DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

CQC ACTION PLAN

Reference Key				
MD = Must Do	S = Safe	Med – Medicine Inc. Older People	M&G = Maternity and Gynaecology	CYP = Children and Young People
SD = Should Do	C = Caring			
	E = Effective	U&E = Urgent and Emergency	EOL = End of Life	O&D = Outpatients and Diagnostics
Reg - Regulation	R = Responsive		Sur = Surgery	
	WL = Well-led	TW = Trustwide	CC = Critical Care	

RAG Key			
Recommendation	Green = Recommendation action complete	Amber = Recommendation action in progress	Red = Recommendation action not fully development
Assurance	Green = Full assurance met	Amber = Partial assurance met	Red = No collated assurance met

TRUSTWIDE

No.	Our Ref	Recommendation	Ref	Action required to meet recommendation	Target Completion Date	Lead Manager / Exec Lead	Evidence	Assurance
1	MD11	All patient records must be stored securely to maintain patient confidentiality.	S Reg17 TW	Consistent approach to security of patient records across the Trust.	01/11/16	Medical Records Manager /IG Lead	IG checklists. IGC minutes	Datix report of Incidences involving security of patient records to Information Governance Committee. IG Checklist Audit reported to compliance of security of notes.

Current Status
Complete:
1. Lockable cupboards and secure processes in areas are now in place, where ordering of new notes trolley is in progress.
2. GUM roof repairs complete. All archived notes now secured.
3. Outpatient Access Co-Ordinator completes an IG checklist each month and any required actions are logged and undertaken.
4. Trolleys now sources through procurement (Bristol Maid MR210- small medical records trolley; MR210- medium medical records trolley or MR410 large medical records trolleywhich are all lockable.

In progress:
1. All outpatient areas to be revisited by the IG Lead and protocols tightened.
2. Initial and follow up walk around of medical/surgical, orthopaedics, REI, maxfax and women's health outpatients completed. Completion of the remaining outpatient departments booked, returning to re-assess two weeks after.

<table>
<tr><td>2</td><td>MD3</td><td>The management and administration of medicines always follows trust policy.</td><td>S
Reg12
TW</td><td>All Actions to be completed and signed off by Medicines Safety and Governance Committee
Detailed Action Plan Available.</td><td>01/11/16</td><td>Matrons / Chief Pharmacist</td><td>Action Plan, Audit protocols, Medicines Governance meeting minutes.</td><td>Quarterly CD Audit and Medicines Management action plan monitored through Medicines Safety & Governance (Minutes).</td></tr>
<tr><td colspan="9">Current status:

EVIDENCE REQUESTED</td></tr>
<tr><td>3</td><td>MD12</td><td>Risk registers at local, directorate and divisional level are kept up-to-date; include all factors that may adversely affect patient safety. And progress with actions is monitored.</td><td>S
Reg17
TW</td><td>Embed processes for recording and monitoring all Risk Registers.</td><td>01/11/16</td><td>Divisional Managers & Heads of Service</td><td>Risk Registers and meeting minutes.</td><td>Risk Management review and sign off of risk registers through Risk Management Committee (minutes).</td></tr>
<tr><td colspan="9">Current status:
In Progress:
1. All Risk registers are being brought up to date and will be maintained via new internal governance process.
Complete:
1. Trust risk register has now been updated.</td></tr>
<tr><td>4</td><td>MD16</td><td>Continue the development of governance processes across all specialties and divisions, with a standardised approach to recording and reporting. Ensure the information is used to develop and improve service quality.</td><td>WL
Reg17
TW</td><td>1. Review of Corporate and clinical governance processes to be undertaken and frameworks developed with robust reporting structures.</td><td>01/04/17</td><td>Director of Nursing and Quality / Chief Executive</td><td>Governance framework, including templates and reporting structure. Board minutes Dashboards. Divisional Governance Minutes.</td><td>Revised governance framework development monitored through Trust Board Meeting (minutes).</td></tr>
<tr><td>5</td><td>SD3</td><td>Recommendations from the external mortality review are implemented.</td><td>WL
TW</td><td>2. Complete coding review as part of the outstanding aspect of the implementation plan from the external review recommendations.</td><td>01/04/17</td><td>Head of IT / Medical Director</td><td>Governance framework. Board minutes. Dashboards.</td><td>Mortality review group notes.</td></tr>
<tr><td>6</td><td>SD22</td><td>Service leads review how they use data to improve patient outcomes.</td><td>R
TW</td><td>3. Data is used across the Trust to assist with service and patient outcome improvement.</td><td>01/04/17</td><td>Director of Nursing</td><td>Governance framework, Dashboards</td><td>Divisional exception reports to Clinical Governance committee.
KPI Dashboards to Quality Committee.
KPI Dashboards to Trust Board.</td></tr>
<tr><td>7</td><td>SD33</td><td>Identify and develop a quality dashboard to monitor the quality of the services.</td><td>R
TW</td><td>4. Dashboard developed, implemented across the trust and monitored through appropriate committees with business intelligence support.</td><td>01/04/17</td><td>Director of Nursing & Director of Finance</td><td>Governance framework, Dashboards Business Intelligence support function.</td><td>Divisional Performance reviews.</td></tr>
<tr><td colspan="9">Current status:
Complete:
1. External review completed and received. Clinical Governance Project manager has been appointed and plan has been presented to the Board for approval.
2. External review received and Mortality Review meeting has been implemented and case notes reviewed.
In Progress:</td></tr>
</table>

