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Some issues
Not on track

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SUR	Surgical Care
CC	Critical Care
MGY	Maternity & Gynaecology
EoLC	End of Life Care
CHI	Children's Services
TRU	Trust

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SD - Should Do
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		Immediate Actions following announced inspection														
IA001**R**	859	Regulation 18 - Staffing We were concerned to see high staffing vacancies in some areas and the reliance on medical locums and temporary nursing staff to keep services safe. It was noted that in some areas the nurse staffing templates had not been reviewed against increasing patient dependency.	TRU	Both	Workforce Director	Head of OD and Transformation	Workforce team	Continually review medical staffing templates	Oct-17	1. Nurse staffing review paper 2. Workforce Review presentation - CQRM 3. Q&S standard agenda 4. Confirm & Challenge example USCG 5. Business Assurance Framework - 859 6. Trust Board agenda & papers 7. NHSi PRM presentation 8. NHSi action log for telephone discussions	Care groups producing medical workforce plans to be presented at Execs in Sept 17. As at 17/11 Awaiting a date for care group medical directors to present their plans to Execs. PD (on behalf of VM) will ensure CGMD presented to execs on 28th Feb.	Some issues	Safe	Medical staffing	Regulation 18 - staffing	
								Recruitment and retention paper for medics (Inclusion within SSP programme both sites)	Oct-17		The Care groups are working to align recruitment plans to workforce plans and also develop new roles to address shortages. Recruitment remains a particular issue due to local complexities in some areas and national shortages. Plans are aligned to business and financial plans that articulate the needs from now and define 1, 3 and 5 years. To be tabled by HJ at next Agency Task and Finish group, 12th February for updates. Currently preliminary draft workforce strategy being developed. Care group workforce plans aligned to finance in place defining workforce needs and development at 1, 3 and 5 years.					
								Reduction of locum use for medics	Dec-17		All locums are now booked through direct engagement. Locums are specifically covering vacancies and difficult to recruit to posts. Care group workforce plans and associated recruitment plans have outlined more sustainable solutions not withstanding significant medical gaps and hard to recruit to posts. A series of workshops have commenced to gain agreement and timescales for operationalizing the recruitment plans . To be tabled by HJ at next Agency T&F group, 12th February for updates.					
								Continually review nursing staffing data at executive rapid review meetings	Jul-17		Monthly safer staffing paper to Q&S. Six monthly nurse establishment review at board (last undertaken Aug-17/March 18) Roll out of safe care.			Nursing & Midwifery staffing	Regulation 18 - staffing	
								Recruitment and retention paper for nursing	Sep-17		Discussed at Trust board - further discussions to agree long term strategy at execs					
								Strengthen governance and escalation of risk of workforce issues from ward to board	Apr-18		Workforce committee reports risk escalation to board and undertakes a deep dive into care groups at every meeting; workforce issues also discussed at confirm and challenge with each care group monthly. NHSi - Monthly Performance Review Measures (PRM) presentation and regular calls to discuss action logs.					
								Identify long term recruitment and retention strategy	Sep-17		The Care groups are working to align recruitment plans to workforce plans and also develop new roles to address shortages. Recruitment remains a particular issue due to local complexities in some areas and national shortages. Plans are aligned to business and financial plans that articulate the needs from now and define 1, 3 and 5 years. Strategy defined in Workforce presentation.					
								Cease reliance on off framework agency registered nurses and strengthen bank and substantive staff utilisation	Dec-17		Agency T&F group have a comprehensive action plan. NHSI support in place. Tier 5 reliance has stopped and use of tier 1&2. Bank campaign launched. Recruitment process streamlined and TRACS System implemented. Recruitment events for nurses and midwives in place. Deputy Director of Nursing & Quality informed carter group and NHSI that due to the additional number of beds associated with winter pressures and because critical care nurses are only employed via Thornbury, it has been necessary to use some tier 5 for this speciality.					

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IA002R		Regulation 15 - Safety & suitability of premises The mortuary at the Princess Royal site is in a poor state of repair, we found consumables considerably out of date, the department was unsecure (unlocked) and in need of a deep clean.	EoLC	PRH	Finance Director	Director of Clinical Support Services	Pathology Centre Manager	Deep dive of the mortuary at PRH	Dec-16	1. Cleanliness certificate 2. Included in regular cleaning report 3. RSH Mortuary IPC Report Dec 2016 4. PRH Mortuary IPC Report Dec 2016	H&S - Mortuary included in regular audit and cleaning schedule and first one September 17. Next IPC audit Feb-18	Delivered	Safe	Cleanliness, infection control and hygiene	Regulation 15 - safety & suitability of premises	
IA003		The theatre storage facilities at Royal Shrewsbury were also in a poor state. There were no cleaning schedules, and the ceiling had broken or missing tiles and there were stains suggesting water damage. Ceiling tiles were also missing from along the corridor patient pass through on their way to theatre.	SUR	RSH	Finance Director	ACOO for Scheduled Care	HoN Scheduled Care	Deep dive to address actions	Dec-16	1. CQC review during unannounced revisit of area 2. Estates inspection of work	CQC revisited and noted replaced ceiling tiles had water marks on them. See SUR action plan for tx action AA001. Confirmation received from Estates that work complete.	Delivered	Safe	Cleanliness, infection control and hygiene		
IA004	670	The mortuary at the Princess Royal site - A hoist needed to lift deceased patients had been broken since October.	EoLC	PRH	Finance Director	Director of Clinical Support Services	Pathology Centre Manager	Deep dive of the mortuary at PRH	Sep-17	1. CQC review during unannounced revisit of area 2. Visual inspection by Estates	August 2017 - 2 mobile hoists in working order and on a service contract. Currently installing a power point for the overhead lift due to be fitted. January 2018 - Overhead lift fitted but no service contract (Estates have emailed Finance for advice). Outstanding job to touch up mortuary department completed. Service contract and risk register.	Delivered	Safe	Environment & equipment		
		Must do actions														
MD001	561	All patients brought in by ambulance are promptly assessed and triaged by a registered nurse. A suitably qualified member of staff (DR/ANP/RN) triages all patients, face to face, on their arrival in ED.	ED	Both	Deputy COO	Director of Nursing, Midwifery and Quality	Matron	Review process	Oct-17	1. ED recovery presentation 2. Admitted plan 3. Non admitted plan 4. NHSi recommendations	Streaming process now in place on both sites. CCG funded corridor RN until end March 18; Escalation template provides a streaming RN Ambulance H/O trial commenced 11th October, now implemented	On Track to deliver	Safe	Assessing and responding to patient risk		
								Implement changes	Nov-17		1 minute brief to be circulated regarding changes					
								Executives to review and agree process post March 17	Mar-18		CQC Executive briefing paper Feb 18. ED Recover plan supplied by ACOO which was presented March 18. AH will chase for an outcome decision.					
MD002R	859	Regulation 18 - Staffing There are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients. *IA001 addressed the issue of reviewing the templates and initial implementation of Safecare (see action for detail)*	TRU	Both	Director of Nursing, Midwifery and Quality	Deputy Director of Nursing and Quality	HoN's for all Care Groups	Implement Safecare electronic system	Dec-17		Safe care acuity tool is now in use so that part is completed however we still have insufficient nursing staff due to high levels of vacancies and low agency/bank fill rate.	On Track to deliver	Safe	Nursing & Midwifery staffing	Regulation 18 - staffing	
								Following implementation phase robust and effective use of tool	Aug-18		Workforce continue to work with wards to increase % of completed data for wards on census periods and are due to present data at NMF in April to increase engagement/address any training issues. Exploring option to include a Safecare metric on the QI dashboard from April 2018. Care groups have agreed and are committed to additional training schedules for staff.					
