Hampshire Hospitals
NHS Foundation Trust

Committee:	Health and Adult Social Services (Overview and Scrutiny) Committee
Date:	08.02.19
Title:	Hampshire Hospitals NHS Foundation Trust :CQC Trust Wide Action Plan
Report From:	Julie Dawes, Chief Nurse

Contact name: Hilary Todd Clinical Governance Manager Email: Hilary.todd@hhft.nhs.uk

Executive Summary

The Trust Wide action plan is monitored on a weekly basis by the Chief Nurse and monthly by the Executive Team at the Executive Oversight Meeting. This is very much a working document with the Divisional Chief Nurses (DCNs) reporting each week on actions that have been completed, those in progress and actions being taken to address any overdue or at risk actions.

The following actions have been competed:

- Approval of the Mixed Sex Accomodation and the Data Security and Protection Policy
- 80% of Wards have submitted an initial ward improvement plan to the Chief Nurse
- The annual safe storage of medicines audit was completed for all wards
- The Trust Safety Instruction supporting ligature risk assessments was completed and circulated to all areas for them to complete.
- The Divisions have achieved the Trusts standard of 80% of staff completing mandatory training.

A number of Issues are currently overdue but all have actions to ensure that progress is being made and assurance been given to the Chief Nurse. It should be noted that a single requirement may have a number of red actions associated with it as it could affect each of the three Divisions.

A CQC Dashboard continues to be developed and it is being used to monitor areas of improvement and those areas that need more attention from the DCNs.

Indicators that have improved this quarter

- Number of overdue risks to be reviewed has reduced from 125 to 38
- News2 compliance has improved to 88.8% from a low of 68%
- Pressure Ulcer Assessments have improved from 59.1%% to 92.6%
- Number of incidents open past 25 days has improved from a high of 1498 to 742 (approximate 50% reduction)
- Dementia awareness training has risen from 66.4% to 81%
- BLS Training has improved from 68% to 76% - although this is still below the 80% Trust standard
- Appraisal rates have improved from 66% to 73% - although this is still below the 95% Trust standard.

Indicators that are being monitored and managed by the DCN include:

- Reduction in compliance of fridge audits- although this is now a more accurate reflection of checks being undertaken and is improving
- Compliance with hand hygiene audits.

The dashboard is shared with the DCNs and can be broken down to divisional level. The themes of the 'red' actions are:

<u>Equipment maintenance</u>

The Trust has recognised the issues with the labelling and maintenance of equipment and the issue is being overseen by the Director of Finance. A standard approach has now been adopted and a single label identifying the date for the next action (being it servicing or insurance) is now in place. There have been significant additions to the Equipment Team on both sites, and a new post created specifically for the maintenance of mattresses and pumps. The team has secured external support and have the company will be supplying additional engineers into the Trust support for a month to assess whether or not it will make a significant difference. If it does, the trial period may be extended taking into account the significant expense. A coordinated programme of sink replacement in theatres has been agreed taking into account availability and theatre closedown. The programme will commence 1st Feb and should be completed by the of March 2019.

<u>Environmental Cleanliness</u>

The Board regularly receives updates on cleaning audits and compliance, however following the Peer Reviews where a small number of issues were noted the cleaning and the content of the cleaning audits being revisited to ensure that the Board assurance is valid.

<u>Appraisal rates</u>

The Chief Nurse set a challenging target of 95% of staff having an appraisal by 31st December 2018, the rate has significantly improved it has not met the Trust target, however all Divisions have confirmed this will be met by the end of March 2019.

<u>Closing of Low/No harm incidents</u>

Again the Chief Nurse set a challenging target and the number of incidents open past 25 days has improved from a high of 1498 to 742 (approximate 50% reduction). The Divisions have confirmed that further reductions will be made by the end of March 2019.

<u>Mental Health Act Training</u>
Discussions within the Trust are ongoing and the work is being developed with Southern Health colleagues.

The action plan has been further developed to add outcomes and identify expected evidence.

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Hampshire Hospitals NHS Foundation Trust