1. Corporate Governance review is underway and all other works will feed into this project.
2. Coding review action from external recommendations in progress and links to PAS system change required (IT action in progress).
3. Performance Framework to go to SMT
4. Link to Governance Framework to be ratified at Board January

8	SD2	There is formal, systematic review and benchmarking against the recommendations in the Francis review 'freedom to speak up' report.	WL TW	1. We will review the incidence of Whistleblowing at Board on a monthly basis. 2. We will review the Staff survey results in relation to staff's confidence in raising concerns, and use national comparators as a source of benchmarking. 3. We will review our Raising Concerns Policy, and ensure it is fit for purpose. 4. We will Embed our Values, and ensure this supports individual's confidence in raising concerns.	**01/09/16** **01/04/17** **01/09/16** **01/11/16**	Director of Workforce / Freedom to speak up guardian	Board minutes. Board report in July 2017. Policy available. SMT report on performance appraisals in June 2017.	Reports monitored through Trust Board and SMT (minutes).

Current status
In Progress:
1.
Complete:
1. Reviewed at Trust Board Meeting Monthly, ongoing.
2. On track, and complete for 2015 staff survey. Results available in March 2017.
3. On track appraisal relaunch in October 2016 as part of a refresh.

9	SD4	All staff report incidents and feedback is given to the member of staff reporting the incident, and learning from incidents is shared with staff and across teams when relevant.	S TW	Review of incident reporting policy as part of Risk management policy then implement and embed the across the trust . Refresh feedback loop via risk management forums and media.	**01/11/16** **01/11/2016**	Head of Risk / Director of Nursing and Quality	Governance Minutes, Datix system reports, Communications, CEO Brief.	Feedback for Learning from incidents monitored through the Risk Management Committee monthly (Minutes).

Current Status
Complete:
1. Development of a Risk management policy/procedures (sign off due at Board 28/09/2016).
In Progress:
1. Process to strengthen feedback for the individual who raised the incident report in development along with the shared learning across services/teams in the Trust.
2. Divisions to add as an agenda item in team meetings

<table>
<tr><td>10</td><td>SD8</td><td>Staff follow trust procedures when patient group directions (PGDs) are updated, so it is clear they are authorised for use.</td><td>S
TW</td><td>1. All trust PGDs to be logged centrally with version control.
2. Review of arrangements for storage within local areas ensuring that latest version is available and signatory lists are up to date.</td><td>01/12/16

<s>01/12/16</s>
01/03/17</td><td>Chief Pharmacist</td><td>PGD documents on SharePoint and within departments.</td><td>Pharmacy checks recorded and reported by exception to the Medicines Safety and Governance Committee (minutes).</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Process revised and implemented.
In Progress:
1. Review of local storage arrangements.</td></tr>
<tr><td>11</td><td>SD10</td><td>Pain score appropriate tools are used for non-verbal patients across the hospital.</td><td>R
TW</td><td>Identify most appropriate tool available, including for non-verbal patients and implement across the Trust.

Install new pain tool onto VitalPac for clinical staff.</td><td>01/11/2016

01/08/17</td><td>Critical Care Lead/
Pain team /LD Advisor

Head of IT</td><td>Identified tool, audit and future monitoring.</td><td>Pain tool development and implementation will be monitored through an appropriate group (to be identified).
Initial meeting taken place 29/09/16.</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Working group in place to develop and implement Assessment Tool.
2. Abbey Pain Assessment tool identified as most appropriate.
In Progress:
1. Development of flexible EWS is still in the planning stage and should be ready the first half of 2017 through vitalpac
2. Abbey Pain Assessment Tool being taken to Medical Clinical Governance and Health Records Group for Approval.
3. LD and Safeguarding information on intranet being reviewed to include Pain Assessment</td></tr>
<tr><td>12</td><td>SD36</td><td>The arrangements for children attending appointments in general outpatient clinics are reviewed.</td><td>R
CYP
TW</td><td>To review current practices and formally include actions into the transformation work.</td><td>01/12/16</td><td>Child Safe guarding Lead</td><td>Outpatient Transformation Group minutes and action plan.</td><td>Action plan to be monitored through the Outpatients Transformation Group (Minutes).</td></tr>
<tr><td colspan="9">Current Status
In Progress:
1. Review of current practice and revise any Trust-wide recommendations at the Outpatient Transformation Group (cohorting of children within clinics.)
Complete:
1. Lead by a member of the Outpatient Transformation Group.</td></tr>
<tr><td>13</td><td>SD 7</td><td>Trust review of procedure that resuscitation trollies are tamper proof.</td><td>S
TW</td><td>Tamper evident seals to be reviewed in line with national practices and any update on current practices to be implemented.</td><td>01/12/2016</td><td>Matrons
Resus Advisor</td><td>Policies. Audit of trollies. Risk Assessments</td><td>Audit of trolleys and review of the policy monitored through the Resuscitation Committee (minutes).</td></tr>
<tr><td colspan="9">Current Status:

