Worcestershire Acute Hospitals NHS Trust

"Improve, Inspire, Innovate"

Quality Improvement Plan

Worcestershire Acute Hospitals NHS Trust

Contents

Background & Summary

CQC Inspection July 2015

The Chief Inspector of Hospitals visited the Trust in July 2015 and published the findings in December 2015. The Trust was rated overall as *'Inadequate'*. The Trust had had a previous unannounced and focussed inspection of ED in March 2015 which resulted in a number of Section 29 Warning notices and weekly monitoring returns to the CQC of ED triage times.

CQC Unannounced Inspection July 2016

Following concerns raised directly to the CQC by a whistle-blower the CQC carried out an unannounced inspection of radiology services. This resulted in a section 31 notice and the trust has remained on weekly monitoring since that time.

Overall rating Nov 2016	Inadequate	
Are Services Safe?	Inadequate	
Are Services Effective?	Requires Improvement	
Are Services Caring?	Good	
Are Services Responsive?	Inadequate	
Are Services Well-led?	Inadequate	

CQC Re- Inspection November 2016

The Trust had its scheduled re-inspection 22 – 25 Nov 2016 followed by a number of unannounced visits. Following this inspection, the level of concern was such that a Risk summit was called by NHSI on the 22 Dec 2016. Whilst the focus of this summit was on the safe care of patients in Urgent Care the CQC raised a number of other areas of concern which included safe medicines management, care of patients on CPAP in paediatrics and safe staffing and monitoring of escalation areas. A follow up risk summit was held on 18 Jan 2017. The Trust then received a section 29A Warning Notice from the CQC outlining concerns at all three sites. The final report from this visit was published on 20 June 2017. This showed a decline in the overall Responsive domain rating from Requires improvement to Inadequate.

CQC Unannounced Inspection April 2017

The CQC undertook an unannounced inspection to review progress against the Section 29A Warning Notice in April 2017 followed up by interviews with the Executive Team and staff focus groups. On this inspection they did not find sufficient evidence to demonstrate that the requirements of the Warning Notice had been met. The report from this visit is due to be published in July 2017

Following on from receipt of the Section 29A Warning Notice a Quality Improvement Plan (QIP) was developed and an internal monitoring group (the Quality & Safety Improvement Group) was established chaired by the Chief Executive. Any outstanding actions from that QIP have either been moved into this updated QIP presented below or into business as usual.

Who is Responsible?

- Our initial actions (focusing on the 'Must' and 'Should Do's') to address the Section 29A Warning notice of January 2017 were agreed by the Trust Board in March 2017
- Trust leaders have developed this Quality Improvement Plan which was ratified by the Trust Board on 5 July 2017, provided to the CQC on 6 July and reviewed at the Quality Oversight Group meeting on 10 July.
- The Chief Executive is ultimately responsible for implementing actions in this document. The Chief Medical Officer, Dr Suneil Kapadia provides the executive leadership for safety and clinical effectiveness and the Chief Nurse, Vicky Morris provides the executive leadership for Quality, CQC regulation and compliance.
- The Trust works closely with NHS Improvement, specifically the Improvement Director allocated to the Trust, Cathy Geddes and the Regional Team, who ensure delivery of the improvements and oversee the implementation of the Quality Improvement Plan.
- Ultimately the success in implementing the recommendations of the Quality Improvement Plan will be assessed by the Chief Inspector of Hospital upon re-inspection of our Trust
- If you have any questions about progress on implementation, contact Vicky Morris at: Vicky.morris@nhs.net

How we will communicate our progress to you

We will update this progress report every month while we are in Special Measures and the Quality Improvement Plan will be available for access following approval by the Quality Oversight Group and the Trust Board.

Chair / Chief Executive Approval (on behalf of the Board):

Chair Name: Caragh Merrick	Signature:	Date:
Chief Executive Name: Michelle Mckay	Signature:	Date:

The CQC findings – A summary

This section provides a summary of the CQC's findings about services at Worcestershire Acute Hospitals NHS Trust. Summary report and full CQC report can be found on the Worcestershire Acute Hospitals Web Site www.worcsacute.nhs.uk or the CQC website: www.cqc.org.uk

General

There had been deterioration in the quality of services provided since the previous inspection in 2015 with a decline in the Responsive domain from "Requires Improvement" to "Inadequate". The trust was rated as Inadequate overall and across all three hospital sites. It was rated as Inadequate for being safe, responsive and well-led, Requires Improvement for being effective and Good for being caring. End of Life Care was rated as Good on both the Alexandra Hospital and Worcestershire Royal Hospital sites and Critical Care services were rated as Good at the Alexandra Hospital site.