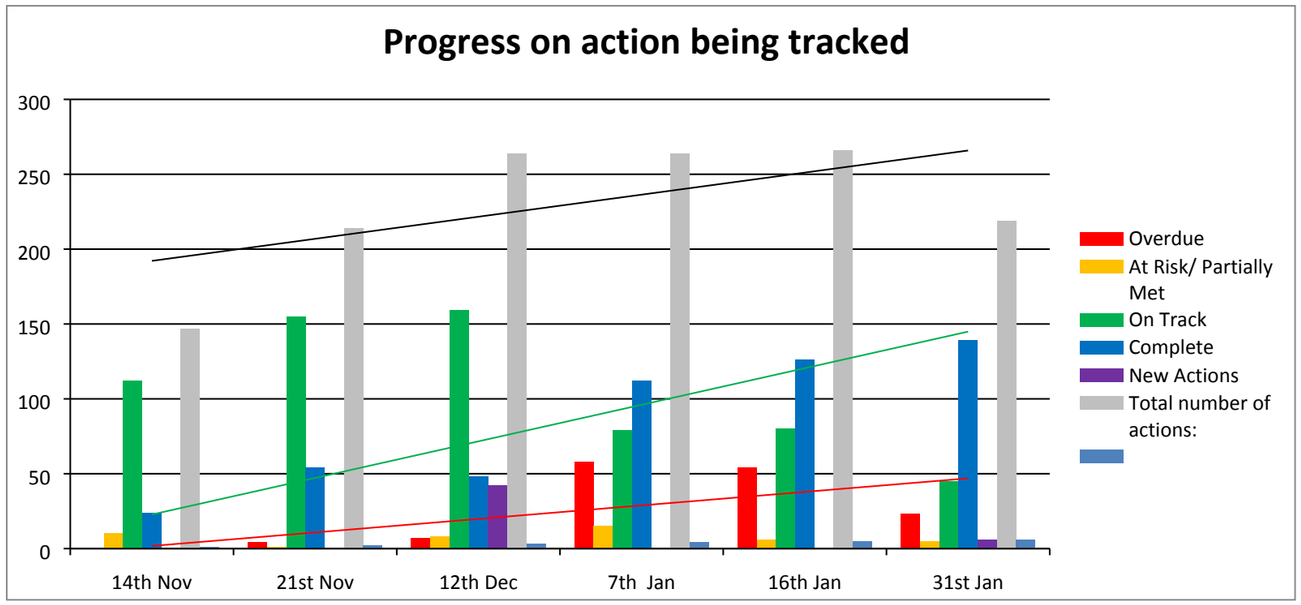
PROGRESS

	14th Nov	21st Nov	12th Dec	7th Jan	16th Jan	31st Jan
Overdue	0	4	7	58	54	23
At Risk/ Partially Met	10	1	8	15	6	5
On Track	112	155	159	79	80	45
Complete	24	54	48	112	126	139
New Actions			42	0	0	6
Total number of actions:	**147**	**214**	264	264	266	219

31st January 2019

Action Plan Baseline revisited with Chief Nurse.

- Outcome and expected evidence added
- Due dates revisited in light of actions taken
- At Risk actions now include Partially Met
- Executive Well Led actions and Use of Resources actions are identified for reference but not included in the count



SAFE			
Requirements - Unscheduled and Emergency Care	**Source**	**Status**	**Outcomes / Process/ Evidence**
1.1. The trust must ensure that there is an effective system in place to assess and monitor the ongoing care and treatment to patients whilst in the emergency department. This includes, but is not exclusive to, the monitoring of pain administration of medicines, tissue viability assessments, nutrition and hydration, falls and early warning scores with regular ongoing monitoring.	U&EC MUST DO S31 29A, R12 2015 report(S)		**Outcomes:** • **95 % Compliance rate in ED Checklist** • **PAUs are open on both sites** • **95% compliance rate in NEWS /PEWS** • **95% compliance in pain assessments where appropriate** • **80% of staff PILS/Paed Aims trained** • **90% of stable workforce to be APLS trained** **Process:** • **Management of Children SOP** • **ED Full Protocol** • **ED Improvement Plan**
1.2 The trust must ensure the environment in the emergency department accommodates the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2012).	U&EC MUST DO S31 29A, R12		
1.3. The trust must ensure an appropriate early warning scoring system is consistently used during the initial assessment process and during the ongoing monitoring of children and adults attending the emergency department for care and treatment	U&EC MUST DO S31. 29A, R12		**EVIDENCE** 1. **Weekly reports as part of S31 Action Plan** 2. **Audits of ED Safety Check list use** 3. **DPR and Divisional Governance Meeting including M&M meetings (2 weekly)** 4. **Safe Staffing reports**

1.4 The trust must ensure pain assessments are routinely carried out in the emergency department in line with the Royal College of Emergency Medicine guidelines for both adults and children.	U&EC S31		**5. Vacancy rates in ED (CQC Dashboard)** **6. Audit R results** **7. Peer Review reports – to include spot check on conditions**

Ref	Action	Who	Due	Update	Status
Cond 1	Establish criteria for eligible staff to have triage training: 12 months experience and competent in all aspects of acute care	HoUC	09/08/18	**08/11/18** Criteria established and applied	Complete
	Manchester triage tool training completed.	HoUC	30/08/18	**08/11/18** There are sufficient numbers of staff trained to ensure rotas are covered on both sites. However, we plan to increase the number of staff trained at BNHH to achieve the 90% target. The next available training date to achieve this is on 4 November.	Complete
	Streaming training day for those not yet completed 9/56 staff	HoUC	08/12/18	**08/11/18** The next training day is 8th December	Complete
	New SOP implemented for triage of children	HoUC	09/08/18	**08/11/18** SOP implemented	Complete
	Audit of paediatric screening compliance (against SOP above)	HoUC	31/12/18	**08/11/18** Weekly audits are ongoing - this includes routine pain assessments for children 09/01/19 the new audit of the ED checklist includes pain assessments	Complete
	Streaming flowchart and triage process on display	HoUC	09/08/18	**08/11/18** Flowchart and process on display	Complete
	Implement Bristol Shine Tool:	HoUC	02/11/18	**08/11/18** HHFT ED safety checklist is a locally adapted version, which is in use. This has been mapped against the Bristol Shine Tool, and is being used in the department.	Complete
	Monitor paediatric patient harms and sharing lessons learned (DATIX) within ED M&M meetings.	HoUC	09/08/18	**08/11/18** All incidents are currently under review by the ED governance lead and Divisional governance team to ensure actions are taken and any identified learning can be shared. 31/12/18 Incidents are now shared at M&M meetings	Complete
	CCG assurance visits (first visit 8 Aug)	HoUC	09/08/18	**08/11/18** Visit completed, but CCG to be involved in peer review process	Complete
	Responses to NHS Choices and patient feedback to be acted upon	HoUC	09/08/18	**09/01/19** Patient feedback is displayed in the EDs and discussed at Comms Cell/ Stand up for Standards as well as discussed in Governance Meetings	Complete
	NEWS training ongoing, with planned Trust-wide implantation of NEWS2 by the 1st October 2018	HoUC	01/10/18	**08/11/18** NEWS 2 implemented	Complete
Cond 2	Rota planned 6 weeks in advance	HoUC	31/12/18	**08/11/18** Following a change of process, all shifts have identified paediatric competent, nursing staff on duty. A spot check audit on 8th November confirmed paediatric trained staff were on duty. The Department has reviewed the forecasted rota for the coming six weeks and an identified, paediatric competent member of the nursing staff is on duty at all times **08/11/18** This condition has been met consistently over the last 16 weeks and there is evidence on the rota for the next 12 weeks that this condition is being met on every shift. This will continue to be reported until it has been signed off by the Trust board as a completed action **03.01.19** this was validated on Peer Review visits	Complete
	Procedure for filling unfiled shifts with paediatric trained staff	HoUC	31/12/18	**08/11/18** This condition has been met consistently over the last 16 weeks and there is evidence on the rota for the next 12 weeks that this condition is being met on every shift. This will continue to be reported until it has been signed off by the Trust board as a completed action **03.01.19** this was validated on Peer Review visits	Complete
	Named ENP to be identified each shift responsible for monitoring and addressing concerns (green dot)	HoUC	31/12/18	**08/11/18** This condition has been met consistently over the last 16 weeks and there is evidence on the rota for the next 12 weeks that this condition is being met on every shift. This will continue to be reported until it has been signed off by the Trust board as a completed action	Complete