Evidence forwarded to CQC for review and sign off</td></tr>
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<table>
<tr><td>14</td><td>SD1</td><td>There are quarterly reports to the Board on progress against implementation of standards for patients with a learning disability.</td><td>WL
TW</td><td>LD report to be included in the safeguarding Reports.</td><td>01/11/16</td><td>Safeguarding Adults Lead/ LD advisor</td><td>Reports, meeting minutes</td><td>Reports to Safeguarding Committee and exception report to Quality Committee.</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Refresh of LD as part of our Safeguarding assurance processes.</td></tr>
<tr><td colspan="9">URGENT AND EMERGENCY</td></tr>
<tr><td>15</td><td>MD1</td><td>All equipment is clean and fit for purpose and ready for use in the emergency department.
A clear process must be implemented to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.</td><td>S
Reg15
U&E</td><td>Robust cleaning regimes are implemented with auditable evidence of completed work.</td><td>05/09/16</td><td>Matron ED</td><td>Audit protocol.
Cleaning records.</td><td>Cleaning audit reports to Infection Prevention and Control Committee (IPC) (minutes).</td></tr>
<tr><td colspan="9">Current Status

EVIDENCE REQUESTED</td></tr>
<tr><td>No.</td><td>Our Ref</td><td>Recommendation</td><td>Ref</td><td>Action required to meet recommendation</td><td>Target Completion Date</td><td>Lead Manager / Exec Lead</td><td>Evidence</td><td>Assurance</td></tr>
<tr><td>16</td><td>MD17</td><td>Regular monitoring of the environment and equipment within the emergency department, and action taken to reduce risks to patients.</td><td>S
Reg17
U&E</td><td>Appropriate storage for equipment and robust cleaning regimes are implemented with auditable evidence of completed work.</td><td>05/09/16</td><td>Matron ED</td><td>Environmental Audits, cleaning schedules.</td><td>Cleaning audit reports to IPC (Minutes).</td></tr>
<tr><td colspan="9">Current Status

EVIDENCE REQUESTED</td></tr>
<tr><td>17</td><td>MD4</td><td>Patients in the minor operations room (used as a majors cubicle) in the emergency department have a reliable system in place to be able to call for help from staff.</td><td>S
Reg15
U&E</td><td>Procurement sourcing interim electronic bleep system for patients.

Sustainable call systems in place to ensure safety of staff and patients .</td><td>01/10/2016

01/04/17</td><td>Matron ED / Chief Operating Officer</td><td>Capital bid, meeting minutes of discussion. Patient feedback.</td><td>Capital bid to Finance and Performance Committee.</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Temporary measure in place for calling staff.
Future planning:
1. Minor alterations planned for minor ops area awaiting capacity for commencement of the work.</td></tr>
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<tr><td>18</td><td>SD6</td><td>Review of hybrid clinical and management roles in ED.</td><td>WL
U&E</td><td>Clearly defined management and nursing split roles within ED.</td><td>01/09/16</td><td>Divisional Manager</td><td>Divisional structure, organisational chart. Job description.</td><td>Job description written and currently submitted to Banding Review. Interim position filled for both service manager and matron post.</td></tr>
<tr><td colspan="9">Current status

EVIDENCE REQUESTED</td></tr>
<tr><td>19</td><td>SD42</td><td>The emergency department environment is reviewed to make it more children friendly.</td><td>S
U&E</td><td>Separate child waiting areas cleaned and maintained for use and well sign posted .</td><td>01/10/16</td><td>Matron ED</td><td>Environmental audits. cleaning rotas
Patient feedback,
Friends and Family.</td><td>Cleaning audit reports to IPC. Friends and Family and patient feedback monitored through Speciality meetings.</td></tr>
<tr><td colspan="9">Current status
Complete:
1. Environmental audits for cleanliness and maintenance. Additional signs to guide young people so they can choose their waiting area. Family/Quiet room available room available as alternative if required.
2. Children's waiting room has link nurse assigned to ensure cleanliness and check toys.
3. Link with children's ward to supply equipment, books, toys etc.
4. Comments from Friends and Family regularly reviewed and actioned.</td></tr>
<tr><td colspan="9"><h2>END OF LIFE CARE</h2></td></tr>
<tr><td>20</td><td>MD7</td><td>Sufficient palliative care consultant staffing provision in line with national guidance and to improve capacity for clinical leadership of the service.</td><td>S
Reg18
EOL</td><td>Develop end of life additional roles to support leadership of end of life care.</td><td>01/12/2016</td><td>Palliative Care Consultant / Director of Nursing and Quality</td><td>Business planning, Rota.</td><td>Developments monitored through the End of Life Care committee. (Minutes).</td></tr>
<tr><td colspan="9">Current status
In Progress:
1. Initial scoping of roles to meet patient and clinical staff need commenced.
2. Plan in place for Leadership.
3. EOL committee to be re-invigorated and membership reviewed to include management lead from Medicine Division and appropriate clinical leadership to represent all areas of the Trust.
Complete:</td></tr>
<tr><td>21</td><td>MD13</td><td>There is implementation of clear and measurable action plans for improving end of life care for patients. There is monitoring and improvement in service targets and key performance indicators, as measured in the National Care of the Dying Audits.</td><td>E
Reg17
EOL</td><td>Development of an internal EOLC strategy and implementation plan for 2016-2021 with clear and measurable action plans progress against which to be to be monitored bimonthly at the EOLC committee.