1. Ensuring Services are safe

The CQC rated the safety of our services as '*inadequate'*. They found a culture of reporting, investigating and learning from incidents but inconsistencies in external reporting for serious incidents. Staffing within the Emergency Department at the Worcestershire Royal site was not in line with national guidance; however, most other areas had adequate staff to ensure patients received safe care and treatment. Management and storage of medicines was poor with a lack of a robust process being in place for monitoring and reporting fridge temperatures. Too many patients were receiving care in the corridors of our Emergency Departments, particularly at the Worcester site, sometimes being placed near exit doors and out of the line of staff's sight.

2. Ensuring Services are effective

The CQC rated the effectiveness of our services as '*requires improvement'*. The Trust mortality indicators (HSMR and SHMI) at the time were both above the national average. Our performance in national audits was poor with some areas performing significantly worse than the England average. Robust action plans were not in place to ensure improvement and there was no standardised approach to local audits. Mandatory training for staff was below the Trust standard in most areas and not all staff understood their obligations under the MCA and DOLS, meaning our most vulnerable patients were potentially at a higher risk of not receiving all the care they need.

3. Ensuring Services are caring

The CQC rated the caring of all our services as '*good'*. They observed staff delivering compassionate care, involving patients in decision making, whilst providing good emotional support to patients and people close to them. However, the privacy and dignity of patients being cared for in corridors within the ED departments was often compromised.

4. Ensuring services are responsive

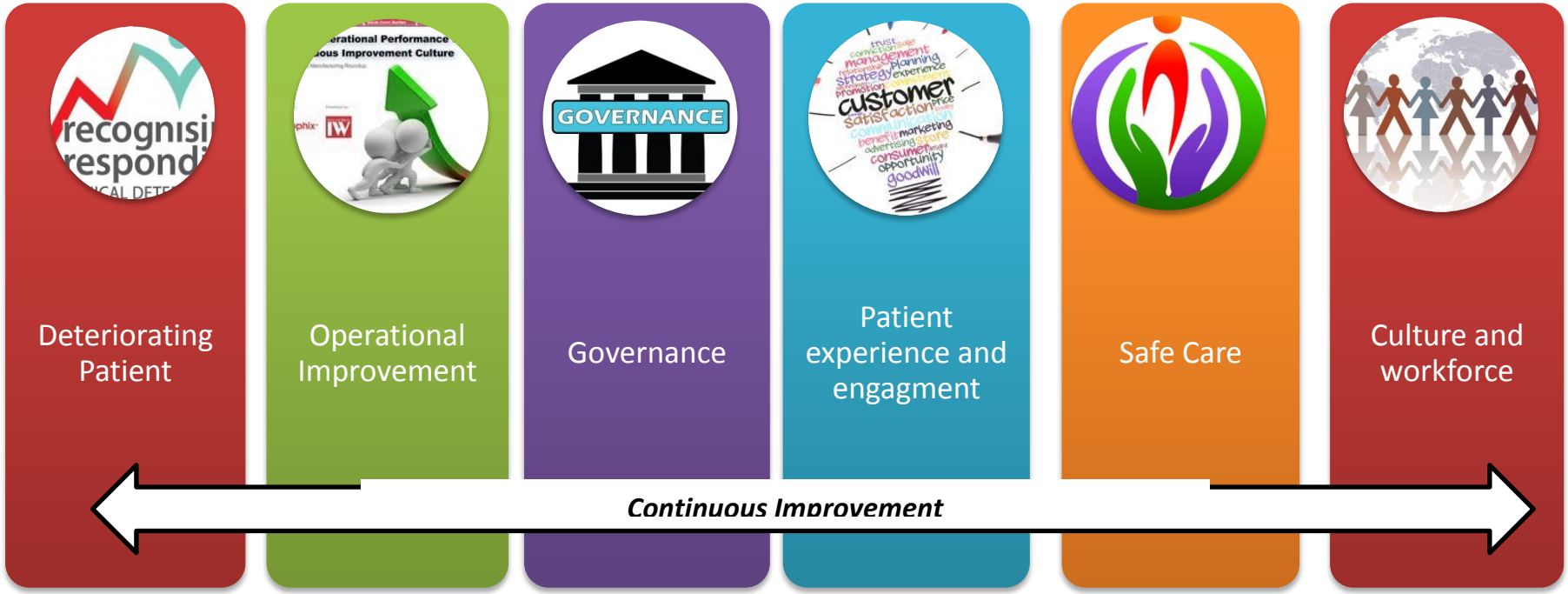
The CQC rated the responsiveness of our services as '*inadequate'.* The Trust was consistently failing to meet the national performance standards (Emergency Access; Cancer; Referral to Treatment and Diagnostics) with the flow of patients through the hospital being poorly managed. However, the Trust did have systems in place to ensure that patients living with dementia had safe care that was tailored to their needs. Staff could also demonstrate good examples of where they had altered care to ensure patients beliefs and diverse needs were met.

5. Ensuring services are well led

The CQC rated the Well Led aspect of the Trust as '*inadequate'.* They had significant concerns about the interim nature of the Board at the time and felt that the executive team did not have effective processes to ensure communication was embedded from ward to board. A revised framework for governance and assurance had been put in place but the CQC felt that it was not operating effectively and so the board did not have clear oversight of the risks affecting the quality and safety of care for patients. The CQC also raised concerns about reported high rates of bullying of staff from patients, relatives and other staff. In addition they noted the lack of BME staff employed in senior posts within the Trust.