				03.01.19 this was validated on Peer Review visits		
Cond 3	Provide a suitable paediatric awaiting area and ensure that all parents are offered the option to wait there	HoUC	18/01/19 31/03/19	BNHH	**08/11/18** An interim arrangement was immediately put in place. A permanent solution will be in place by mid Jan 2019 **09/01/19** The PAU is due to open mid Feb	On track
				RHCH	**16/11/18** Spot checked indicated not all parents had been offered the option to wait in the appropriate area. DDN will complete a further spot check **21/11/18** DDN and HoUC have confirmed that staff understand and aware of the requirement to advise parents that there is a waiting area for them. It has been acknowledged that at the moment parent may not choose to utilise the current waiting area but once the new PAU is complete, all parents will be sent there **09/01/19** The PAU is due to open end March	On Track
	Named ENP to be identified each shift responsible for monitoring and addressing concerns (green dot)	HoUC	09/08/18	**08/11/18** Green dot in place		Complete
	Nurse training matrix and gap analysis undertaken	HoUC	09/08/18	**08/11/18** Gap analysis completed		Complete
	80% of Nursing staff to complete PILS or Paeds Aims training	HoUC	31/12/18	**08/11/18** 88% of staff trained at BNHH, 76% trained in RHCH (82% over both sites)		Complete
	Protocol for access to play therapists in place	HoUC	09/08/18	**08/11/18** Protocol in place		Complete
	Hourly rounding introduced for paediatrics	HoUC	09/08/18	**08/11/18** Hourly rounding in place and part of weekly audit		Complete
	Post event debriefs for all paediatric arrests	HoUC	09/08/18	**08/11/18** No arrests have occurred **03.01.19** this was validated on Peer Review visits, all arrests will be discussed at M&M meetings		Complete
	Trust trauma committee to review all Paediatric trauma cases attending ED (BNHH)	HoUC	09/08/18	**08/11/18** These actions will be on going until embedded in new governance arrangements **03.01.19** this was validated on Peer Review visits, all trauma calls will be discussed at M&M meetings		Complete
	ED Paediatric M&M quarterly.	HoUC	18/09/18	**08/11/18** These actions will be on going until embedded in new are now in place		Complete
	Shared learning for deteriorating paediatric patients	HoUC	09/08/18	**08/11/18** These actions will be on going until embedded in new governance arrangements **03.01.19** this was validated on Peer Review visits, deteriorating paediatric patients will be discussed at M&M meetings		Complete
Cond 4	Medical rota has been managed to ensure that there is at least 1 APLS trained member of staff on each shift.	HoUC	31/12/18	**08/11/18** 81% of medical staff is currently APLS trained. This is sufficient to ensure there is always an APLS training member of staff on duty. 16% of medical staff have been booked on their APLS training. The 3% is currently non-clinical. However we are aiming to increase this to over 90% of the medical staff by the end of December 2017. 06/01/19 this has been achieved and validated during the peer reviews		Complete
	SOP to manage events if no APLS trained individual on shift in place.	HoUC	09/08/18	**08/11/18** SOP in place		Complete
	90% of stable medical workforce to have APLS training	HoUC	31/12/18	**08/11/18** SOP in place		Complete
Cond 5	Review of rotas to ensure nursing provision on each shift (day before review)	HoUC	09/08/18	**08/11/18** Review is in place		Complete
	Ongoing recruitment to support workforce requirements	HoUC	09/08/18	**08/11/18** Recruitment activity is on going and is part of the weekly report		Complete
	Development of the ED Full protocol;	HoUC	12/11/18	**08/11/18** The task and finish group led by an ED Consultant continue to meet. Medical Director has taken on responsibility for completing this protocol and Trust response to ED escalation. This development work continues with engagement from other divisions within the hospital and outside providers to ensure a system approach to supporting ED pressures. The physicians and Directors of the Day are currently in progress of testing the methodology of the protocol for launch Trust wide on 12 November **21/11/18** ED Full Protocol launched, A subsequent action will be identified to monitor the efficacy of the protocol and its impact on patient flow		Complete