Dashboards developed to monitor Key Performance Indicators.</td><td>01/04/17</td><td>Palliative Care Consultant / Director of Nursing and Quality</td><td>Dashboards.
Quality Committee Minutes.
EOLC Minutes.</td><td>Action plans monitored through the End of Life Care Committee. (Minutes).
KPI Reports to Quality Committee (Minutes).</td></tr>
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<tr><td></td><td></td><td></td><td></td><td>Engage in Dorset wide collaboration for End of Life and continue to work on information sharing across health systems.

Internal action plan adapted as part of the wider system for working for End of Life Care.</td><td>01/04/17

01/11/2016</td><td></td><td>Collaborative work with our stakeholders as agreed at the Quality Summit.</td><td></td></tr>
<tr><td colspan="9">**Current Status**
Complete:
1. Key performance indicators (as identified by the National care of the Dying Audit) being collected monthly.
2. Service targets set and being collected monthly and monitored at the End of life Committee meeting.
3. Development of local strategy completed and approved
In Progress;
1. Two KPIs monitored on Quality Committee dashboard.
2. Work underway to review working practices with our stakeholders and identify resolutions through collaborative working.</td></tr>
<tr><td>22</td><td>SD20</td><td>Face-to-face specialist palliative care service, 7 days per week, to support the care of dying patients and their families.</td><td>E
EOL</td><td>Full compliance with recommendation for end of life support.

Develop action plan to address shortfall in face to face palliative care.</td><td>01/08/17

~~01/12/16~~
01/03/17</td><td>EOL consultant / Director of Nursing and Quality</td><td>Rota/timetable showing cover for 7 day service. Meeting minutes.</td><td>Monitoring of action plan through End of Life Committee (Minutes).</td></tr>
<tr><td colspan="9">**Current Status**
In Progress:
1. Review scope for altering current service to better meet demand. Scoping exercise started</td></tr>
<tr><td>23</td><td>SD37</td><td>The Trust will review the provision for Training staff around the Care of The Dying.</td><td>S
EOL</td><td>All relevant staff receives access to training on End of Life Care.

All relevant staff to have completed revised training.</td><td>**01/12/2016**

01/08/2017</td><td>Divisional Manager / Director of Nursing and Quality</td><td>Training records.</td><td>Report of completed training to End Of Life Committee.
Exception report to Clinical Governance Committee.</td></tr>
<tr><td colspan="9">**Current status**
Complete:
1. Review clinical staff training requirements as part of mandatory education review and redesign
2. Consultant Staff will have received end of Life Communication Training as part of their clinical audit half day by end of 2016.
3. NC TJ to meet to arrange tiers of training requirement
In Progress:
1. return visits with some consultant staff
2. finalise implementation of training for other staff</td></tr>
</table>

CRITICAL CARE

24	MD18	Mixed sex breaches in critical care must be reported within national guidance and immediately that the breach occurs.	R CC	Mixed sex breaches are managed within NICE Guidance recommendations. Processes are clarified and redeveloped as part of Pan-Wessex critical care network and Dorset CCG, to ensure that this is defined within our trust policy.	**01/11/2016** 01/04/17	Matron /Director of Nursing and Quality	Local policy. NICE Guidance. Audit data. Handover sheets Critical Care Delivery Group Minutes Surgical Clinical Governance Minutes	Local policy and associated compliance audits. NICE Guidance is monitored through the NICE Implementation Committee.

Current Status/
Complete:

1. Baseline data for October/November collected and provisional actions agreed to improve compliance and accuracy of data essential for avoiding breaches and improved escalation.
2. Local agreement with CCG and network. Discussions to take place with stakeholders regarding best practice.
3. Accurate recording of breach times on database and CCU handover sheets.
4. New policy approved through Critical Care Delivery Group Meeting and the Surgical Division Governance Committee – COMPLETE

REQUEST EVIDENCE

25	SD 9	A recognised pain assessment tool is used in critical care to assist in the monitoring and managing pain for patients.	R CC	Appropriate tool available and used across the Trust.	~~01/11/16~~ 01/02/17	Critical Care Lead/ Pain team /LD Advisor	Identified tool, audit and future monitoring.	Development and implementation monitored through the Critical Care Delivery Group.

Current Status
Complete:
1. Introduce behavioural pain assessment tool for patients that are unresponsive.
2. Audit of use of the behavioural pain assessment tool registered and results available in January 2017

REQUEST EVIDENCE

26	SD21	The critical care unit access is secure to maintain infection prevention and control and the safety of vulnerable patients on the unit.	S CC	Operational policy to be updated to reflect changes to processes to improve security.	**01/12/16**	Matron Surgery	Operational Policy.	Operational policy agreed and ratified by Clinical Governance Committee.

Current Status
Complete:
1. Full risk assessment undertaken These include red tape place on floor to distinguish ITU boundaries for non-relevant staff/visitors. Guidance for Lock down process has been revisited and attached to the Operational Policy.
In Progress:
1. Options for further security are being considered. Either moving the connecting doors or extending the Call bell range

27	SD23	The development of critical care 'follow up' clinics, in line with national guidance, in consultation with stakeholders and commissioners.	R CC	Fully review pilot service and identify any additional resources and undertake patient feedback. Introduce patient support group.	**01/10/16**	Matron Surgery	Clinic templates. Critical Care delivery Group Minutes	Report post implementation to the Critical Care Delivery Group. (Minutes).