Developing our Improvement Plan

The six themes within our plan are:



Each section of our improvement plan outlines the CQC findings, the improvement projects identified and how we intend to measure success.

Quality Improvement Plan Governance

It is important that we ensure robust governance arrangements through which the quality improvement plan (QIP) will be managed. Immediately following the publication of the Section 29A Warning Notice in January 2017, regular Quality and Safety Improvement Group (QSIG) meetings were established with Divisional representation to monitor delivery against that Improvement Plan. This meeting is chaired by the CEO. The Trust will build on that meeting and will now become the Quality Improvement Board (QIB) which over time will develop into the group that monitors delivery of all Improvement Programmes across the Trust.

The QIB reports into the Quality Governance Committee which is a Board Committee.

Responsibilities of: Divisional Leads/ Trust Leads/ Staff with Actions

- The Divisional triumvirates / Trust Leads are responsible for ensuring that the QIP actions are achieved and the plan is updated on a regular basis, and any issues escalated appropriately and within a timely manner.
- The QIP must be monitored on a regular basis by the Divisions/Trust Leads to ensure it remains on track, pro-actively identifying slippage and mitigating actions to rectify as soon as possible.

Responsibilities of: Executive Leads

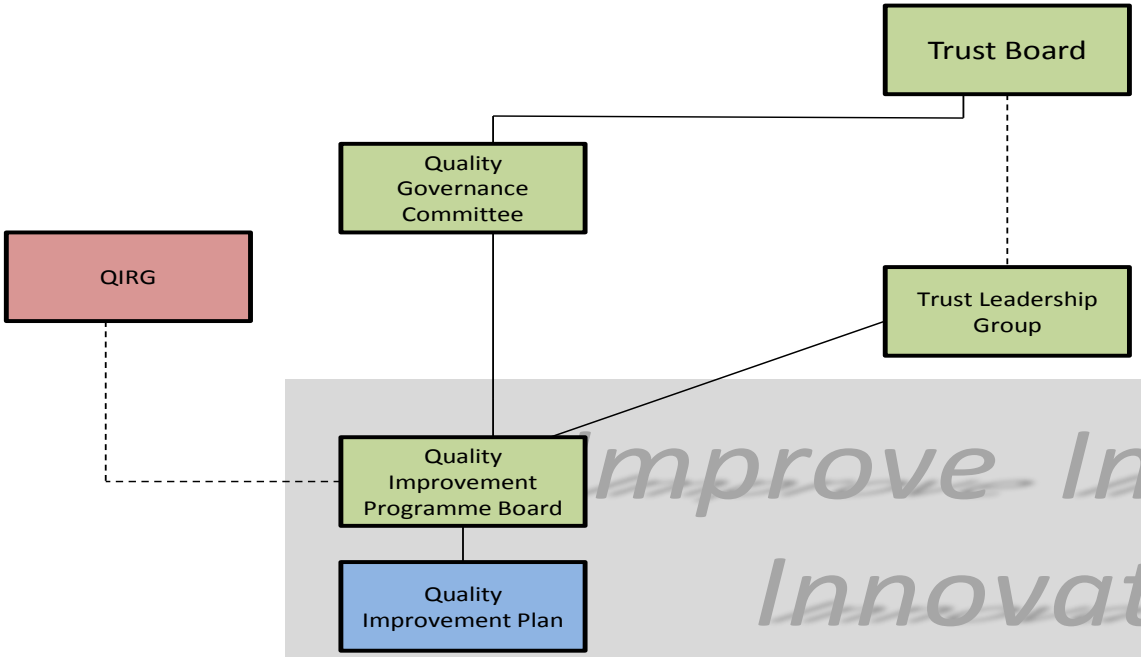
- The Lead Executive for each 'concern' identified is responsible for ensuring that the identified outcome, KPI (and associated trajectories) and action are appropriate. They are responsible for signing off their relevant parts of the QIP.
- A Lead Executive will be allocated responsibility for overseeing the implementation and impact of each of the 6 work streams (Deteriorating Patient, Operational Improvement, Governance, Patient Experience and Engagement, Safe Care, Culture & Workforce)
- The Executive leads will provide both support and challenge to the Divisions/ Trust leads at the relevant governance meeting if concerns are identified, or the delivery of actions are delayed to meet the stated outcomes. Divisions/Trust leads will be requested to identify mitigating actions to bring the delivery back on track.

Responsibilities of: Programme Management Office

- Will provide support to the Divisions / Trust Leads to ensure that the QIP is co-ordinated appropriately working closely with the Deputy Chief Nurse (Quality) who has operational oversight of the plan.