	Board rounds to monitor staffing allocation three times a day	HoUC	09/08/18	**08/11/18** Board rounds are in place	Complete
	Staffing escalation protocol; Director of the Day	HoUC	12/11/18	**08/11/18** Escalation process is in place	Complete
	A review of the nursing staffing levels to be undertaken using the ECIST model	DDN/HoUC	31.12.18	**07/01/19** Information from RBH and ECIS has been used to model the staffing requirements	Complete
1.3	A target for PEWs compliance will be set, and an action plan put in pace to monitor compliance	HoUC	24/10/18	**17/10/18:** Sepsis and PEWs assessments are part of the triage of children and paediatric screening process that is part of the compliance audit every week	Complete
1.4	Review pain assessment within HHFT ED safety checklist to ensure compliance with Royal College of Emergency Medicine guidelines	HoUC	24/10/18	**17/10/18:** The pain assessment in use is in line with RCEM guidelines which has been confirmed by the DMD M	Complete
1.4	Produce an overarching operational policy for the management for Children in ED (BHHT/WHCH)	HoUC	31/10/18	**17/10/18:** The operational policy has been developed to take into account the temporary arrangements that are in place until the redevelopments of the EDs are completed. The paediatric admission booklet provides advice and guidance to staff on the management of children. 07/11/18 The operational policy will be amended to reflect the re-development which is due for completion mid Jan 19	Complete
1.1/.4	An ED improvement plan is developed to reflect on the findings in the reports and address all the issues	OD M	29/11/18	**17/10/18:** A draft Improvement Plan has been developed and will be signed off by the Executive Team, OD M and DMD M. This is being presented to the Executive Team on the 25/10/18 **06/11/18** : Plan is due to be presented to the Executive Team on 29th Nov - complete	Complete
All	All the actions will be reviewed and assured via the Peer Review Process – Review to include CCG / RBH/QGM/DDN	CNO	14/12/18	**07/11/18:** DDN to consider most appropriate time for visit and confirm with CNO **21/11/18** Peer review planed for 30th November in BNHH **03/01/19** Peer Reviews have taken place across both sites	Complete

Evidence Notes:

- At the point that the s31 is lifted outcomes and evidence will need to be reviewed
- Outcomes and evidence to be amended in light of ED Improve plan and to reflect actions from there.

Requirement – Medicine Management	**Source**	**Status**	**Outcomes/Process/Evidence**
2.1 The proper and safe management of medicines at all times.	MED /SURG MUST DO S29A R12 2015 report		**Outcomes:** • **Medicine management incidents (CQC Dashboard)** • **90% compliance with fridge monitoring audits** • 100% of safe storage of medicines audits **completed** • **reduction in incidents relating to poor pharmacy support that have caused harm** • Trends in Datix resulting from CD audits to be reviewed by MERG and Divisional Governance Boards **Process:** • **Revised Medicines Policy** • **Process/guidance for the storage, checking and disposing of medicines**
2.2 There are effective medicines management arrangements in place to store administer and dispose of medicines.	MED /SURG MUST DO S29A R12 2015 report		
2.3 The trust must ensure medicines are stored in line with national requirements	MED /SURG MUST DO S29A R12 2015 report		**EVIDENCE** **1. DPR and Divisional Governance Meeting minutes** **2. Number of medication incidents** **3. Compliance with fridge monitoring standards** **4. Annual safe storage of medicines audit report** **5. Any failure in CD Audits to be reported to Division**
2.4. Staff have sufficient access to pharmacy support	MED /SURG		

				MUST DO S29A R12 2015 report		**and Medicines Event Review Group (MERG)** **6. Medicines Event Review Group minutes and action Tracker** **7. Divisional Governance and DPR minutes**

Ref	Action	Who	Due	Update		Status
2.1 -3	The Medicines Policy will be reviewed to ensure it contains adequate guidance for staff, on the safe storage of medicines, roles and responsibilities for management of and if required develop implementation plan for revised Policy	CP	30/11/18	**26/10/18** The medicines policy will be presented to the Drugs and Therapeutics Committee meeting on 21/11/18 – any changes to policy will be agreed at this meeting 31/1/19 The policy is done and a summary poster has been distributed to staff		Complete
2.1	An update for all staff will be provided by the Pharmacy Team confirming arrangement for storage, checking and disposing of medicines	CP	7/12/18	**26/10/18** The advisory poster will be signed off by Drugs and therapeutics Committee meeting **12/12/18** Poster was circulated in trust communications		Complete
2.1 -3	6 mthly programme of CD medicines audits will be developed and communicated to Divisions, it will also include requirements for remedial action plans where the audit fails	CP	26/10/18	**26/10/18** Programme is in place already, failures to be reported at MERG.		Complete
2.1/2	Findings from the audits will be built into the Peer Review / Ward accreditation process	CP/ CNO	31/3/19	31.01.19 Peer reviews will be using data and information from medicines audits		On Track
2.1	Any findings or learning from incidents discussed at the Medicines Events Review Group will be disseminated to wards /services together with the requirement improvement plans where necessary. These findings will be evidenced at ward /service level	CP	9/11/18	This is now in place and feedback from MERG (of Moderate or above) has commenced since October, findings are always added to the Pharmacy Intranet pages. Divisions receive a quarterly feedback report on medicine incidents. Any CD incidents are fed back immediately		Complete
2.1/2	Medicine incidents will be fed back to Divisions and discussed at Divisional Governance Meetings	CP	31/12/18	Med	**07/01/19** This is now in place for the Division from January onwards	Complete
				Surg	**07/01/19** This is now in place for the Division from January onwards	Complete
				Family	**07/01/19** This is now in place for the Division	Complete
2.1	Medicine management to be a regular agenda item at all Divisional Governance meetings	Divisions	2/11/18	Med	**17/10/18:** Medicine Management has been added to all revised DPR and Divisional Governance Meeting agendas.	Complete
				Surg	**17/10/18:** Will be added to the agenda from the November Divisional Governance Meeting (DGM) and DPRs	Complete
				Family	**26/10/18:** there will be a set agenda with this as an item as from the November Divisional Governance Meeting (DGM) and DPRs	Complete
2.2	The annual safe storage of medicines will be completed by the end of December but any failures will be reported to division immediately and a remedial action plan implemented	CP	31/12/18	**07/01/19** The annual safe storage of medicines audit was completed and the audit is to be shared at the divisional governance meetings		Complete
2.4	Review of pharmacy provision to be developed into a risk assessed implementation report . The report will include • Details of where the current gaps are • Priority of where support is needed • Immediate safety issues • Immediate actions to be taken • Identification of quick wins	CP	16/11/18	**16/11/18** report sent to Chief Nurse, for further discussion 5/12/18 where any additional actions will be confirmed 15/1/19 Report has been received but as yet not approved – this will be considered as part of the business planning cycle		Complete

