices in two places already. Upgrade added a further measure to alert requester to ensure that they have selected the correct patient. Added a double check to the request form which will send alerts to the Clinical Safety Officer.

Ref	Core Service	Requirement	Action Taken
7.28	Trustwide	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.	Service Line HSMR and SHMI data is reviewed at Mortality Review Group. Care Groups receive regular reports on Mortality from the Service Lines.