Corporate Governance Structure (Quality and Safety Focus)

NHS
Worcestershire
Acute Hospitals
NHS Trust



How we will implement this plan

The governance section above outlines the committee structure responsible for ensuring delivery and assurance against the QIP. This section identifies how the trust is going to operationalise the delivery of the plan.

The Trust has identified one of its substantive Executive Directors to take on the lead responsibility for Quality Improvement across the organisation. This is the Chief Nurse. The Deputy Chief Nurse (Quality) will be accountable to the Chief Nurse and will oversee the delivery of the Improvement Plan, utilising a programme management approach.

Each of the 6 themes identified within the programme (Deteriorating Patient, Operational Improvement, Governance, Patient Experience and Engagement, Safe Care, Culture and Workforce) has been allocated an executive lead that will be accountable for the successful delivery of the desired outcomes documented within their section of this plan to the Quality Improvement Board. This Group will be chaired by the Chief Executive Officer and supported by the Chief Nurse. This group currently meets fortnightly and it is the aim of the Trust that this Group will be a long-standing group which will be responsible for monitoring the continuous quality improvement across the organisation beyond the next CQC inspection.

Supporting the implementation of the improvement plan with be the development of a three year strategy within the Trust which will be delivered to support and educate staff in utilising improvement science to implement and monitor small and large scale change; to utilise staff's expertise (such as that of consultants and other staff who have a special interest in improvement and who have skills in mapping, implementing lean methodology etc.) to support staff implement change in practice and to utilise staff's knowledge of particular topics, such as aspects of functional management, leadership, change management etc. as well as offering facilitation, coaching and mentoring skills to all levels of staff within our organisation.

The Plan – Deteriorating Patient. Executive Lead, Chief Medical Officer

What the CQC found

Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the patient's stay in hospital.	The risk of patients deteriorating was not always appropriately managed particularly for those patients moved to outlying wards.
Lack of clear oversight of the deterioration of patients and the inaccuracies in completion of National Early Warning Score	The ED at the Alexandra Hospital could not ensure that there was always a senior doctor available who was qualified to resuscitate children. Staff had not been trained to use a new system to help staff recognise when a child's condition was deteriorating.
Inaccuracies in completion of the Paediatric early Warning Scores and failure to escalate appropriately	Robust and appropriate systems were not in place for carrying out VTE assessments which contravened NICE guidance.
The Trust was performing worse than expected for two mortality indicators (SHMI and HSMR)	The critical care team were able to ensure safety across the county wide service by transferring skilled staff to assist with the management of patient care according to need.
Patients were cared for in environments that did not always have the equipment to safely care for a deteriorating patient.	Not all equipment had been safety tested and the emergency neonatal trolley in the delivery suite was not always checked properly.

Our plans to improve

1. ***Improve the morbidity and mortality processes across the Trust to enhance shared learning and to reduce unnecessary harm to patients.*** We will achieve this through the successful implementation of the following:

- Introduce standardised primary & secondary mortality reviews across the Trust based on The Learning from Deaths Guidance (NHSE 2017), reporting to the Board as per guidance.
- Enhanced shared learning from morbidity & mortality reviews, by reviewing the current Trust process to ensure that every death is reviewed by the appropriate clinical teams (not just those patients at the end of their life, or from the DNACPR audits) and through the appointment of an additional clinical lead responsible for leading on mortality reviews.
- Reviewing and strengthening the Trust-wide Mortality Review Group.
- Review the existing VTE project plan and strengthen this based on best practice learned from elsewhere.

2. ***Improve the accurate recording of NEWS and PEWS and ensure appropriate escalation happens when needed.***
   We will achieve this through the successful implementation of the following:

   - Strengthen the programme of audits to monitor compliance with the NEWS and PEWS policies, supported by an on-going training programme.
   - Roll out the use of SBAR as the communication tool between clinicians for requesting support for deteriorating patients and handover.
   - Standardise and implement Safety Huddles across all wards.
   - Develop the business case for procuring a mobile clinical system to enable real time patient monitoring and escalation.

3. ***Improve the early detection and timely treatment for patients admitted with Sepsis.*** We will achieve this through the successful implementation of the following:

   - Review of the work programme of current Sepsis Improvement Group, ensuring all actions are going to deliver the improvements required.
   - Development of a business case to support the additional resource required to deliver improvements.
   - Embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics.
   - Timely identification of sepsis in emergency departments and acute inpatient settings.

4. ***Ensure robust individual patient and environmental risk assessment processes are in place that will ensure patients are cared for in the right place, by the right person who has the right equipment to support care delivery.***
   This will be monitored at daily bed meetings and audited quarterly.