Evidence Notes

Requirement – Risk Assessment	Source	Status	Outcome / Process/Evidence
3.1 Staff assess the risks to the health and safety of service users of receiving care and treatment and do all that is reasonably possible to mitigate such risks.	MED / SURG MUST DO R12		**Outcome** • **95% compliance VTE assessment (CQC Dashboard)** • **reduction in incidents relating to ligatures** • **50 % reduction in number of red environmental audits** • **5% overdue actions on risk register** • **100% of ward/service areas have an improvement plan that includes the identification of gaps in**

			assessments and an action plan to address. **Process** • **TSI on ligatures** • **Revised Rik Management Policy** • **Introduction of 6 monthly re-audit of non-compliance with infection control environmental audits** •
3.2 Systems are in place to assess, monitor and mitigate risks relating to the health safety and welfare of service users.	MED / SURG MUST DO		**EVIDENCE** **1. Ward /Unit Improvement plans** **2. BI reports on VTE assessments** **3. DPR and Divisional Governance Meeting minutes** **4. ED / Ward / Department Risk Register** **5. Annual Environmental Audits and 6monthly re-audits of non-compliance** **6. CQC Dashboard**
3.3 The trust must ensure the level of risk in the emergency department is identified, recorded and managed appropriately.	U&EC MUST DO R12		

Ref	Action	Who	Due	Update		Status
3.1	Each ward / service will complete a physical risk assessment of their areas based on the cohort of patient that are cared for , this may include: • Environmental assessment– IPC/H&S/ ligature • Equipment (linked to 4.1)	**Divisions**	31/03/19	Med	**07/01/19** awaiting SOP for equipment to understand the requirements for equipment assessments	**Split action**
				Surg	**07/01/19** This is in progress but awaiting SOP for equipment to understand the requirements for equipment assessments	**Split action**
				Family	**02/01/19** The division has completed all the assessments apart from the equipment assessment. The date for the completion of the equipment assessment is to be confirmed	**Split action**
3.1	Each ward / service will complete a patient centred risk assessment of their areas based on the cohort of patient that are cared for , this may include: • Pressure Ulcer • Falls risk • MUST • Pain	Divisions	~~31/01/19~~ 31/03/19	Med	**07/01/19** This is at risk, high risk areas will be completed in Feb, The direct care assessments are in place , but awaiting SOP for equipment to understand the requirements for equipment assessments	On Track
				Surg	**07/01/19** This is in progress but awaiting SOP for equipment to understand the requirements for equipment assessments	On Track
				Family	**02/01/19** The division has completed all the assessments apart from the equipment assessment. The date for the completion of the equipment assessment is to be confirmed	On Track
3.1	Once assessments have completed, each ward /service area will include any improvements required into their ward improvement plan to ensure that any gaps or findings are addressed	Divisions	~~31/01/19~~ 30/04/18	Med	**07/01/19** The improvement plan cannot be completed until the final equipment assessment has been completed	On Track
				Surg	**07/01/19** The improvement plan cannot be completed until the final equipment assessment has been completed	On Track
				Family	**02/01/19** The improvement plan cannot be completed until the final equipment assessment has been completed	On Track
3.1	The current arrangements for Environment Audits will be reviewed by the IPC Team, with feedback to wards. The Divisions must ensure that actions from any	IPC	~~21/12/18~~ 28/02/19	IPC Team	**06/11/18** The IPC have introduced a more robust system of environmental audits that now includes a 6 mthly review, follow up of action plans and improved provision of	On Track