MD003R	859	Regulation 18 - Staffing Review its medical staffing to ensure sufficient cover is provided to keep patients safe at all times. IA001 addressed the issue of initially reviewing the templates. This action relates to the ongoing review)	TRU	Both	Workforce Director	Medical Director	Head of OD and Transformation	Review at a granular level within each care group	Mar-18	1. Job planning review complete	Specific work is being undertaken at a granular level in each care group to review the medical workforce requirements across all services- this is being done by the Care Groups, led by the medical directors and work should be reaching fruition in the next week (Sept) to share with the CEO, Execs and the Medical Director. Care group plans will be scrutinised at Confirm and Challenge and the Care Group Boards. E-job planning commissioned as a tool to enable full review of all job plans.	On Track to deliver	Safe	Medical staffing	Regulation 18 - staffing	2
MD004	423	All staff are up to date with mandatory training	TRU	Both	Workforce Director	Head of Education	Head of Education	Revised SSU targets agreed by September 2017 Workforce Committee and Trust Board based on current programmes	Nov-17	1. TB Approval - Minutes 2. Risk Mgmt. Matrix approved by both Committees 3. Confirm and Challenge example	Discussed at February Workforce Committee summary for Trust Board approval on 9th February 2018. *Target approved by Trust Board from 100% to 90% from Mar 2018.* *Deadline revised from Sep-17 to Nov -17*	Some issues	Safe	Competent staff		
								Risk Mgmt. training matrix revised and approved by Education Sub-Committee and Workforce Committee	Jan-18		Revision of Trust Matrix in progress to go to March 2018 Education Committee which is the next meeting (January cancelled due to operational pressures affecting attendance. *Deadline revised from Nov-17 to Jan-18 .*					
								Care Group SSU improvement actions formulated and monitored at Confirm and Challenge	Oct-17		Confirm and Challenge meetings held monthly – ongoing focus on SSU compliance. Copy of USCG template on file which includes SSU					

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								Non-attendance rates (wasted places) at SSU to be recorded by Corporate Education and reported to Care Group HRBPs monthly for follow up with operational Managers with the aim of reducing avoidable wasted places	Nov-17	template 4. Reduction of avoidable non-attendance figures	Monthly report of non-attendance developed and added to November 2017 Workforce Assurance reports. Monitoring of trends commencing.					
								Review feasibility of protection of study leave during peak activity	Oct-17		High activity affecting attendance levels but as training programmes have been reduced to minimum over winter, cancellation of whole courses not an issue. Ward Manager protecting study leave commitments where possible. Confirmation that cop Thorne training centre is no longer at risk. HJ in process of producing a SOP for when cancelling study leave					
MD005R	423	Regulation 11 - Need for consent All staff have an understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments are completed, when required - Mental capacity documentation had not been always completed for defined ceiling of treatment decisions - Nurses understanding of the Act was inconsistent	TRU	Both	Medical Director	Associate Director of Nursing (Quality and Patient Experience)	Medical Director	Formal communication (global email/1 minute brief/message of the week) reminding staff of their requirements relating to mental capacity act	Sep-17	1. Resus lesson plans updated 2. Evidence of review and action in minutes of meetings, one minute brief 3. SC Safer Times Newsletter 4. VMI_Updated EoLC plan 5. Band 6 Masterclass agenda 6. DCT_AND_Audit results_Aug_2017 7. Medical Director Communication 8. DNAR, CPR and MCA training event		Some issues	Effective	Consent, mental capacity act and DoLs	Regulation 11 - Need for consent	
							Patient Safety Advisors	Include a refresh on consent/MCA in FY1/FY2 teaching session by patient safety team	Nov-17		FY1's completed Sep-17; FY2's have DoL's in Nov-17 which covers MCA. TL has done an RCA with emphasis on mental capacity which has been approved. VR is trying to organise the next wave of training for permanent staff with the Trust Solicitors.					
							Lead Nurse for Education and Quality Lead Resuscitation Officer Adult Safeguarding Lead Patient Safety Advisor	Ensure nurses attend various forums: Band 6 Masterclass (oct-17) Stat training (receive update in CPR section regarding DNAR - Sep-17) Shared learning presented at NMF (TL)	Dec-17		Band 6 Masterclass October 17 Resus lesson plans for medical & registered staff updated to include MCA Corporate Education lead to review feasibility of including within 3 yearly update for RN's Patient safety - stand up training completed. We did an RCA with emphasis on mental capacity which has just been approved, so I haven't been able to take it to NMF before now.					
							Patient Safety Advisors	Update doctors at medical/surgical clinical governance meeting on DNR's	Nov-17		Chair of Medical Governance will provide updates - scheduled for Oct/Nov 2017. USCG rescheduled for December CGE due to time constraints. Patient Safety Advisor includes in Safer Times which is circulated to all governance groups in Scheduled Care. *Deadline revised from Nov-17 to Dec-17 (on the agenda for December) 'This was completed on 18/12/2017 when it was presented at the USCG Clinical Governance meeting.'*					
							Associate Director of Nursing (Quality and Patient Experience)	Plan and organise Mental Capacity Study Day 2. seek 50% funding from medics and nursing	Apr-18		CPD event 'DNAR, CPR and MCA' - 29th March open to Doctors and Nurses. Simon Charlton, Consultant @ Browne Jacobson solicitors to deliver					
							Adult Safeguarding Lead	Safeguarding intranet page will signpost to MCA/DoL's app	Dec-17		The apps are now up and running. This includes MCA DoLs and Best interest decisions and consent . The web page has also been updated.					
							Quality Manager	Review RaTE self-assessment question to ascertain knowledge & understanding following training	Sep-17		Question on Mental Capacity reviewed with Lead Nurse					
							Quality Assurance Lead	Check understanding & knowledge as part of Exemplar Programme	Oct-17		Incorporated into the next version update					
							End of Life Co-ordinator	VMI methodology to review EoLC documentation (streamlined)	Feb-18		Workshop has taken place and documentation streamlined and checklist introduced					
							End of Life Co-ordinator	EoLC/Palliative care team to meet with Hospital @ Night team and design a training pack which will include EoLC plan and out of hours support	Jan-18		As at Nov update, EoLC Facilitator is meeting with Hospital @ night team December 2017. Meeting to be re-arranged due to site pressures - see JB. Hospital at Night team under different line Manager - the EoLC facilitator will have to liaise with new matron. JL and EC met with Liam from Capacity re EoL but still need to progress the Hospital at Night due to management change					
							Associate Director of Nursing (Quality and Patient Experience)	Explore/implement blue ribbon initiative	Sep-17		Blue ribbon - do not transfer being explore - Dementia lead nurse leading					
							Clinical Audit Manager	Audit compliance relating to completion of documentation	Sep-17		Audit complete, Lead Resus officer due to present results at CGE Oct-17					

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							Medical Director	Review results of audit at CGE and create appropriate action plan	Dec-17		DCT & AND' Bi-annual audit results presented at CGE which overall shows an improvement on previous. Discussion around using the standardised or SaTH form took place with agreement to discuss at future meeting. SA emailed HV for an update on any further progress/actions. Next audit due to take place Feb 18. Emailed HV response to AH 22/01. Action plan sent to Lead Resuscitation Officer. The agreement of further discussion of the respect documentation is included & monitored on database. Resus team carry out training for completion of the forms- ongoing.					