Current status
Complete:
1. 1. New follow-up clinics now implemented
2. Trial of new service in September 2016 to be reviewed 3 months post implementation.

In Progress:
REQUEST EVDENCE

28	SD43	There are ongoing risk assessments and improvements in the environment of the critical care unit, taking into account the guidance set out in HBN 04-02.	S CC	Ensure that environmental risk assessments undertaken and recorded.	**01/12/16**	Matron of Surgery	Risk Assessments.	Risk assessment monitored through the Critical Care Delivery Group.

Current Status
Complete:
1. Compliant to Building regulations at point of construction.
2. Mission criteria for HDU has been revised and includes risk assessments of the environment and suitability of patients and the equipment required around bed space.
3. Operational Policy has been updated to provide updated criteria
In Progress:

Evidence requested

SURGERY

29	MD2	The five steps to safer surgery checklist is appropriately completed.	S Reg12 Sur	All WHO Checklists are completed in an appropriate manner and signed off by relevant staff. The compliance is audited on a regular basis and required actions taken.	**01/09/16**	Head of Theatres /Divisional manager	Audit protocol.	Audit report to Surgical Division Governance Committee.

Current Status
Complete:
1. Process for the audit of the checklists for compliance (monthly) with daily verification at the end of each Theatre list to ensure that all documentation is complete.
2. Green status on completion of a full audit cycle.
In Progress:
1. Review of the audit tool and process being undertaken
2. report back TO Clinical Governance

30	MD6	The numbers of nursing on duty are based on the numbers planned by the trust all times of the day and night to support safe care.	S Reg18 Sur Med	Appropriate numbers and skill mix as agreed through the Nurse staffing review.	**01/09/16**	Matrons / Director of Nursing and Quality	Safe staffing board reports.	Reports to Quality Committee and Trust Board (Minutes).

Current Status **Complete:** 1. Skill mix review has been completed. 2. Board has supported £1.2m investment to nursing and Midwifery staffing which is being phased in to enable supervision support. **In Progress:** **Evidence requested**								
31	SD5	The trust electronic incident reporting system is fully implemented throughout the surgical specialty.	S Sur	Datix system being reviewed for specific drop down list for anaesthetics to support improved reporting.	**01/10/16**	Matron Surgery	Report from Datix.	Incidents reports to Surgical Division Governance Committee.
Current status **Complete**: Incident post-box removed. All theatre and Anaesthetic risks reviewed monthly by Clinical Director and discussed at Governance meetings. Reporting of risks promoted by CD. **In Progress:** **Evidence requested**								
32	SD38	Cleaning between cases in day surgery is sufficient and there are effective arrangements to prevent cross infection.	S Sur	Further discussion with IPC on robustness of new policy and standards. Policy to be agreed via the Infection Prevention Control Committee.	**01/10/16**	Day Surgery Lead	Revised Policy.	Cleaning audit reports and ratification of policy update through IPC.
Current Status **Complete:** 1. Risk assessment undertaken and policy reviewed. All staff aware of new standards. 2. Policy for ratification in December **In Progress:** **Evidence Requested**								
OUTPATIENTS AND DIAGNOSTICS								
33	MD5	There is sufficient therapy staff available to provide effective treatment of patients.	S Reg18 O&D	Appropriate staff available to provide effective treatment to patients with clear standard for operating intervention by therapists outlined. Final review and any staffing remodelling complete and implemented, linked to Clinical	**01/12/16** 01/04/17	Head of Therapies / Chief Operating Officer	Contract Report Action plan Staffing reports. SMT minutes. Workforce plan for STP.	Contract Monitoring (Minutes).

<table>
<tr><td></td><td></td><td></td><td></td><td>Services Review and care pathway changes.</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="9">Current Status
Complete:
1. OT review complete and presented to SMT.
In Progress:
1. Review of services provided across the Trust using Carter metrics to ensure efficiency and effectiveness of current workforce is maximised.
2. STP and CSR planned public engagement/consultation process as per national directive and local CCG plan.</td></tr>
<tr><td>34</td><td>MD10</td><td>Turnaround times for typing of clinic letters are consistently met, monitored and action taken when targets are not met across all specialities within the trust.</td><td>R
Reg17
Reg12
O&D</td><td>Action plans to manage turnaround times for typing letters is in place for each service.</td><td>01/09/16</td><td>Service Managers / Chief Operating Officer</td><td></td><td>Monthly report of turnaround times to Clinical utilisation Group (minutes).</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Action plans are in place for each service.
2. Clinical utilisation group set up with Service Manager attendance. Monthly report on turnaround times shared with CCG.
In progress
1. Tracking of turnaround times and any intervention to resolve any delay in progress through Clinical Utilisation Group.
2. Outliers of the standard to be reviewed and reported
3. IT tasked with piloting voice recognition technology in this financial year</td></tr>
<tr><td rowspan="2">35</td><td rowspan="2">SD11</td><td rowspan="2">Discharge letters are sent to GPs in a timely way and patients are given a copy.</td><td rowspan="2">S
O&D</td><td>To implement ICE EDS for all discharge letter.</td><td>01/09/16</td><td rowspan="2">Divisional Manager / Medical Director</td><td rowspan="2">Audit protocol.</td><td rowspan="2">Reports to Quality Committee</td></tr>
<tr><td>To ensure that the escalation protocol is in place and embedded within the services.</td><td>~~01/11/16~~</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. ICE EDS has been implemented.
In Progress:
1. Re-review process for capture of EDS within time requirements.
2. Duplication of EDS to be resolved</td></tr>
<tr><td>36</td><td>SD12</td><td>Standards of cleanliness are maintained in all outpatient areas.</td><td>S
O&D</td><td>Standards are maintained and evidence is recorded .</td><td>01/10/16</td><td>Matrons for Surgery</td><td>Cleaning rotas, audit results.</td><td>Cleaning audit reports to IPC.</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Cleaning rotas are completed and records kept.
In Progress:</td></tr>
</table>