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
HSMR and SHMI rates are in line or better than the national average	**31/08/18**
Compliance with the Sepsis 6 bundle is in line or better than national average	
There will be a reduction in unexpected Cardiac arrests from the 16/17 baseline	
There will be a reduction in unplanned admissions to our ITU's from the 16/17 baseline	

***Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Operational Improvement. Executive Lead – Chief Operating Officer

What the CQC found

Lack of privacy and confidentiality for patients being cared for on trolleys on the corridors of the emergency department at Worcestershire Royal Hospital and the Alexandra Hospital.	The flow of patients into and through the hospital was not well managed across the Trust
Medical patients on non- medical wards were not always effectively managed.	The Trust was not meeting the cancer 62 day standard of 85%
Patients who were moved were not always reviewed to check the move was appropriate.	There was a high volume of patients moving between wards overnight.
The amount of time patients spent in ED waiting for treatment was consistently worse than expected standards.	Only 50% of ambulance patients were handed over to ED staff within 15 minutes.
Patients are waiting too long from the decision to admit until being admitted so patients are not accessing care in a timely way.	The admitted referral to treatment time was consistently below the Trust standard of 90%

Our plans to improve

1. ***Implementation of the Trust wide Flow project.*** We will achieve this through the successful implementation of the following:

- Implementation of Red 2 Green 7 days No Delay project to speed up flow through the hospitals.
- Robust daily reviews of “stranded” patients to ensure the right care delivered in the right place.
- Length of stay review & Implementation of the 6A ‘s of managing emergency admissions project with the support of ECIP
- Bed management review
- Establishment of a Frailty Unit including a Frailty model across the health economy
- Increase the number of ambulatory care pathways.
- New capital build aligned to current Emergency Department increasing capacity and improve streaming.
- Review of the Paediatric Assessment Unit and urgent care pathways to ensure there is sufficient capacity.
- Review of SOPs for placing patients into escalation areas, ensuring they cover off risk assessments, staffing and equipment checks.

2 ***Capacity and Demand analysis and job planning to ensure we right size capacity and match resources required.*** We will achieve this through the successful implementation of the following projects:

- Capacity and Demand analysis June 2017
- Review of job plans for all Consultants July 2017
- Bed and theatres right sizing once Capacity and Demand analysis complete
- Review of Clinical Nurse Specialist roles and job plans September 2017
- Medical bed modelling supported by Intensive Support Team
- Review of Paediatric Urgent care pathway and staff.

3 ***Increase capacity to ensure delivery of Cancer and RTT improvement trajectories.*** We will achieve this through the successful implementation of the following:

- Approval of 7 business cases to increase the clinical workforce; outsource where required and run additional sessions internally.
- Review of Waiting List processes ensuring strong Divisional oversight

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
Achievement of the improvement trajectory for the Emergency Care Access standard	**31/03/18**
Achievement of the improvement trajectory for Cancer waiting standards.	
Achievement of the improvement trajectory for Diagnostic wait standard	
Achievement of the improvement trajectory for 18weeks RTT standard	
25% of discharges before midday	
Established Estimated Date of Discharge (EDD) for all patients	
Red 2 green actions standardised in all wards	
All patients streamed from front door into the most clinically appropriate setting – Right Patient, Right Ward, 1st Time	
A consistent reduction in the Delayed Transfers of Care (DTOC) to 3.5%	
Ambulance handovers consistently complete handovers within 15mins	
Ensure maximum theatre utilisation, in order that the number of cancelled operations reduces in line with the England average	
A consistent improvement in A&E FFT results	

***Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Governance. Executive Lead- Chief Nurse

What the CQC found

Nursing documentation was poorly completed.	Performance in national audits was in some areas significantly worse than the England average with limited evidence of action plans to address all areas for improvement.
There was a culture of reporting, investigating and learning from incidents throughout the Trust. However, not all incidents that were required to be reported externally as "serious" were correctly classified and externally reported.	There was no standardised approach to completion of audit.
The Executive Team did not have effective processes to ensure communication was embedded from Ward to Board	Although a revised framework for governance and assurance was in place, it was not operating effectively and the board did not have clear oversight of the risks affecting quality and safety of care for patients.
There was not an appropriate system in place to support the fit and proper person's requirements.	Risk registers were not fully populated with risks at Divisional level.

Our plans to improve

1. Enhance our Quality and Corporate Governance, so there no longer exists a gap between the clinical areas and the board.
We will achieve this through the successful implementation of the following:

- Implement the outstanding recommendations from the Buddy Trust Governance Review
- Review the Divisional Governance meetings and implement changes required in order to ensure a consistent approach.
- Commission external expert advice on Corporate Governance and implement recommendations.
- Ensure a robust process is in place for meeting the Fit and Proper Person guidance.
- Undertake the NHSI Well Led Governance Review.

2. Strengthen our Risk Management processes, so there no longer exists a gap between the clinical areas and the board.
We will achieve this through the successful implementation of the following:

- Implement the outstanding recommendations from the Buddy Trust Governance Review
- Roll out a programme of training on risk management both to the Board and operational teams.

- Review and update the BAF and Risk Management Strategy.
- Review Risk Registers via the Trust Risk Management Group.