							Clinical Audit Manager	Audit compliance relating to complete of MCA and DoL's form	May-18							
							Clinical Audit Manager	Strengthen the governance of CGE and Quality & Safety committee to challenge and monitor progress of all the above actions via Trust CQC action plan	Mar-18							
MD006	423	Up to date safety thermometer information is displayed on all wards	TRU	Both	Director of Nursing, Midwifery and Quality	Deputy Director of Nursing and Quality	Quality Assurance Lead	Communicate need for compliance at NMF	Sep-17	1. Improved compliance	Communicated at NMF Sept-17	Some issues	Safe	Incidents		2
								Include additional check within Exemplar	Oct-17		Exemplar v2.4 updated to include Safety Thermometer					
							Quality Manager	Review existing question on RaTE self-assessment to specifically mention safety thermometer	Sep-17							
							Lead Nurse for IPC	Include within IPC Quality Ward Walks (QWW)	Sep-17		QWW include a question to check safety thermometer is being displayed (areas checked 4 times a year/some twice)					
							HoN's for all Care Groups	Matrons perform spot checks and review RaTE information	Dec-17		Communicated at NMF Sept-17 For SC this is complete. DR confirmed this is inconsistent across the Trust. Corporate Nursing working on standardising a peoplelink board with VMI lead (DR/HJ/AH)					
							HoN's for all Care Groups	Act upon results of pharmacy audits and reinforce consequence of non-compliance (ward manager, matrons & governance meetings)	Dec-17		To be included and reviewed as part of HoN preparation for confirm & challenge meetings. Included on NMF agenda Sept-17 W&C - spot checks undertaken TRAKKA cupboards installed & medicines stored appropriately . CQC Exec briefing paper to raise issue Feb 18 - outcome to be included as a standing agenda item for confirm & challenge (AH emailed HJ to include 09/03). Drugs and therapeutics not always well represented by care groups - DF will try and improve attendance 09/03. Development in progress to include as a metric on new QI dashboard.					
								Pharmacy audit action plans in place and monitored	Dec-17		Following CQC Exec briefing paper Feb-18 to be included as a standing agenda item on confirm and challenge					
MD007R	423	Regulation 12 - Safe care and treatment Ensure medicines are securely and appropriately stored at all times (PRH ED 'we saw missed temperature checks of refrigerators used for the storage of temperature sensitive medicines in the resuscitation room' added as a x Trust action)	TRU	Both	Medical Director	Chief Pharmacist/ Care Group Mgr	Operational Head Pharmacist Clinical Pharmacy & Governance	Rolling program for Ward and clinical Areas Storage and Security Audits, established with an extended series on monthly audits concerning the security and storage of medicines.	Sep-17	1. NMF Quarterly Performance Report 2. Q&S Committee Workplan 3. Improved compliance	All results currently being collated and will be provided to Care Group Nursing Teams, Matrons, Ward Managers, Nursing and Midwifery forum and the Patient Safety Team in September 2017 to robustly implement any actions required. Email sent from CA to Matrons requesting that they prioritise this, in turn need to liaise in with new HoN to ensure in place.	Not on track	Safe	Medicines	Regulation 12 - safe care & treatment	
							Operational Head Pharmacist Clinical Pharmacy & Governance	Quarterly updates from pharmacy to NMF regarding issues of compliance scheduled	Sep-17		First presentation by pharmacy Sept-17					
							Ward Managers	Add agenda item to monthly ward meeting template	Sep-17		Updated template, communicated at NMF (Sept) and updated to intranet					
							HoN's for all Care Groups	Review RaTE for medicines management compliance and identify issues	Dec-17		Communicated at NMF Sept-17 On going issues – not completed for SC					
							Quality Assurance Lead	Medicines management - Exemplar Standard	Aug-17		Wards must scores 100% on last quarterly CD audit and Score 100% on at least 1 of the last 3 rolling monthly medicine management audits* with no more than 1 failed question on each of the remaining audits to gain the minimum of Silver award.					

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MD008	423	Medication refrigerator temperatures are recorded daily and appropriate action is taken when temperatures fall outside accepted parameters	MED	RSH	Medical Director	Chief Pharmacist/Care Group Mgr	Pharmacist	All wards and clinical areas storing medicines will be audited to ensure they have suitable equipment, appropriate records and are aware of exception reporting and actions if out of range.	Sep-17	1. Improved compliance	Extended monthly audit program finalised and in place by the end of August 2017. All wards and clinical areas have completed additional audits reviewing both room and fridge temperature monitoring and recording. All results currently being collated and will be provided to Care Group Nursing Teams, Matrons, Ward Managers, Nursing and Midwifery forum and the Patient Safety Team in September 2017 to robustly implement any actions required.	On Track to deliver	Safe	Medicines		
							Pharmacist - VJ	If not in place calibrated dual areas thermometers will be provided, along with register and training information	Oct-17		Thermometers procured and delivered to ward and clinical areas September 17. All areas identified in the audit as requiring calibrated thermometers have been provided them along with recording documentation and escalation guidance. In newly identified areas and areas undergoing a change of use medicine storage will be assessed for suitability by pharmacy and provided thermometers where required					
							Quality Assurance Lead	Question included on RaTE self-assessment & Exemplar	Dec-16							
							HoN's for all Care Groups	Monitor and act upon RaTE results	Nov-17		**USCG** - Daily checks of fridge temperatures to be monitored by matrons. Daily checklist completed by Ward Manager. To check this is completed Dec 2017 Completed for SC					
							HoN's for all Care Groups	Consistent improvement in pharmacy audits from baseline	Jun-18							
MD009R	1134 423	Regulation 12 - Safe care and treatment Relevant learning from incidents is shared across all departments for all its sites	TRU	Both	Director of Nursing, Midwifery and Quality	Associate Director of Nursing (Patient Safety)	Patient Safety Manager	To identify and then implement an effective way of sharing learning from incidents across all staff groups across the Trust (Ward level/Clinical Governance/Care Group and Trust)	Dec-17	1. Rapid review ToR & presentation 2. Rapid Review Sample Agenda 3. Rapid Review Sample Minutes 4. Quality Improvement Report Sample 5. Improved quality of incident reporting and evidence of learning	Review of governance and learning opportunities complete. The process will require Care Groups to ensure that learning from incidents is shared robustly through existing governance processes with all staff and that changes in practice are identified, monitored and measured through audit, patient and family feedback and incident reporting. DR (Associate Director of Patient Safety) signed action off - completed Dec 2017. Rapid review meetings commenced Sep-17 Commenced learning at CGE through the sharing and discussion of an incident that has learning applicable to all care groups and that is presented alongside a complaint that has similar themes	Delivered	Well-Led	Incidents	Regulation 12 - safe care & treatment	
								Draft Quality Strategy in development (Trust paper to outline proposed changes and opportunities for the management of incidents and cascade learning)	Nov-17		Included on Q&S Committee Meeting 23/11/17 then to Trust Board *Wording of action amended and deadline revised from Sep-17 to Nov-17.* *Quality Strategy was reviewed by the Quality and Safety Committee and the Board in November. Following this, the final draft is being prepared for the Q&S Committee in February - outcome further work required Patient Safety Associate Director leading.*					
								Roll out of executive rapid review weekends - All moderate/severe harm incidents (focus on learning/grading/DoC)	Sep-17		First meeting on 08 September. Meetings held weekly					
								Commission bespoke RCA training - external provider	Nov-17		One day Essentials of Effective Investigations 12 October Two day Effective Investigation Workshop 21/22 November Company also happy to provide Exec/Board briefing – date to be confirmed.					
								Quality Performance Report includes themes	Aug-17		The Quality Performance Report has been designed to provide a quarterly thematic review of quality and safety metrics.					