Evidence requested

37	SD13	Patient outcome data is recorded and analysed to identify improvements to services for patients.	E O&D	Robust processes for Business Intelligence.	01/03/17	Deputy Chief Operating Officer / Director of Finance	Business Intelligence Planning.	Business Intelligence strategy currently being finalised .

Current Status
In Progress:

1. Revision of Business Intelligence within the Trust and Implement change.

EVIDENCE REQUESTED

38	SD18	Increased compliance with recording of key metrics in outpatient services, such as the time the patient is seen, to enable data analysis to be more meaningful when used to monitor service quality.	E O&D	Develop and implement Dashboard of Key Metrics. Develop the effective utilisation Work stream.	**01/11/16**	Deputy Chief Operating Officer	Dashboard. Action plan .	Development monitored through OPD transformation Group (Minutes).

Current Status
Complete:

1. Dashboard in place and Work stream developed.

EVIDENCE REQUESTED

39	SD14	Staff working in outpatients always follow the trust interpretation policy for patients who are non-English speaking.	R O&D	Staff are aware of Trust Policy and adhere to the practices identified.	**01/09/16**	Deputy Chief Operating Officer	Meeting minutes and newsletters. Posters.	Reaffirming processes through team meetings (Minutes).

Current Status
Complete:
1. Staff reminded via staff meetings and minutes of the need to adhere to Trust policy on this matter.
2. Posters for staff areas developed.
In Progress:
PALS and NEDS to be invited to test the use of the Interpretation Policy in all Outpatients.

40	SD19	Daily recording of data on missing notes for outpatient clinics, which is audited and actions taken.	E O&D	Processes and policies reviewed and updated in line with current practices . Enhance Medical Records Governance arrangements Robust audit procedures.	~~01/09/16~~ 01/02/17	Head of Medical Records/ Deputy Chief Operating Officer	Meeting minutes and Newsletters. Health Records Group Minutes	Reports to Outpatients Transformation Group.

Current Status
In Progress:
1. Processes reviewed and monitored through the OPD transformation Group.
2. Records kept of missing notes
3. Local risk register of missing notes

41	SD40	There are arrangements for more timely discharges earlier in the day (before lunchtime) and more effective use of the discharge lounge by all ward teams.	R O&D	Safer patient flow bundle implemented across Medicine linked to the full transformation work.	01/01/17	Access and flow Lead	Meeting minutes.	Implementation of bundle monitored through the Patient flow steering group and Access and quality transformation group Minutes.
				Roll out Trust wide key aspects of safe flow bundle to all inpatient adult wards.	**01/11/16**			

Current Status
In Progress:
1. Part of wider system partnership working action plan.
2. Surgery awaiting further work

REQUEST EVIDENCE from Medicine

42	SD41	Governance arrangements provide sufficient overview of the quality and risks across outpatient services.	WL O&D	Enhance Governance arrangements ensuring they are robust and complete.	**01/12/16**	Chief Operating Officer	Meeting minutes. Performance review notes. Action Plans.	Action plans monitored through the Outpatient Transformation Group.

Current Status
Complete:
1. The Outpatient Transformation Programme brings together clinical and managerial staff from across the organisation in a number of action groups with service improvement plans across a range of quality and access issues.

EVIDENCE REQUESTED

MATERNITY & GYNAECOLOGY

43	MD8	The number of midwives is increased according to trust plans and in line with national guidance, to support safe care for women.	S Reg18 M&G	Midwife to birth ratio reduction to 1:28.	**01/11/16 for phase I.** 01/07/17 for phase II.	Head of Midwifery	Record of establishment. Staffing reports.	Reports of establishment monitored through the Division Governance Committee.