***3. Strengthen the Trusts ability to transform the safety and quality culture across the organisation*.** We will achieve this through the successful implementation of the following:

- Undertake a Trust wide Safety Culture questionnaire.
- Introduce a Trust-wide transformation and PMO team who will support the delivery of this overarching piece of work, focusing on long term continuous improvement
- Work with the West Midlands Academic Health Science Network (WMAHSN) to support an improvement in staffs understanding of improvement methodologies.
- Review the Trusts Incident reporting Policy and training programme to ensure increased awareness and knowledge amongst staff.

4 Strengthen the outcomes from local & national audits, demonstrating learning by continuously improving compliance. We will achieve this through the successful implementation of the following:

- Establishment of a system to co-ordinate results from audits, the resulting action plans and evidence of implementation and compliance which will be monitored via the Trust Clinical Governance Group.

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
Our quality & Corporate governance systems are robust and can demonstrate a dynamic flexible process which moves seamlessly from ward /department to board and back again	**31/03/18**
Our risk management systems are robust, and can demonstrate a dynamic responsive oversight and approach to risks identified at all levels within the organisation, strengthening board oversight of risk.	
An enhanced safety and improvement culture which reaches all levels of staff across the organisation and focuses on: learning, sharing the learning, continuous quality improvement and the use of appropriate information to evidence performance against agreed success metrics (Clinical effectiveness)	
100% compliance with the Fit and Proper Persons Process (FPP) by 30/06/17	

***Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Patient Experience and Engagement. Executive Lead- Chief Nurse

What the CQC found

Feedback from patients and those who were close to them was positive about the way staff treated them. Patients were observed being treated with dignity, respect and kindness.	Close working between the specialist palliative care team and ED staff was observed at the end of life
Relatives of patients in critical care had access to facilities to enhance their stay on the unit including overnight accommodation.	The need for emotional support was recognised and specialist and spiritual support was provided.
Managers did not have clear oversight of mixed sex breaches or the need to report them in line with national guidance.	Pain in children attending the MIU was not always managed effectively.
The NHS FFT had been suspended in children's clinics (KTC) since the service reconfiguration. Patient's feedback could not be used to monitor and improve services.	Patient's privacy and dignity was often compromised for patients being cared for in the Emergency Department corridors.

Our plans to improve

1. ***Reduce the number of mixed sex breaches and ensure robust reporting mechanisms are in place.*** We will achieve this through the successful implementation of the following:
   - Development of a Standard Operating Procedure (SOP) for monitoring and reporting mixed sex breaches.
   - *See Section 2 on Operational Improvement for linked actions that will reduce MSA breaches*

2. ***Ensure all Divisions have robust processes in place to capture patient feedback in a meaningful way and involve patients more in our improvement journey.*** We will achieve this through the successful implementation of the following:
   - Development and implementation of a Patient Engagement Strategy that focusses on actions to increase real time patient feedback, strengthens the patient voice at the Board and engages Patients and carers in the Trust's improvement journey.
   - Review of the current Complaints policy ensuring Divisions become more responsive to concerns raised and learn from the patient feedback.
   - Improve the reporting of complaints to the Board ensuring more in depth analysis of complaints and compliments received.
   - Review of current patient feedback mechanisms, exploring options to improve.

3. ***Ensure all staff that care for children are appropriately trained to identify and manage their pain.*** We will achieve this through the successful implementation of the following:
   - Undertake a training needs analysis and roll out of competency based training.
   - Audit effectiveness of training including Parent and Child feedback.

4. ***Improve flow and streaming in order to reduce the number of patients cared for in the ED corridor at Worcestershire Royal Hospital and ensure appropriate facilities are in place to provide privacy for patients within the department.*** We will achieve this through the successful implementation of the following:
   - *See Section 2 on Operational Improvement for actions that will support this*.
   - Deliver on the planned capital build for the Emergency Department at Worcester Royal site, thereby increasing capacity within the department and improving the ability to provide care in appropriate settings.

We will know when we have succeeded when we have demonstrated:

Outcomes	*** Theme Achievement Date**
Achievement of Trust standards in complaint response times	31/03/18
FFT results that are in line or better than the national average	
An improvement in the 17/18 patient survey results against the 16/17 results	
Active engagement of patients in a range of groups and improvement projects	
Patients are not routinely cared for in the corridors of the Emergency Departments	
Audits show children's pain is being appropriately managed	
Patients are not cared for in a mixed sex environment	

*** Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Safe Care. Executive Lead – Chief Medical Officer

What the CQC found

The level of safeguarding children's training was low and not compliant with national guidance.	Staff were unaware of FGM and child sex abuse. There was a risk staff would not recognise when a child was being abused or exploited.
Medicines management was poor with medicines that required cool storage being stored in fridges which were either below or above the manufacturers recommended temperature.	There was inadequate review and document control of protocols for standard x-ray examinations.
Emergency medicines were not protected from tampering and poor practice was observed relating to staff signing for controlled drugs in the Endoscopy dept. at KTC.	Not all staff had undertaken relevant mandatory training. This included safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
Wards and clinical areas were visibly clean, however, some poor adherence to the trusts infection, prevention and control procedures was observed.	Patient's records were not always stored securely.
Aging and unsafe equipment was used in radiology departments across the trust that was being inadequately risk rated.	Assessments for paediatric patients' requirement of 1:1 care from a mental health nurse were not always undertaken and care was not consistently provided by a member of staff with appropriate training.
Patients with mental health needs were not always cared for in an appropriate environment within ED.	There was not a robust, consistent process in place for Harm Reviews