							Patient Access Manager	Publicity in ED & OPD informing staff/patients how to access language services	Dec-17		Outpatient leaflets are currently being designed and these will be sent to Absolute to translate into several languages. This action is linked to the below Update: Leaflets these have not been progressed further and upon discussion we are trying to determine whether we can display patient information in other languages other than English on televisions set with OPD that currently show information on SaTH. We are currently in the process of contacting Provision. Feb 2018 confirmation of contacting Provider required.					2

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MD010	1186	Ensure patient information leaflets can be provided in languages other than English (RSH ED)	TRU	Both	Director of Nursing, Midwifery and Quality	Associate Director of Nursing (Quality and Patient Experience)	Associate Director of Nursing (Quality and Patient Experience)	Communicate, audit and report on outcome (Quality & Safety Committee)	Dec-17	1. Annual report to E&D 2. Six Monthly written report to Q&S	AW has produced an update paper for the Q&S Committee for March 2018.	Some issues	Responsive	Compassionate care		2
							Patient Access Manager	Key information/signage displayed in Polish and review OPD letters to see if a sentence can be provided on how to access alternative languages	Dec-17		Absolute interpreting services to translate main outpatient and inpatient letters into several languages. Request made to PAS team to update system to enable first language to be selected. Once received translated letters will be added to database to enable correct selection. They will also complete a survey to ascertain which are the most common languages used. Booking and scheduling have been informed of changes. Site survey being undertaken by estates regarding appropriate signage needed. Update: A Questions to ask Poster originally on display in OPD has been translated into the top 5 languages spoken at SaTH based upon interpreter usage. Having undertaken a site survey it appears that the universal signage used i.e. toilets, way out are what you would expect to see in other countries are already on display. With regards to the leaflets these have not been progressed further and upon discussion we are trying to determine whether we can display patient information in other languages other than English on televisions set with OPD that currently show information on SaTH. We are currently in the process of contacting Provision. Patient Access are still exploring the possibility of implementing our outpatient letters in other languages.					
							Emergency Centre Manager	Top 10 most frequently used leaflets in ED made available in Polish	Feb-18		Currently in contract negotiations with company (held corporately) and until resolved we are unable to request additional supplies. Director of Corporate Governance liaising with company.					
							Emergency Centre Manager	Ensure ED staff know how to access the SaTH communication handbook (hard copy provided to every department in 2017)	Sep-17		Complete					
MD011	670	Patient medical records are kept secure in all areas at all times (Areas highlighted Surgery RSH & Medicine PRH)	TRU	RSH	Director of Nursing, Midwifery and Quality	Deputy Director of Nursing and Quality	HoN's for all Care Groups	Remind staff about importance of correct storage of medical records	Oct-17	1. IG Audit Results 2. Improvement in compliance	Secure notes trolley in place on Gynae Poster circulated to all care groups to circulate/display within teams	On Track to deliver	Safe	Records		
							Information Governance Manager	IG lead to audit Surgery RSH & Medicine PRH	Mar-18		IG audits due to be complete by end Mar (Medicine - WD6, 7, 9, 15, 16, TAMU; Surgery - WD22, 23, 25, 26, SAU & DSU). Findings to be presented to HoN/NMF - due mid Feb 18. AH offered Jill April/May NMF to present and to confirm which CGE meeting 15/03 *Original date revised from Jan-18 to Mar-18 due to high escalation and site pressures*					
							HoN's for all Care Groups	Review & address any issues highlighted in audit	May-18		*Original date revised from Jan-18 to Mar-18 due to high escalation and site pressures*					
MD012	561	Ensure that it meets the referral to treatment time (RTT) for admitted pathways for surgery	SUR	Both	Chief Operating Officer	Deputy COO	ACOO for Scheduled Care	Action plan to recover	Sep-17	1. Improvement in compliance	Action plan in place which is presented at CQRM Full recovery trajectory in place. Detailed in trust operational plan. Currently on target for delivery at end of September 2017. Caveat to this is a fragile ophthalmology service/workforce. 17/11/17 Assistant Chief Operating Officer confirming this has consistently been delivered since Sep-17 at 93.88%	Delivered	Responsive	Access & flow		
MD013	423	Application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist is improved in theatres	SUR	RSH	Medical Director	Deputy Care Group director	Scheduled Care Group Medical Director	WHO checklist revised to include signature	Sep-17	1. Improvement in compliance	Complete	On Track to deliver	Safe	Assessing and responding to patient risk		
							Scheduled Care Group Medical Director	Record prelist briefings	Sep-17		Complete					
							Scheduled Care Group Medical Director	Rolling programme of Human factor training	Sep-17		Complete					
							Workforce Director	Observational report/recommendations from Human factor training (Trevor Dale)	Mar-18		Internal baseline assessment (not shared widely) of where the organisation is currently against the principles of human factors to help identify how best we allocate resource to HF training - Report due October, position to agree focus November					
							Scheduled Care Group Medical Director	Introduce integrated theatre documentation.	Nov-17		New documentation presented at NMF Oct-17 Confirmation / commencement date 4/12/2017					
MD014	423	Theatre recovery staff have completed advanced life support (ALS) training as per national guidance	SUR	Both	Director of Nursing, Midwifery and Quality	HoN Scheduled Care	Theatres Matron	Trajectory plan to ensure all recovery staff trained to ALS level to enable 1 ALS nurse per shift	Jun-18	1. Increased ALS training	Theatre manager booking staff onto available capacity, limited places. Issues 1. clarity is being sought regarding the actual requirement for every member of staff to be ALS trained as currently the plan is for the team leader to be ALS trained. 2. if every member of staff is required there is a funding issue. Fwd KP response to Lead Resuscitation Officer for comment as DF emailed 02/02 (LW) AH to liaise with Lead Resuscitation Officer & HoN Scheduled Care ?inclusion in exec flash report.	Some issues	Safe	Competent staff		

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MD015	423	Ensure all staff complete accurate paper and electronic records in a timely manner to document patient care and treatment, including early warning scores (PRH - Paper records were not always completed accurately or in a timely manner. Electronic patient information boards were not used consistently by all staff, which meant patients were not always seen in priority order of need)	ED	Both	Medical Director	Assistant COO Unscheduled Care	Emergency Centre Manager	Whiteboard SOP to be signed off by clinical lead and nursing lead	Oct-17	1. Improvement in compliance 2. Audit compliance example	Shared with all current staff and is part of induction for new starters	Some issues	Safe	Assessing and responding to patient risk		
								Audit of documentation at PRH following discussion at clinical governance	Oct-17		Completed – outcome fed back to leads and patient safety lead for Unscheduled Care.					
								Quarterly internal audit to check compliance for both paper and electronic records	Apr-18		ECDS implemented 1st October creating the need to higher level validation of records undertaken on a daily basis which has increased time taken to complete from 1.5 minutes to 6 minutes. Currently takes place via daily checks following the implementation of ECDS on a selection of CAS cards and regular review of electronic information. Will revert to quarterly checks once ECDS has embedded. Electronic patient information board does talk to all systems and an off the shelf ED package required longer term when SSP funding in place.					
								Following ECDS requirements identify support required for clinicians to improve compliance	Apr-18		In process of advertising for 2 x junior admin posts at each site (B4/5) to support clinicians with some of the data entry. Trial to see how effective this will be.					
MD016R		Regulation 15 - Safety & suitability of premises Ensure maintenance and cleaning schedule in place for : - Theatres storeroom - Mortuary	SUR	PRH	Finance Director	ACOO for Scheduled Care	Patient Access Manager	Identify a schedule of cleaning & displayed	Dec-16	1. H&S audit results 2. Matron confirmation of actions 3. RSH Theatres c4c report 4. QWW RSH Theatre recovery 5. QWW PRH Theatre recovery	* R&D responsible for stores; Floors & general environment theatres. Quality checks undertaken weekly - any issues escalated to Head of Procurement. * Cleaning schedule displayed in the sluice in recovery. * Recovery staff have been reminded of the necessity of keeping the bed space trolleys dust-free. * Recovery staff to be vigilant with changing bed space orange bags when two thirds full or containing bodily fluids. * Theatre staff reminded of correct handover and completion of per-operative documentation when inserting catheters.	Delivered	Safe	Cleanliness, infection control and hygiene	Regulation 15 - safety & suitability of premises	
							Theatres Matron/Head Biomed Scientist Cellular Path & Microbiology	Audit programme to monitor performance: IPC/H&S	Oct-17		**IPC Quality Ward Walk** in theatre recovery biannually - PRH July results 71%, theatre manager advised (dust on trolleys/clinical waste bags stored behind bed spaces). IPC revisited Jan 18 - results 71% with same issues highlighted. RSH results Dec 17 88%. **H&S** - 1st Audit carried out Mortuary (Oct) - 69%; Main theatres 57% (Nov). Equivalent to Exemplar Silver, 2nd visit within 3 months and will be arranged in due course. **Theatres** - areas outside the operating theatres are monitored monthly by facilities, this will be increased to bi-monthly from Oct-17 then back to monthly if no concerns as per guidelines. RSH theatres 9 month report to Dec-17 shows an average of 95.90% (target 98%) **Storeroom -** Cleaning schedule completed daily and regular checks are carried out. **Mortuary –** facilities will monitor monthly from Oct-17 then back to monthly if no concerns as per guidelines **Theatre Matron** - checklist set up following CQC inspection in tray room which is checked by theatre manager and will be part of environmental walk round.					