	failed audits will be addressed by a remedial action plan				advice and guidance. The new cycle of audits will commence on 01.12.18 **03/01/19** The Peer Review process has identified that the current cleaning audits are not providing sufficient assurance. Further actions may need to be identified to ensure the current arrangements are robust enough This will then be addressed by the DCN **15/01/19 IPC –** Annual audits and 6 monthly re-audit of non-compliance will now • Ensure that the audit programme includes nursing responsibility • Management reports to insure right actions/right escalations are completed • NIC/Matron to sign off audit	
				Med	**17/10/18:** Initial H&S environment risk assessments have begun. 7 completed to date. Programme of remainder in development with H&S lead **07/01/19** This cannot be completed until the audits have been reviewed. This will then be addressed by the DCN **15/01/19** DCNs to ensure all audits/ actions plans are signed off by end Feb	On Track
				Surg	**06/11/18** Assessments have commenced and areas are also considered in the Surgical Walkaround. Areas for action will be noted in the Ward Folders and discussed at the governance meetings **15/01/19** DCNs to ensure all audits/ actions plans are signed off by end Feb	On Track
				Family	**26/10/18** Assessments are reported at DPR but the service needs to consider a way to consolidate actions and to gain assurance that they are complete. All audits are considered at DPR **15/01/19** DCNs to ensure all audits/ actions plans are signed off by end Feb	On Track
3.1	The completed assessment will be reviewed by IPC - any findings and resultant actions are compiled into one ward based action plan that will be monitored at DPR	IPC	~~31/12/18~~ 28/02/19	**24/10/18.** The completed assessment is reviewed by the IPC Team and actions for both the area and Estates are considered.		On Track
3.1	The Trust Safety Instruction – Ligature safety audit and risk assessment will be produced by the H&S Advisor to provide advice and guidance to all areas associated with the care of patients at risk of self harm or suicide	H& S A	30/11/18	**24/10/18.** The draft guidance has been produced and is being reviewed in ED. The final document will be produced for CN sigh off by 30/11/17. At that point it will be issued to the high risk areas for them to complete their risk assessments. It will also be available to all wards and areas for general advice and guidance		Complete
			19/12/18	**5/12/18 –** CNO office recommend some amendments. Document to be finalised for use across the Trust. In the meantime, use draft document tested in ED in high risk areas –Paeds / Child Health/ Gastro and Detoc wards **02/01/19** The document has been finalised and circulated		Complete
3.1	The Organisation will implement a wider campaign of "Ligature Awareness" to ensure that vulnerable patients are adequately care for and their specific needs are addressed	CNO/DDN	31/03/19			On Track
3.1	The ED departments/ Charlies DAU/ G2/Northbrook/ Maternity must complete a detailed assessment to identify a place of safety for the care of vulnerable patients (At Risk of suicide or self-harm)	Divisions	~~21/12/18~~ 31/03/19	ED	**18/11/18** The ED place of safety for children is being considered as part of the PAU . redevelopment **03/01/19** The BNHH PAU includes a place of safety for children this is due to be open by end Jan. This is outside control of the Dept. The RHCH PAU is due to open Mar 19	On Track
				Family	**26/10/18** This is already in place for children, vulnerable children are risk assessed using the local self harm guidelines that includes identification for a place of safety or where care should be given Maternity are yet to formally identify a place of safety	On Track
3.1	All divisions will consider and identify a place of safety for the care of vulnerable patients (at risk of suicide or self-harm)- taking into account the Trust Safety Instruction. (TSI)	Divisions	31/12/18	Med	**06/11/18** The Division is considering appropriate places but will await final version of TSI 07/01/19 This has not been progressed and is now outstanding it will be taken forward by the DCN	Partially Met

					31/01/19 **Division has considered the need for places of safety and subsequent action will be** taken forward by the DCN	
				Surg	**06/11/18** The Division is considering appropriate places but will await final version of TSI 07/01/19 This has not been progressed and is now outstanding it will be taken forward by the DCN 31/01/19 **Division has considered the need for places of safety and subsequent action will be** taken forward by the DCN	Partially Met
				Family	**26/10/18** this will be discussed at the next divisional meeting . **02/01/19** Places of safety will be formally identified at the next meeting 07/01/19 This has not been progressed and is now outstanding it will be taken forward by the DCN 31/01/19 **Division has considered the need for places of safety and subsequent action will be** taken forward by the DCN	Partially Met
3.1	The identified places of safety will be communicated within the Trust and be known to the Matrons and Directors of the Day	Corporate/ Divisions	~~31/12/1~~ 31/03/19		**02/01/19** This cannot be completed until all the Divisions have identified places of safety	On Track
3.1	The VTE / Risk of Bleeding Policy will be fully implemented and compliance will monitored in every Division. The Divisions will achieve 95% compliance	Divisions	~~31/12/18~~ 31/01/19	Med	**17/10/18:** OSM Haemophilia will lead the Divisional compliance response through the Thrombosis Group. **12/11/18** These are part of the regular compliance audits and non compliance actions will be monitored as part of the Ward DPR and raised with individual Consultant Teams **07/01/19** Compliance was over 95% at both sites	Complete
				Surg	**17/10/18:** VTE and risk of bleeding assessments are completed on every admission and reported via BI. **06/11/18** These are part of the regular compliance audits and non compliance actions will be monitored as part of the Ward DPR and raised with individual Consultant Teams **07/01/19** This has been completed	Complete
				Theatres	**06/11/18** Theatres are identifying a work plan to ensure that EPR can be accessed to ensure that Teams can access the VTE / risk of bleeding assessment that is recorded in individual patient records **07/01/19** This will be confirmed on the Peer Review planned for 10th Jan 31/01/19 The peer review identified that further work is required and is now part of a theatre action plan. This is being overseen by the DCN, and will be completed by end March	On Track
				Family	**02/01/19** Maternity – all patients are reviewed throughout pregnancy and on admission. Compliance is monitored at DPR	Complete
3.1-3.3	The Risk Management Policy will be reviewed by the CN and recommendations made to the Directors and Board	CN	31/03/19			On Track
3.3	The process for identifying the level of risk and appropriate management will be included in the ED Improvement plan	OD M	26/10/18	**24/10/18** Risks are now discussed at ED site meetings fortnightly, at monthly ED governance meeting and at USC DPR, where the level of risk and management of the risk is identified		Complete
3.1-3.3	The Divisional risk register entries will be reviewed to ensure that all entries are appropriate, have a review date, mitigations and action plans in place for all Business Units	Divisions	31/12/18	Med	**17/10/18:** Divisional Governance lead meeting with all OSMs to review and update risks. **07/01/19** This is now in place for the Division and on the Divisional Governance Meeting agenda	Complete
				Surg	**06/11/18** The divisional risk register will be reviewed to ensure all entries are appropriate **07/01/19** This has been completed	Complete
				Family	**26/10/18** The divisional risk register is discussed every quarter with each business unit.	Complete

					The division will consider how to gain assurance that the discussions are also held at ward / service level	
3.1-3.3	The Risk register will be a regular agenda item on all DPRs and Governance Meetings	Divisions	31/12/18	Med	**17/10/18:** Divisional and Business Unit Risk Registers added to respective agendas	Complete
				Surg	**06/11/18:** The divisional risk register is reviewed every quarter, however the Directorate intend discuss high level risks at every Divisional Governance Board and then implement risk registers for each y ward / business unit , and risks will be discussed at governance meetings	Complete
				Family	**26/10/18** The divisional risk register is discussed every quarter with each business unit. The division will consider how to gain assurance that the discussions are also held at ward / service level	Complete