Our plans to improve

1. ***Improve the management and security of medicines*.** We will achieve this through the successful implementation of the following projects:

- Improving the way that the Trust learns from medication errors by: a) ensuring that all Divisions include monthly reviews of all medication errors reported from Medicines Optimisation and Divisional Governance processes through to the Clinical Governance Group on a quarterly basis and b) distribution of a regular medicines management newsletter
- Enhanced staff knowledge regarding medication issues, as a result of implementation of '5-minute pharmacy alerts' as screen savers which outline medication issues and learning
- Applying the principles of the 'Hospital pharmacy transformation plan' as part of the Carter Efficiency Programme
- Conduct a review of all medicines and fluid storage areas ensuring safe and secure storage is provided.
- Review the medicines policy to ensure it reflects a risk based approach to safe and secure handling in line with national guidance (Duthie report)

2. ***Ensure equipment is well maintained, stored and safety checked, focusing particularly on:*** *Radiology equipment, Resuscitation Trolleys & Fridge Temperatures.* We will achieve this through the successful implementation of the following:
   - Regular audits of Resuscitation trolley checks and fridge temperatures as part of the Nursing SNAP audits triangulated by Pharmacy audit for the safe and secure handling of medicines
   - Development of a SOP for temperature checks, escalation and subsequent action.
   - Development of an equipment replacement programme and identification of a minor equipment budget.
   - Review and update the Asset Register within Radiology
   - Audit of all electrical equipment safety checks.

3. ***Ensure our Healthcare Records are stored securely.*** We will do this through the successful implementation of the following:
   - Conduct a review of all areas where health records are stored ensuring safe and secure storage is provided.

4. ***Improve our compliance with Infection prevention and control procedures.*** We will do this through the successful implementation of the following:
   - A follow up peer review visit to take place within 3 months, to include NHSI and NICE colleagues- implement recommendations following review.
   - Re-establishment of the Anti-microbial Stewardship Group
   - Monthly monitoring of all relevant statutory requirements (e.g. water and ventilation requirements) via the Trust Infection Prevention and Control Group.

5. ***Improve our staff knowledge in caring for all vulnerable patient groups and ensure provision of an appropriate environment at all times.*** We will do this through the successful implementation of the following:
   - Training needs analysis and review of current training packages provided
   - Divisions to set and deliver improvement trajectories on mandatory training specifically in relation to Safeguarding, FGM, Domestic Violence, MCA and DOLS. This will be monitored via Performance Reviews.
   - Review of mental health rooms within ED, undertaking a ligature risk assessment.
   - Establish a standardised process for conducting Harm Reviews and establish a group to oversee outcomes of reviews.
   - Review of procedures for implementing the “5 Steps to Safe Surgery” guidance.

We will know when we have succeeded when we have demonstrated

Outcomes	***Theme Achievement Date**
Compliance with mandatory training standards	**31/03/18**
Positive audit results relating to healthcare records storage, medicines administration and storage, fridge temperature checks and ligature assessments.	
Full compliance with mandatory training with staff able to describe the care needed for vulnerable patient groups.	
All divisions have up to date asset registers and an equipment replacement programme	
A reduction in incidents relating to incorrect storage of medicines	
Regular communication of lessons learnt from incidents relating to medicines	
Patients get the care required through early identification of risk as part of the Harm review process.	
SNAP and Observational audits demonstrate robust hand hygiene and compliance with PPE	
Outbreak RCA's demonstrating effective isolation management.	
Decreasing C.Diff cases and achievement of improvement trajectory	

*** Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Culture and Workforce.	Executive Lead – Chief Executive Officer

What the CQC found

The Executive team at the time were made up of mainly interim executive directors who were not recognisable or visible to staff through the Trust.	Staffing levels within the emergency department were not planned and reviewed in line with national guidance. There were not enough consultants to meet the RCEM recommendations. However, most other areas had adequate staff to ensure patients received safe care and treatment.
There were not effective processes in place to ensure communication was embedded from ward to Board.	Staff did not feel valued or listened to by divisional and executive teams
The trust has poor performance in the NHS Staff survey	Nursing staff competency records in some departments were out of date.
The rates of bullying for both black and minority ethnic and white staff from patients, relatives and the public along with other staff were high and represented a significant risk to patient care.	There was not a Freedom to Speak up Guardian in place.
The Trust staff appraisal rate was below the Trust standard of 90%	