MD017R	670	Regulation 15 - Safety & suitability of premises Ensure equipment in theatres is repaired or replaced as required to ensure it is fit for purpose and keeps people safe	SUR	RSH	Finance Director	ACOO for Scheduled Care	Patient Access Manager	Implement robust process	Jan-17	1. Improvement in compliance	Process in place to report all broken/faulty equipment, add to Datix and Medical Engineering who keep an up to date asset register and RAG rate all assets.	Delivered	Safe	Environment & equipment	Regulation 15 - safety & suitability of premises	
MD018R	423 1204	Regulation 12 - Safe care and treatment Ensure that midwives consistently prescribe medicines given in labour, in line with Nursing and Midwifery Council practice standards. Ludlow MLU specifically	MGY	MLU	Director of Nursing, Midwifery and Quality	Head of Midwifery	Deputy Head of Midwifery	Staff communication on NMC requirements on prescribing medicines in labour	Jan-18	1. Improvement in compliance 2. Evidence of embedded practice	Memo circulated to staff regarding responsibility and accountability in accordance with NMC rules Sept-17	Not on track	Safe	Medicines	Regulation 12 - safe care & treatment	2
							Guidelines Midwife	Reduce number of PGD's (patient group directives) and revert to midwives exemptions (do not require prescribing)	Jan-18		Exemption list identified correlated with PGD reduction. Policy circulated to HoM Directory of Quality Nursing and Midwifery and Pharmacy. (Deadline moved from Nov 2017 - April 2018 due to limited no. of safer medicine committee meetings). Policy complete, however Pharmacy are currently producing self-adhesive sheet which will allow midwifes to dispense med under MW exemptions. PGD's Policy paper presented at PAG meeting Mid Feb 2018.					
							Deputy Head of Midwifery	Midwifery advocates to spot check and action non-compliance with midwives	Apr-18		To commence January 2018 Email sent on 12/01/18 to JO. Follow up sent on 23/01					2

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							Assurance Lead Midwifery	Audit midwives compliance on prescribing and recording medicines in labour (prescription sheet)	Mar-18		Documentation of medicines to be audited. To undertake pilot audit on prescribing and recording meds in labour stand alone MLU deliveries. To be followed by an audit across Consultant led and Midwife led services.					2
MD019	423 1204	Ensure accurate monitoring of the maternity escalation policy for all areas including Wrekin MLU.	MGY	Both	Director of Nursing, Midwifery and Quality	Head of Midwifery	Deputy Head of Midwifery	Escalation process to be reviewed and policy to be updated	Nov-17	1. Improvement in compliance 2. Evidence of embedded practice	(Deadline moved from Nov 2017 - April 2018 due to further, required process changes following RCOG report and action plan - Red Flags) RCOG report received and currently being checked for factual accuracy. Recommendations to be incorporated into escalation policy, therefore, delayed until this is finalised.	Not on track	Safe	Escalation policy		
							Wrekin MLU Midwife	Refine process for recording and monitoring Wrekin midwifery hours when consultant unit busy (initiate full escalation process)	Dec-17		Escalation forms in use					
								Ensure Wrekin MLU use central database for recording	Dec-17		Escalation forms monitored via central database at Maternity Governance					
							Community Midwife	Ensure Labour ward adhere to escalation process	Dec-17		Spot checks by Matron Complete reporting at Maternity Governance					
MD020	1187	Stroke patients did not always receive timely CT scans due to availability and reliability of diagnostic imaging equipment	MED	PRH	Medical Director	Director of Clinical Support Services	Radiology Centre Manager	CT scanner on risk register	Sep-17	1. Reduced downtime 2. Stroke patients reiving timely scans	Monthly review of risk register in place. Gold standard maintenance contract with remote diagnostics in place to ensure maximum uptime	On Track to deliver	Responsive	Service planning and delivery		
								Overarching review of care pathway to streamline and make effective use	Apr-18		The Stroke Radiology pathway was recently review in November 2017 and is now an integral part of the Stroke patient pathway. It is a dedicated operational plan for the stroke service when the CT scanner is non-functional. The pathway is held by the Stroke team as they have the responsibility of implementing it.					
							Assistant Business Manager for Stroke	Progression on west midlands peer review/stroke improvement plan	Apr-18		Stroke Improvement plan action 1.1 - all stroke patients receive a scan within 4 hours (1 hour target) due for delivery Dec-17. Stroke plan update - Business case being developed and SOP to be presented at next CGE Feb (Dec_17 cancelled due to site pressure)					
							Radiology Centre Manager	Plan for capital replacement	Sep-19		Replacement planned for 2019/20. Awaiting update from Radiology Manager.					
							Assistant Business Manager for Stroke Radiology Centre Manager	Business continuity plan in place (Equipment and also Stroke patients)	Oct-17		BCP for equipment in place; GM developing BCP for stroke patients (in place by end Oct-17)					
MD021	670	Ensure they are preventing, detecting and controlling the spread of infections, associated in the mortuary department by ensuring surgical instruments are decontaminated to a high level and there are arrangements in place for regular deep cleaning. Following our inspection the hospital arranged a visit from an infection control lead who recommended a washer disinfector to comply with HSE guidance.	EoLC	Both	Director of Nursing, Midwifery and Quality	Associate Director of Nursing (Patient Safety)	Pathology Centre Manager	Procurement of washer disinfector	Nov-17	1. Draft Business case for washer disinfector 2. Washer disinfector quotation 3. IPC audit 2018 4. Reported at care group board	Post-mortem activity for the Trust was transferred to RSH from October 16th 2017. Our DIPC, PON, has confirmed that a washer-disinfector needs to be installed at RSH, but there is therefore no longer a requirement to install one at PRH. A preferred instrument has been identified, together with the costs for purchasing and installing (circa £9k). 23/1/2018 – SF was advised CPG that it was highly unlikely this item would be approved due to competing high priorities. An alternative source of funding is being sought from the Clinical Support Services contingency fund. 26/01The funding available for this financial year was allocated on 25/1. Funding for the washer/disinfector could not be prioritised above other critically endangered equipment. The next available opportunity to bid for CSS contingency funding is April 2018, assuming the Care Group is allocated a fund. IPC report recommends the purchase and adding to the risk register, emailed Head Biomed Scientist Cellular Path & Microbiology/Pathology Centre Manager to confirm when added or update.	Not on track	Safe	Cleanliness, infection control and hygiene		
								Inspection by IPC team	Jan-18		IPC Consultant Microbiologist /IPC Nurse inspection Feb 2018. Main concerns: * Lack of hand washing facilities * Former viewing/equipment room needs complete review and refurbishment * Adequate washer disinfectant facilities required * Repeated exposure to various chemicals Report to be presented to IPCC March 18. Senior Technician has started work on the action plans. Update anticipated mid April 2018.					