Evidence Notes:

- **Level of risk in ED is also linked to implementation of ED Full Protocol**

Requirement – Equipment	Source	Status	Outcome/Process/Evidence
4.1. Equipment used for providing care or treatment to a service user is safe for use and is used in a safe way.	MED /SURG MUST DO S29A R12 2015 report		**Outcome:** • **100% of wards /care areas have a environmental audit and any remedial actions are captured in ward improvement plan** • **100% compliance with completed resus audits with no repeat failures** • **100% compliance with completed quarterly IPC Audits** • **100% compliance with completed appropriate cleaning audits** • **100% wards/ care service areas will have competency matrix in place** **Process** • **Equipment maintenance SOP** • **Hoist checking SOP** • **Revised Resus Policy** •
4.2 That premises and equipment are fit for purpose and infection control standards are followed at all time	MED /SURG MUST DO S29A R15		
4.3 There were not always sufficient quantities of equipment to meet the needs of service users	SURG MUST DO S29A R12		**Evidence** • **Equipment testing and maintenance compliance reported to H&S Committee** • **Sink replacement programme reported to H&S Committee** • **DPR and Divisional Governance Meeting minutes** • **Board Reports** • **Ward improvement plans** • **Staff competency matrix** • **CQC Dashboard** • **Peer Review Reports**
4.4 The trust must ensure resuscitation equipment in the emergency department is safe and ready for use in an emergency	MED MUST DO S29A R12 2015 report		

Ref	Action	Who	Due	Update	Status
4.1/3	The date for a review of those areas identified in the S29A report will be agreed to ensure that changes have been sustained (for locations please see S29A report)	Divisions	~~31/12/18~~ 31/01/19	Med **17/10/18:** Section 29A to be reviewed at DPRs and HoOC to identify resus equipment in place and serviceable. **07/01/19** The actions for medicine at AWMH will be validates on the 10th Jan Peer Review	On Track

				Surg	The areas identified in Surgery will be reviewed during a Peer Review visit. Date yet to be agreed **07/01/19** The actions for surgical wards have been validated but will require further checks, actions for theatres will be validated on the 10th Jan Peer Review	Over due
4.1	The equipment SOP will be reviewed to ensure that it provides a robust framework on the testing and maintenance of equipment	AD E	30/11/18			Overdue
4.1	Each ward / service area will develop a 'passport' to ensure that all staff have been trained on the equipment in use. This will include a competency matrix that staff must achieve. The details will be held at ward level and centrally. Competencies will be reviewed at appraisals (aligned to 5.1)	Divisions	31/01/18	Med	**07/01/19** This is not yet compete	At Risk
				Surg	**07/01/19** This has not been actioned as yet and will be taken forward by the DCN	At Risk
				Family	The Division has clear arrangements in place to ensure that staff are trained appropriately . There are robust arrangements for PoC testing but other competencies need to be fully checked.	On Track
4.1	~~Schedule for testing and labelling all equipment will be produced, together with a trajectory for full compliance~~ All hoists will be appropriately labelled to ensure that staff are clear that they are safe to use	AD E	~~31/10/18~~	**06/11/18** All new labelling of hoists is due for completion by 9/11/17. **15/11/18** There has been no assurance of completion for the labelling of all hosts. A schedule for testing has not been received and there will be a need to prioritise high / med / low risk items. The initial action has now been split into to actions . One for labelling and one for testing **21/11/18 :** In terms of this action all hoist have been relabelled with a single one **10.01.19** : during the Peer Review process a number of hoists still have more than one label 31.01/18 The Peer Review visits have confirmed that in the majority of places hoists only have one label. 05/02/19 monthly rounds in place to ensure only one sticker are in place. If any have been added during servicing they get removed at this inspection.	Partially Met
4.1	All equipment will be compliant with the safety testing requirements – a trajectory to achieve compliance will be produced identifying high /med/low risk priorities.	AD E	31/10/18	**15/11/18** A trajectory for compliance has not been produced, actions have been confirmed to identify high /med/low risk items. A trajectory for full compliance of medical equipment PPM is not likely to be above 80% until the end of Jan. **21/11/18** the Medical Devices Group is meeting on 9th December where this action will be discussed and a plan 31/01/19 Compliance is currently at 70% . Additional internal and external support has been secured. Compliance should show and improvement by the end of March		Overdue
4.1	A review of the medical equipment replacement programme to be undertaken to include those items that are under the capital threshold	Divisions	30/11/18	Med	**17/10/18:** All areas requested to review and prioritise all medical equipment required under capital threshold. Divisional review to prioritise and endorse according to risk. Local identification of equipment that requires replacement and flagged as part of capital funding requests.	Complete
				Surg	**17/10/18:** Division has arrangements for the purchasing of equipment under capital threshold	Complete
				Family	26/10/18 Division has arrangements for minor equipment replacement but needs to consider a robust process for larger pieces of equipment that are still under the capital threshold **21/11/18** Division has confirmed that this process has now been identified	Complete
4.2	All theatre sinks will be assessed against the new HBN standards and a replacement programme with a trajectory for a replacement programme identified and monitored	AD E	~~24/10/18~~ ~~14/01/19~~ ~~14/02/18~~ 31/03/19	**25/10/18:** the sinks that need replacing have been identified. A tender process is in place for replacement over Christmas of 2 sinks at BNHH first and then 1 per month thereafter. There is a potential complete works at RHCH (if contractors available) but the current plan is replace all over the next 12 months. The 2 sinks identified as part of the S29A report are due for replacement 7th and 14th Jan 2018 Issues with manufacture, procurement and installation means that the sinks will now not be installed until mid Feb 31/01/19 Estates have confirmed the replacement programme. Programme to commence 1st Feb and due for completion by end of March		On track