Complete:
1. Feb 2017 - first phase of midwifery recruitment complete. Midwife to birth ratio now 1:30. Second phase in new financial year
In Progress:
1. Phased recruitment of midwives

2. Review of substantive staff verses budgeted to be undertaken								
44	MD9	Staff attend and or complete mandatory training updates.	S Reg18 M&G	Full compliance with attendance and or completion of mandatory training sustained.	01/04/17	Service Manager / Director or workforce	Education report.	Education Report to Quality Committee and SMT
Current Status **Complete:** 1. New KPI report has been produced for presentations to Clinical Governance which includes training updates. New KPI report has been produced for Clinical Governance which will is discussed at the monthly meetings and incudes training updates **In progress:** 1. Revised Divisional performance reviews to ensure trajectory of delivery remains on track – local divisional management team to oversee performance.. 2.HoM to put together an action plan for maternity mandatory training for when maternity staffing levels increase.								
45	MD14	Care and treatment in all services consistently takes account of current guidelines and legislation and that adherence is audited.	E Reg12 M&G	All National guidance is reviewed and compliance is audited and recorded centrally. Local guidance is reviewed on a regular basis and recorded centrally.	01/11/16	Head of Midwifery / Medical Director	Clinical Guidelines and NICE Guidance reports Current guidelines report from SharePoint.	Reports to all Division Governance Committees. Report to Clinical Governance Committee.
46	SD24	All maternity guidelines are reviewed to ensure they are up to date.	S M&G					
Current Status **Complete:** 1. All Guidance is discussed at the monthly Divisional clinical Governance meetings and attendance at NICE Implementation Committee to feedback on progress. **In progress:** 1. Divisional Governance and Trust clinical audit team are revising processes to ensure compliance of most appropriate national guidance, with the associated audit trail of decisions. 2. Divisional Governance leads are validating local guidance to ensure only relevant guidance remains on the system. **EVIDENCE REQUESTED**								
47	MD15	Consultants supervise junior registrars in line with RCOG guidance.	S Reg12 M&G	All Junior registrars to be supervised in line with RCOG guidance clearly outlined to medical leads. Audit process and feedback to demonstrate compliance.	01/08/2016 01/11/16	Head of Midwifery / Medical Director	Audit protocol and report.	Audit report to Division Governance Committee.
Current Status **Complete:** 1. Discussions have taken place at the Divisional Governance Meeting and agreement of actions required. **In Progress:** 1. Spot audit throughout the coming year. Jan 2017 - Audit is currently being completed 2. Feb 2017 - daily risk review checks if consultant present in hours for difficult instrumental/difficult caesarean section – 100% compliance. Out of hours will be called in if there is time **EVIDENCE REQUESTED**								

48	SD25	Pregnant women's mental health is assessed throughout pregnancy using a tool as recommended by NICE 'Antenatal and Postnatal Mental Health' guidance.	E Reg12 M&G	Joint clinics in place and running. Guideline on intranet and audit on its use. Use of the new national notes will ensure that women are screened throughout pregnancy.	01/12/16	Head of Midwifery	Training records, and protocol Appropriate tool and guidance.	Audit reports to Division Governance Committee.

Current Status
Complete:
1. Now have a mental health midwife lead in place (continuation dependant on funding agreement with CCG) and a joint Obstetric mental health clinic is being set up.

In Progress:
1. Lead midwife will provide training and is currently producing guidelines.
2. Introduction of new National Maternity Notes scheduled for March 2017 will ensure assessment is incorporated into the booking details. This process has taken time as all staff require training to use this new notes system. Project led by two senior midwives

49	SD26	The use of a NICE recommended CTG evaluation tool which should be entered into the woman's notes every time the trace is reviewed.	E M&G	Audit on sticker use, patient's notes and updated guideline.	01/12/16	Head of Midwifery	Copy of the sticker to be used. Evaluation tool and protocol.	Guidance ratified by Clinical Governance Committee.

Current Status
Complete:
1. CTG sticker developed and now embedded

In Progress:
Guidance for care of women in labour requires review

50	SD27	The use of a software package, with an individualised growth chart designed to more accurately detect foetal growth problems which are associated with stillbirth.	E M&G	Appropriate midwives trained on system and using (i.e., patient notes audit).	01/04/17	Head of Midwifery	Audit results and report.	Audit reports to Division Governance Committee.

Current Status
Complete:
1. GROW package. 1 midwife lead for GROW package and all midwives now trained in correct fundal height measurement.

In Progress:
1. Audit currently in progress to identify how many scans this is. Planned implementation date of January 2017
2. Drs require training to correctly measure fundal height.
3. IT link required so that the growth charts can be generated for each woman.
4. Concerns raised by USS department regarding increased numbers of scans. the use of this software package is a national requirement, linked with the Saving Babies' Lives Care Bundle.