MD022	561	ED meets the Department of Health's target of discharging, admitting or transferring 95% of its patients within four hours of their arrival in the department (Part of Trust operational plan)	ED	Both	Deputy COO	Assistant COO	Emergency Centre Manager ED Operations Manager	Work with Director of Transformation who is leading with ED development. Embed internal actions to improve patient flow: fit2sit/SAFER/bed realignment and frailty	Sep-18	1. RSH Fit2Sit SOP 2. AE Delivery board 3. Weekly Executive meeting 4. Sustainability Programme 5. Trust board minutes 6. Copy of handover process	Introduction of fit2sit, improved ambulance handover process and review of specialty input are all ongoing to help improve patient experience. GP streaming has also now been implemented at PRH since 28th October 17. 25/01 - Director of Transformation has now moved on to another project. Weekly meetings have stopped so will recommence fortnightly meetings and include 95% target as a standard agenda item. Copy of agenda/ToR to be filed as assurance. RSH Fit to Sit SOP filed	On Track to deliver	Responsive	Assessing and responding to patient risk		
MD023	668	Review the arrangements for the care of children in the emergency department to ensure it reflects the Royal College of Paediatrician (RCP) standards	ED	Both	Medical Director	Women's & Children's Care Group Director	Lead Nurse for Women & Children	Review and recommendations to ED to be completed	Sep-17	1. AE Delivery board 2. Weekly Executive meeting 3. Sustainability Programme Trust board	Scheduled to be completed by end of Sept-17. LA requested meeting with HJ - to discuss this action in relation to STP/Future Fit	On Track to deliver	Responsive	Environment & equipment		
								Formulate plan based on recommendations	Dec-17		Formulate plan based on recommendations					
								Ensure RCP standards included within SSP programme	Sep-17		All our new buildings in relation to the SSP will be in accordance to the Department of Health's HTM (Health Technical Memoranda) and HBN (Health Building Notes) HJ to organise meeting with ED consultant, paed matron, lead nurse, and Care Group director. ED ops leads and centre manager to be invited and ED matrons.					

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MD024R	668	Regulation 15 - Safety & suitability of premises Ensure sufficient emergency equipment is available to respond to emergencies ED 'the corridor was not fitted with oxygen or emergency equipment, and we saw ambulance staff using equipment they had brought from their ambulances to monitor patients'	ED	Both	Finance Director	Emergency Centre Manager	HoN Unscheduled Care	Explore options for having an oxygen storage facility near the ED corridor	Oct-17	1. Care group board sign off	Estates/Matron have explored options - mitigation in place includes: Every A&E trolley has a large oxygen cylinder on the trolley which is checked daily **PRH -** Oxygen cylinders are secured to the wall just off the main corridor (where waiting crews are accommodated). **RSH** - There is portable suction in Resus that can be used in the corridor but in the case of a patient deteriorating in the corridor the patient would be moved immediately into Resus. It would cause health and safety and fire issues to store equipment in the corridor. We have portable dynamaps to carry out observations in the corridor.	Delivered	Safe	Environment & equipment	Regulation 15 - safety & suitability of premises	
								Executives to review and sign off action or provide feedback	Feb-18		Overview included in paper to Executives regarding appraisal of risk and mitigation in place. Detailed in CQC Exec briefing paper Feb 18. Outcome approved; awaiting evidence of minutes. AH chasing JC					
								Inclusion within SSP programme	Sep-17		All our new buildings in relation to the SSP will be in accordance to the Department of Health's HTM (Health Technical Memoranda) and HBN (Health Building Notes)					
MD025	1186	Staff have access to a translation service, and that all staff are aware of the service	ED	Both	Director of Nursing, Midwifery and Quality	Associate Director of Nursing (Quality and Patient Experience)	Associate Director of Nursing (Quality and Patient Experience)	Part of actions to address MD010	Dec-17		See MD010	On Track to deliver	Responsive	Compassionate care		
		Should Do Actions														
SD001	423	All staff receive an annual appraisal	TRU	Both	Workforce Director	Care Group Directors	Head of Education	Review practicality of current targets	Sep-17	1. TB Approval - Minutes 2. Evidence of improvement in performance	Discussed at February Workforce Committee summary for Trust Board approval on 9th February 2018	Some issues	Effective	Competent staff		
								Review at board	Nov-17		Paper drafted and submitted to October Workforce Committee and approved for onward transmission to Trust Board on 30/11/2017. It is on the February Workforce Committee summary for Trust Board approval on 9th February 2018. Revised targets approved at Feb Trust Board - 90% effective from 1st March 2018 so will move to back on track in next update. double checking with MB as originally she advised 95% but TB states 90% *Deadline revised from Oct-17 to Nov-17*					
								Raise awareness to all staff of responsibility (1 minute brief)	Nov-17		1 minute brief will be drafted and disseminated following decision at February 2018 Trust Board					
								Monitor through dashboard & education department	Sep-17		Process in place					
SD002	423	Regulation 12 - Safe care and treatment Audits of adult oxygen prescription & administration records are completed	TRU	Both	Medical Director	Chief Pharmacist/ Care Group Mgr	Pharmacists	Formal Communication by Medical Director regarding requirements to prescribe oxygen (Regulation 12). Monthly Audit program to be extended to review adult prescriptions and administration records for Oxygen Therapy, in addition to routine prescribing and record completeness audits.	Mar-18	1. 1 minute brief 2. Improvement in performance	1 minute brief emailed to staff November 2017 In September the pilot audits will be developed for both sites. The pilot audits will commence in October 2017 (respiratory wards) and any deficiencies and resultant actions provided to the Care Group Governance meetings in November/December 2017. Inclusion into Medicines Management audit program across all wards and clinical areas in Quarter 4 2017/18 with any identified training support. Subsequently regularly audited on a rolling basis to assure continuing improvement. Support to be provided by Care Group Governance leads to fully support rapid implementation in response to any deficiencies and resultant action plans . My colleague, Pharmacist, who undertook to collate the audits has provided the attached email to inform on the progress so far undertaken and the results of the audit. The Safe Medication committee received the audit for onward actions, see minutes section 3.7. It was advised to the clinical practice team over the educational aspects which the results seem to suggest needs some work and also that of the Medical leads. The results need to now turn into actions and it is likely those centre around education and raising awareness of Medical gases in particular. It does not yet appear to have to reported back to the CGE as indicated in the discussion with the Medical leads and the Medical Gas committee does not appear to have met actively since either to have this tabled and discussed. AH emailed EB for inclusion on medical gas agenda. 30/01 - Clinical Lead confirmed CGE was cancelled ue to winter pressures but he will email IT to include on next CG agenda. In addition he has arranged a training session for all staff on oxygen prescribing to take place in March 2018. AH to include in exec update paper re poor compliance.	On Track to deliver	Safe	Medicines		
SD003	423	Audits of adult 24-hour fluid balance charts are completed.	TRU	Both	Director of Nursing, Midwifery and Quality	Deputy Director of Nursing and Quality	Lead Nurse for Education and Quality	CPF's & Corporate Nursing team to provide support and guidance to wards	Jan-18	1. Improvement in compliance 2. NMF 3.CGE	In place	On Track to deliver	Safe	Nutrition & hydration		
							Quality Assurance Lead	Include Fluid balance on Masterclass for band 6	Oct-17		Included in October Masterclass					
								Audit of completion of fluid balance charts (clinical audit)	May-18		Included in audit planner for May-18 Need to check with SA if brought forward following HC discussion - Audit looking at Dec-17 charts to establish baseline following CPE/Corporate Nursing support 2017) Jan 18 - Clinical audit to commence the nursing documentation audit, in which we will review December nursing documentation. As we are doing this and Helen has undertaken a lot of teaching with the nurses we are going to audit December 2017 records to see what impact this has had, and what the current position is. Response to be forwarded once complete.					