Our plans to improve

1. ***Implement a cultural change programme that embeds signature behaviours and creates a greater sense of accountability within the Trust.*** We will do this through the successful implementation of the following:

- Identification of signature behaviours
- Roll out of the Pulse cultural change programme with surveys of all staff three times a year
- Measurement of net leadership score for Board and Executive three times a year

2 ***Improve the recruitment and retention of our staff.*** We will do this through the successful implementation of the following:

- Development and implementation of a comprehensive recruitment strategy with a particular focus on medical staff recruitment.
- Undertake an overseas recruitment trip to India for medical staff in July.
- Development of a workforce strategy that focusses on retention, leadership development and development of new roles.
- Taking part in the NHSI supported programme for developing the role of Advanced Care Practitioners

- Explore reward and recognition schemes as part of the Pulse programme.
- Undertake 6 monthly staffing reviews in order to ensure the correct skill mix and staffing numbers.
- Working with STP partners in exploring development of roles to work across boundaries and organisations.
- Strengthen the Trust links with Health Education England.
- Strengthen the appraisal process, enhancing the quality of that process, whilst improving compliance across the Trust
- Implement a robust process for clinical supervision; ensuring staff have time to participate.
- Learn from best practice e.g. the Retention Programme at UCLH.
- Divisions to ensure all staff are up to date with their competency frameworks, monitored via Divisional Boards.

3 ***Improve how we engage with our staff to help us to deliver the best possible care to the local population.*** We will do this through the successful implementation of the following:

- Hold staff discussion forums to better understand how we can improve our communications from ward to board.
- Sustain the Senior Nurse profile in all clinical areas to ensure support to frontline staff (in line with Statement of Intent)
- Increase the use of social media to engage with staff.
- Increase Board visibility through leadership walk-abouts
- Employ an independent Freedom to Speak Up champion and ensure systems are embedded that encourage and support staff to raise concerns.
- Review and re-launch the trust Equality and Diversity Group.
- Establish a Workforce Board Committee.

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
Reduction in vacancy rates against 16/17 rates	**31/03/18**
Improvement in turnover rates to bring them in line with the national average	
Improvement in staff FFT and the national staff survey against the 16/17 rates.	
Improvement in net leadership score	

*** Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

Appendix 1 Example of the reporting format

Progress report			
Project Name:		Division or programme:	
Project Manager:		Senior Responsible Owner:	
Report Date:		Reporting month:	
Project purpose and objectives			
[The high level aim/purpose of the project]			
Progress Summary			
Forecast end date:		Status this period:	Green - On plan
Progress statement this period		Future activity information to highlight	
[High level progress statement for this reporting period, aligning to deliverables]		*[Information of note relating to the following reporting period]*	

Milestones / Deliverables				
Milestone or deliverable	Target date	Revised completion date	Status	Comment
			Blue - Fully Complete	
			Blue - Complete but monitoring	
			Green - On plan	
			Amber - At risk	

			Red - Overdue	

Key Risks & Issues		
Risk or Issue	Severity	Mitigation
	High - Entire project at risk	
	Med - Deliverable at risk	
	Low - Minimal impact to project	

Support or decisions to escalate
[Escalations for support requests or decisions to be made]
A metric dashboard with relevant run charts will accompany this for reporting.

Appendix 2 –Initial KPIs

Theme	KPI's						
Deteriorating Patient	HSMR, SHMI, Primary and secondary mortality review compliance	VTE compliance (Oasis only)	Sepsis 6 compliance	Unplanned ITU admission	Unexpected cardiac arrests	NEWS / PEWS compliance, NEWS / PEWS escalation (SNAP)	Escalation of deteriorating patient
Operational Improvement	RTT 18 week, RTT 52 week waiters	Cancer 62 day, Cancer 2ww, Cancer 104 day breaches	Diagnostics	EAS Ambulance Handovers within 30 minutes/1 hour	12 hour breaches	Harm review completion	EDD compliance within 24 hrs.
Governance	Documentation audit questions (TBC by DCNO when review complete)	National audit compliance	Outstanding audit action	Overdue risks, Risks with overdue actions, High / moderate risks with no actions	Overdue policies	Compliance with Fit and Proper Persons Guidance	
Patient Experience & Engagement	Mixed sex breaches	Bed moves between 22:00 - 07:00	Complaints responded within 25 days, Complaints open over 6 months	Inpatient survey (key questions)	Friends and family test score & participation (inpatient, A&E and Maternity)	Compliments	
Safe Care	MRSA Cdiff (SNAP audit) hand hygiene compliance Missed medication	Grade 2, 3 and 4 avoidable pressure ulcers	Medication incidents per 1000 bed days	Falls with serious harm per 10000 bed days	Children safeguarding training,	Adult safeguarding training,	MCA training, DOLs training
Culture & Workforce	Staff turnover (all) Staff turnover (nurses and doctors)	Mandatory training	Net Leadership score (Pulse)	Staff FFT	Length of time from application to appointment	Vacancy Rates	