<table>
<tr><td>51</td><td>SD28</td><td>The development of a midwifery led birthing unit, in line with National Maternity review recommendations.</td><td>R
M&G</td><td>Awaiting finalised arrangements for building work to begin.</td><td>Tbc (Dependent upon confirmed construction from builder)</td><td>Head of Midwifery</td><td>Building works completed and area used as MLU.</td><td>Monitored through Division Governance Committee.</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. The MLU has been designed with Funding and business case granted.
In progress:
1. Funding and business case has been granted for the MLU. Oct 2016: Estates going to tender for the work. Needs to be completed by Feb 2017. Jan 2017 - Date of completion has moved as surveys need to be done. A company has been identified to complete the surverys - date TBC..</td></tr>
<tr><td>52</td><td>SD30</td><td>The use of the Stillbirth Care Bundle developed by NHS England to ensure that all known measures are taken to reduce the chances of stillbirth.</td><td>E
M&G</td><td>Full implementation and sustained delivery of the GROW package by lead Midwife.</td><td>01/03/17</td><td>Head of Midwifery</td><td>Local guidance.</td><td>Implementation monitored through Division Governance Committee.</td></tr>
<tr><td colspan="9">Current Status
Completed:
1. Identified lead in place and plan developed.
2. 3 of the 4 care pathways completed – smoking cessation support, reduced FMs management, analysis of CTGs. The use of the GROW package is as above.
In progress:
1. Gap analysis to be undertaken to ensure that all aspects of the bundle are covered.
2. Individual areas of the bundle have been implemented with scheduled full embedding by March 2017.</td></tr>
<tr><td>53</td><td>SD29</td><td>The use of the modified ‘Sepsis 6 care bundle’ in the maternity units.</td><td>E
M&G</td><td>Implementation across maternity unit.</td><td>01/04/17</td><td>Head of Midwifery</td><td>Guideline completed and uploaded to SharePoint. Box available on the unit for use.</td><td>Guideline ratified by Clinical Governance Committee. Monitoring of use through audit report to Division Governance Committee.</td></tr>
<tr><td colspan="9">Current Status
In Progress:
1. Midwife identified to lead on Sepsis. Box to be agreed to treat women on the unit and guideline to be written.</td></tr>
<tr><td>54</td><td>SD32</td><td>A robust system to support lone workers in the community.</td><td>S
M&G</td><td>Mobile phones for midwives in place.

Trust-wide roll out and compliance with Lone Worker Policy and monitoring embedded within local areas.</td><td>01/09/2016

01/04/17</td><td>Head of Midwifery

Health and Safety Coordinator</td><td>Policy for lone workers.</td><td>Implementation monitored through Divisional Governance Committee.</td></tr>
<tr><td colspan="9">Current Status
Complete:
1. Home birth team have mobile phones and protocol for keeping in touch.
2. All staff working in the community now have access to a smart phone (some phones still awaiting collection from ICT).
3. All women booked are now risk assessed regarding visiting. Details of this assessment are kept in the woman’s caseload folder in the community office.
In progress:</td></tr>
</table>

1. Local Arrangements within teams –interim measure in place with robust Trust-wide policy processes in development.
2. The lone worker app to be reviewed.

CHILDREN AND YOUNG PEOPLE

55	SD15	Nurse staffing on the children's unit is reviewed in line with The Royal College of Nursing (2013) guidelines in terms of numbers or ratios of nurse to healthcare assistants.	S CYP	Business planning cycle paediatric nursing to be included. Ratios are currently within 5% of target.	01/04/17	Safeguarding Children Lead	Business planning cycle and Report of Establishment.	Report to Division Governance Committee.

Current Status
Complete:
1. RCN guidelines are met for day time shifts Monday-Friday.
In Progress:
1. Weekend days required further work
2. Review of Band 3 role development and subsequent effects on staffing ratio.
3. ANP development will increase reg nurse complement.
4. Remain within 5% of target

56	SD16	Review of medical staffing in line with British Association of Perinatal Medicine (2010 Standards) requirements for sufficient medical staff on the neonatal unit at all times, including overnight (9pm to 8am).	S CYP	Sufficient cover of the neonatal unit and Kingfisher Ward according to final model as per CSR and STP outcome.	01/04/17	Divisional manager	New model following CSR.	CSR Model to Trust Board.
57	SD17	Compliance with Facing the Future- Standards for acute general paediatric services (RCPCH, Revised 2015) requirements for consultant paediatrician present and readily available during the times of peak activity, seven days a week.	S CYP	Compliance with guidance.				

Current Status
In Progress:
1. Introduction of a project manager to oversee options appraisals.
2. Review as part of the CSR and Vanguard work with the report from the Royal College recommendations. CCG leading

58	SD34	Implementation of nursing staffing acuity tool in child health.	S CYP	Successful pilot and complete implementation.	**01/12/16**	Child Safeguarding Lead	To review the tool after 3 months.	Monitored through Divisional Governance (Minutes)

Current Status
In Progress:
1. Collaborative Pilot of Sheffield Tool with Poole to ensure consistency across providers
2. Tool now in place . review after 3 months

59	SD35	Supervision for staff involved in children's safeguarding.	S CYP	Safeguarding committee will monitor compliance.	**01/10/16**	Child Safeguarding	Training records	Reports to Safeguarding Committee.

						Lead		

Current Status
Complete:
1. Supervision training complete.
In Progress:
1. Models now being introduced.

MEDICINE INCLUDING OLDER PEOPLE

60	SD31	Improved rates of dementia screening to ensure that all emergency admissions over 75yrs are screened and then appropriately assessed.	R Med	Trust meeting national recommendations for screening and assessment of dementia. Trust aims for stretch target of meeting the dementia alliance concordat recommendations and sustained achievement.	01/04/17	Divisional Manager / Chief Operating Officer	Compliance rates as reported in the Divisional Dashboard.	Report to Dementia Group.

Current Status
Complete:
1. Daily review of compliance against the screening to be monitored by matron for older people services and relevant consultant for each ward.

61	SD39	Nursing handover on Day Lewis ward are arranged to respect patients' privacy and dignity.	C Med	All staff hand overs will be conducted to maintain patients' privacy and dignity.	**01/10/16**	Divisional Manager	Handover documentation. Transformation initiative meeting minutes	Observational Spot checks performed by Matrons

Current Status

EVIDENCE REQUESTED