							Clinical Audit Manager	Review results of audit and any associated action plans	May-18							

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SD004	423	Staff understand their part in responding to a major incident in their area	TRU	Both	Chief Operating Officer	Deputy COO	Emergency Planning and Resilience Officer	Recruit full time Emergency Planning and Resilience Officer (EPRO)	Jul-17	1. EPRO sign off	Fulltime EPRO in post since Jun-17	Some issues	Safe	Major incident awareness and training		
								Undertake live exercise	Jul-18		Scheduled to take place Jul-18					
								Commence table top exercises for all specialities	Dec-17		Process implemented with first exercise due to commence in Dec-17 Email sent on 12/01/18 to SM. '22/01/2018 Several Care Groups have expressed interest however have requested that they be re-contacted once winter pressures begin to subside. USC Matrons did book but was cancelled due to clinical pressures. Paediatric Band 6 incident table-top booked for 14th March. Exercises available short notice if required. ONGOING' - LW chased SM for update 09/03					
								Bespoke EP Awareness sessions to be offered at Ward/Department level	Jan-18		Away days/forums of 1-2 hour duration developed. RSH ED commenced with PRH starting in Dec-17. ED department scheduled to be complete by Jan-18 Email sent on 12/01/18 to SM. 22/01/2018 All ED Q & NQ frontline nursing and HCA staff booked Incident Response training (90% attendance) CSM's PRH completed training and RSH date booked. All Trust on-call Senior Managers and Execs booked onto training (80% attendance so far with additional dates booked Feb '18). Other requests for post winter pressures have declared interest across Care Groups. Action Closed					
								Develop bespoke business continuity plans for each service/ward/department and staff aware of content	Jun-18		Clinical areas will be the priority					
								Incident response folders in place for all ward areas with evidence that staff have read and understood the guidance	Mar-18		In progress. 22/01/2018 Being encouraged via on-call staff to review areas and promote. Full enforcement and implementation will be ongoing with awareness sessions throughout ss18					
SD005	423	Ensure agency staff competencies are monitored or assessed to ensure they were safe to work on the wards	TRU	Both	Director of Nursing, Midwifery and Quality	Deputy Director of Nursing and Quality	Head of Workforce Resourcing & Assurance	Introduce robust process for reviewing competencies on induction	Oct-17	1. Evidence of a 'fit for purpose' contract 2. Improvement in compliance	Proposal presented at NMF Oct-17	On Track to deliver	Safe	Nursing & Midwifery staffing		
								Governance incorporated into agency contracts	Apr-18		Report cards discussed at NMF. As part of VMI recruitment work stream - standardising.					
							HoN's for all Care Groups	Consistent practice of checking agency competencies on arrival to ward	Aug-18		**USCG** - Matrons to check comprehensive records kept					
SD006	423	Consider introducing competency frameworks for nursing staff working in surgical specialisms to ensure they had the right skills. (e.g. urology/vascular)	SUR	Both	Director of Nursing, Midwifery and Quality	Deputy Director of Nursing and Quality	HoN Scheduled Care	Extend work to cover other specialities	Jul-18	1. Improvement in compliance	Ophthalmology, Endoscopy, Tracheostomy in place already. HoN exploring other specialisms that require specific competencies. Mar 18 Matrons are currently working on finalising the competencies within their areas.	On Track to deliver	Safe	Competent staff		
SD007	1186	Wider learning from complaints is promoted as staff did not get to hear about complaints in other areas	TRU	Both	Director of Corporate Governance	Head of PALS & Complaints Associate Director of Nursing (Quality and Patient Experience)	Reps from Care Groups attending CGE	Learning report to be taken to CGE on a regular basis for dissemination amongst care groups	Oct-17	1. CGE Minutes - learning report standard agenda item 2. Yousaidwedid Template Poster 3. Sample Learning presentation 4. NMF sample minutes 5. Evidence disseminated in individual care group meetings	Learning report is now a regular agenda item and has been presented at the September and October meetings. 22/01 emailed JP for a copy of the report or template for assurance evidence	On Track to deliver	Well-Led	Learning from Incidents & Complaints		
							HoN's for all Care Groups	Communication on wards to share information	Jan-18		'You said, we did' posters on some wards. 'Episodes of care' posters used in staff rooms to share experience of an episode of care/patient story. 09/03/18 emailed JP for a copy and to check she is happy for this to now be closed					
						Care Group Directors	Head of PALS & Complaints	Reports at Care Group Board meetings and Governance Meetings to include details of learning	Oct-17		Reports to Care Board meetings now include details of learning. All learning from incidents & complaints in Women & Children's Care Group presented to Governance meetings & Care Group Board on a monthly basis.					
						Associate Director of Nursing (Quality and Patient Experience)	Head of PALS & Complaints	Develop closer links with Patient Safety team for triangulation of data and sharing of joint learning	Mar-18		Work has commenced through reporting at CGE and weekly rapid review meetings. Following meetings SCG share with all matrons and learning is taken through to CGE, NMF and Q&S committee.					
						Associate Director of Nursing (Quality and Patient Experience)	Care Group Directors	Patient stories to be shared and discussed at the start of each Care Group Board Meeting	Dec-17		Patient stories shared at NMF Scheduled Care to start using patient stories in November, standard agenda item on care group board from Feb 18 Women and Children's to start from January 18. SC have shared patient stories to date at CGE and NMF. LW requested agenda/minutes of USCG care group meetings to add as assurance 15/03 LA & NE					
SD008R		Regulation 12 - Safe care and treatment Provide signage on the store room door containing portable Entonox to inform people that compressed gases are stored there.	MGY	Both	Finance Director	Associate Director of Estates	Deputy Head of Midwifery	Ensure signage on room doors where Entonox cylinders stored Compliance to be monitored via Health & Safety Audit	Sep-17	1. Observational check	Areas have temporary laminated signs to denote gas storage. Permanent signs to comply with HTM have been ordered Emails sent to ward managers asking them to identify if any other areas that require signage stickers H&S audit updated to include question to check appropriate signage in place	Delivered	Safe	Environment & equipment		
SD009	423	Any changes to medications are signed for appropriately	TRU	Both	Medical Director	Chief Pharmacist/ Care Group Mgr	Pharmacy	Monthly Audit program to be extended to review prescriptions and administration records to verify any changes are signed appropriately.	Mar-18	1. Improvement in compliance	The pilot audits will be developed for both sites. The pilot audits will commence in November 2017 and any deficiencies and resultant actions provided to the Care Group Governance meetings in January/February 2017. Inclusion into Medicines Management audit program across all wards and clinical areas in Quarter 4 2017/18 with any identified training support. Subsequently regularly audited on a rolling basis to assure continuing improvement. AH included poor compliance in exec paper requesting robust governance.	On Track to deliver	Safe	Medicines		
								Review the Trust Prescription Writing Standards to consider emphasising the importance of recording and signing any change in prescriptions (increase awareness/compliance)	Mar-18		An initial review of the Trust Prescription Writing Standards is complete, no changes were required at this time. This was discussed at the Trust Safe Medication Practice Group. A further review is due in March 18 which will take into account the findings and actions from the pilot audits. *Deadline revised from Sep-17 to Mar-18*					
SD010	1204	Consider using the maternity specific safety thermometer to	MGY	Both	Director of Nursing,	Head of Midwifery	Quality Assurance Lead	Working party to scope implementation and project plan	Dec-17	1. Audit in place	Implementation methods in consideration. Working party reviewed RaTE and decided to access tool directly with the Safety thermometer web site All metrics with the exception of 3 are currently collected elsewhere.	Some issues	Safe	Incidents		
							Deputy Head of Midwifery	Implement process and verification of data	Jan-18		No not applicable as will access tool on website					

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No	BAF	Recommendation	Core Service	Site	Exec Sponsor	Responsible Lead	Implementer	Agreed actions	Deadline	Assurance required, embedded and tested	This month's progress against timescale	Status	Domains	Themes	Compliance Action	Escalation Process
	423	measure compliance with safe quality care			Midwifery and Quality		Quality Manager	Train staff and promote awareness	Feb-18		HJ emailed SJ for update regarding verification of data process. SJ confirmed that AGP is leading on this. AH emailed AGP 30/1/18 for an update.					
							Head of Midwifery	Maternity governance to review outcomes and formulate actions to address deficits	Apr-18							
SD011	1204 423	Ensure access to Woman's notes when women arrive at the MLU in labour so that staff have relevant information about the woman.	MGY	Both	Director of Nursing, Midwifery and Quality	Head of Midwifery	Deputy Head of Midwifery	Prompt on Medway (at completion of delivery records)	Oct-17	1. Monitor Dashboard	Prompt on Medway (at completion of delivery records)	On Track to deliver	Safe	Records		
								Memo to remind staff to complete a Datix if notes unavailable at time of delivery	Oct-17		Memo to staff to be sent					
								Add bookings of women without notes to the dashboard	Apr-18		Discussions with Data Analyst to add this metric to dashboard - planned for April 2018					
SD012	1186	Ensure dying patients and their families are asked about their preferred place of death and that their wishes are recorded.	EoLC	Both	Director of Nursing, Midwifery and Quality	Associate Director of Nursing (Quality and Patient Experience)	Associate Director of Nursing (Quality and Patient Experience)	Progression against National End of Life national audit and delivery	Dec-19	1. Monthly written CGE report 2. Quarterly written report to Q&S 3. Improvement in performance on national audit 4. Palliative care recorded on Somerset 5. Palliative Care SaTH internet page 6. FY1/FY2 teaching presentation	Not appropriate to include on fast track checklist, included on EoLC input form. EoLC team have started documenting PPC in the notes when they have the conversation. No date as yet for the national EOLC audit. This is beyond our control. Change date to Dec 2019	On Track to deliver	Effective	Compassionate care		
							End of Life Co-ordinator	EoLC input form to include Preferred Place of Care (at end of life)	Aug-17		Palliative care on Somerset register PDD EoLC plan checklist developed which asks staff to consider PPC (18/10). 16/3/18 in place					
							End of Life Co-ordinator	More training on EoLC plan as questions about preferred place are already included	Nov-17		18/10 Documentation workshop. Plan redesigned and checklist created involved a workshop & a small trial of a new EOLC Plan a working document that is in progress & should be ready to roll out in March 18					
							Lead Palliative Care Consultant	Raise awareness foundation 1&2	Mar-19		FY1 awareness training delivered Feb; FY2 scheduled for March. 2 hour session to include recognising dying, symptoms at end of life, role of the Dr, DNACPR discussions, EoLC plan, Hospice Care, Pain Control in Palliative Care					
							Associate Director of Nursing (Quality and Patient Experience)	Raise profile of what matters to me @ NMF	Oct-17		Presented at NMF Oct-17					
							End of Life Co-ordinator	1 minute briefs/chatterbox/screensaver	Jan-18		Email sent on 12/01/18 to JL &EC. LW chased EC 30/01. 16/3 JL conf in chatterbox regularly and EC still to update against her actions					
							End of Life Co-ordinator	Masterclass briefings	Oct-17							
							End of Life Co-ordinator	intranet page reviewed - palliative/EoLC	Jan-18		Palliative care intranet page developed and live - Feb 2018 now in place					
							Lead Palliative Care Consultant	change audit proforma	Jan-18		SaTH specific EOLC audit proforma changes in progress. I had hoped to combine some of the questions from the national audit but that will not be possible now. The audit will not be done until JW's return from leave. Likely march.					
							Clinical Audit Manager	Re-Audit of documentation	Feb-18		Likely march.					
							End of Life Co-ordinator	Review provision of information regarding home care and increase awareness	Nov-17		The EOLC Team record PPC on our input records and in notes. PCT also say they record.					
SD013	423	Risks in relation to EoLC are recorded on the risk register	EoLC	Both	Director of Nursing, Midwifery and Quality	Associate Director of Nursing (Quality and Patient Experience)	Head Biomed Scientist Cellular Path & Microbiology	Mortuary/EoLC to review current issues and identify any risk which require escalation to risk register	Sep-17	1. Up to date risks in place	Manual handling of bodies (Ref 1119) included regarding transfer of services to RSH	Delivered	Well-Led	Governance, risk management & quality improvement		
							End of Life Co-ordinator	EoLC to review current issues and identify any risk which require escalation to risk register	Sep-17		EoLC Service (Ref 1270) added to register CQC report identified lack of palliative care consultant at time of inspection but this has since been part resolved with recruitment of part time palliative care consultant, gap at consultant level is now on the risk register					
SD014	668	Hand washing facilities are available in the emergency department's corridor, to prevent patients; dignity being compromised when staff use hand basins in nearby cubicles	ED	Both	Director of Nursing, Midwifery and Quality	HoN Unscheduled Care	Lead Nurse for IPC	Ensure added to risk register	Oct-17	1. IPC audit/observations 2. Reduction in risk score on risk register	IPC have reviewed and a sink not required due to change in process	On Track to deliver	Safe	Cleanliness, infection control and hygiene		
								Consult and review the need for portable sinks	Feb-18		RSH - Estates confirm no space for a permanent HWB and IPC confirm legionella risk associated with portable sinks. RSH have reorganised the area and introduced a fit to sit assessment area which have sinks. PRH Estates are exploring option of installing in main corridor (VR to raise this with DC - LW chased for update 09/03) *Deadline date changed from Nov-17 to Feb-18 in line with when introduction of new CDU at PRH* 19/03 VR email querying - passed all info to AH/HJ to see if we should discuss with CQC Inspector					
								Inclusion within SSP programme	Sep-17		All our new buildings in relation to the SSP will be in accordance to the Department of Health's HTM (Health Technical Memoranda) and HBN (Health Building Notes)					
SD015	670	Review the exterior lighting and signage at ED to ensure members of the public are directed to the correct entrance.	ED	RSH	Finance Director	Assistant COO	Emergency Centre Manager	Patient journey to be walked through to identify areas of improvement	Oct-17		Session to be arranged (Ops & Ward Manager). Update 17/11 Following a further review with POWYS further review is required right up to the mini island at RSH, still outstanding. However, ELCLIP project report January 18 has highlighted issues with lighting/signage, to be followed up with an NHSi visit in March 18, report due April. GM also confirmed funds have been allocated to start works on improving the lighting - update April Estates are able to provide costings but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017).	On Track to deliver	Safe	Environment & equipment		
								Act on recommendations from patient journey and further review	Dec-18		22/01 - Results of ELCLIP report to be discussed with ED dept leads January 2018					
SD016	668	Access to the emergency department children's waiting area	ED	RSH	Finance Director	Women's & Children's Care	Security Manager	Security Manager to scope requirements/costs	Sep-17	1. Risk assessment	SD016/17 combined - potential costs in excess of £5k. Review recommends key padded locks in place of 'press to exit', timer programmes, doors locked during quieter periods 11pm-1am, relocating relatives room. Estates are able to provide costings to fit permanent HWB but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017). 17/11 New action carried forward for business case.	On Track to	Safe	Environment &		

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SD016	668	is controlled	ED	RSH	Finance Director	Children's Care Group Director	Security Manager	Review recommendations and agree plan	Apr-18		Associate Director of Estates confirms if work to go ahead paper/business case required to Capital Planning. Action taken to Executives for feedback on whether a business case should be progressed for funding or accept the risk and include in the SSP programme. Paper to Executives Jan/Feb which provides update of costs and risk appraisal. CQC Exec briefing report Feb - Execs approved funding - Associate Director of Estates meeting 15/03/17 with JS/DT	On Track to deliver	Safe	Environment & equipment		
SD017	668	Review the security of access from the public waiting area into the resuscitation, majors and minors patient treatment areas to ensure staff and patients are protected from avoidable harm.	ED	RSH	Finance Director	Associate Director of Estates	Security Manager	Security Manager to scope requirements/costs	Sep-17	1. Risk assessment	SD016/17 combined - potential costs in excess of £5k. Review recommends installation of opaque (safety) glass panel and key padded locks. Requires further discussion with wider team around any new risks introduced from potential changes and identify funding for any agreed changes. Estates are able to provide costings to fit permanent HWB but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017). CQC Exec briefing report Feb - Execs approved funding - Associate Director of Estates meeting 15/03/17 with JS/DT	On Track to deliver	Safe	Environment & equipment		
								Review recommendations and agree plan	Apr-18		As SD016					