4.2	The Environmental Cleaning Policy will be adhered to and Audit results and recommendations will be reviewed by the Senior Facilities Management Team monthly in accordance with the policy. The Senior Facilities Management Team is responsible for addressing any issues identified.	Divisions	31/12/18	Surg	**17/10/18:** Cleaning schedules are in place to indicate cleaning requirements. Domestic staff carry out weekly cleaning audits in high risk areas such as theatres which are reported to the division and Infection Control Committee. It is rare for a negative result to occur but should this happen immediate action is taken and a repeat audit is carried out within 24 hours. The Division has devised a schedule for a safety walk around and assurance of the changes will be gained on these. **21/11/18** IPC Lead has identified that there are still issues with the cleaning of Theatres, to be raised with AD Facilities The divisions cannot complete any actions until further audit requirements have been agreed	Overdue
				Med	The divisions cannot complete any actions until further audit requirements have been agreed **03/01/19** The peer review s in EDs identified issues with cleaning	Overdue
				Family	The divisions cannot complete any actions until further audit requirements have been agreed	Overdue
				Facilities	Issues with audits / standards have been identified during peer reviews, audits and standards to be discussed	Overdue
4.2	Clear guidance will be produced to ensure there is clarity between nursing and domestic responsibilities ensuring equipment /areas are clean and safe to use	CNO / AD F	31/12/18	**03/01/19** this is contained within the cleaning policy and has been circulated to allstaff		Complete
4.3	The review of current resuscitation equipment to be assessed by the CN	HoOC /CN	24/10/18	**25/10/18** Review shared with CN		Complete
4.3	The replacement resuscitation equipment to be delivered to the wards with appropriate guidance	HoOC	14/12/18	**24/10/18** HoOC will confirm final delivery date of all trollies and equipment. The first wave of equipment has already been delivered, second wave to be confirmed. Third wave bid to be completed for CFO **08/01/19** The remaining pieces of equipment will be delivered today which means that all areas that were identified as requiring updating or extra equipment due to sharing etc have been rectified.		Complete
4.3	A review of the Resuscitation Policy to be undertaken to ensure that the checking requirements are clear and unambiguous.	HoOC	14/12/18	**24/10/18** The review of the resuscitation policy has been delayed, key members of the team are involved in the delivery of PILS/APLS training in ED **13/11/18** The resuscitation policy has been reviewed and will be shared with stakeholders. This includes new guidance and resus checklists. This will require virtual sign off by PAG. Early messages around the policy will be included in Managers Message and reiterated in December.		Complete
4.3	An implementation plan together with training on the new requirements to be communicated to all appropriate staff.	HoOC	14/01/19	**24/10/18** the implementation plan cannot be delivered until the policy has been revised **16/11/18** Programme to visit all areas with a resus trolley has been put in place to be completed by early Jan. At this point the new checklist will be issued to the matron of the area **03/01/19** programme and checklist communicated to all areas		Complete
4.4	Spot check audits will be undertaken in the ED department and findings reported at DPR	HoOC	31/12/18	This is already in progress. Findings are reported to the Matrons but need to be evidenced at DPRs. Spot check audits of BNHH, RHCH and Andover ate being planned by the Resus Team for early December and January. **03/01/19** Spot check audits were carried out during the Peer Reviews. All checks had been competed		Complete

Evidence Notes:			
Requirement – safe staffing	**Source**	**Status**	**Outcomes/Process/Evidence**
1.1 That persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Staff have an appropriate level of life support training to respond to emergencies.	MED/SURG MUST DO R12		**Outcomes** • **95% Appraisal rate** • **80% of appropriate staff are trained in BLS** • **100% of clinical staff will have access to supervision as per the Policy** • **100% of wards will have a competency matrix** • **80% staff will attend Trust Wide induction with 3 mths of starting and** • **100% of "22222" calls in AWMH are audited by the Resus Team** **Process** • **Supervision Policy** **Evidence** • **DPR and Divisional Governance Meeting minutes** • **Divisional dashboard** • **Staff records** • **Resus Audits for AWMH**

Ref	Action	Who	Due		Update	Status
5.1	The Trusts target for appraisals i.e. 95% of staff have had an appraisal within the last 12 mths	Divisions	31/12/18 31/3/19	Med	**17/10/18:** Ward level matrix being developed to include all mandatory training and appraisals rates. To include improvement trajectory to meet Trust targets and demonstrate sustainability. **07/01/19** awaiting confirmation of compliance rates but will not be at 95%. Will meet this by March 31/01/19 Improvement in rate continues, on target to meet end March date	Overdue
				Surg	**06/11/18** Compliance rates are slowly improving but compliance rates will not meet the target by end of Dec Will meet this by March 31/01/19 Improvement in rate continues, on target to meet end March date	Overdue
				Family	**26/10/18 Maternity Services;** the removal of midwifery supervision has been a significant challenge and a new system was discussed and agreed with the DoP. The service expects to achieve 80% compliance by the end of Dec and 95% compliance by end of March. All midwives and nurses will move to Clarity as from 31/3/18 **Children's services.** Children's services are facing a similar challenge and expect to be at 95% by end march The Division will improve its current position across all staff groups by 31/12/18 31/01/19 Improvement in rate continues, on target to meet end March date	Overdue
5.1	The Divisions will develop a robust process to ensure all new starters attend the Trust wide induction and have appropriate local induction according to their role	Divisions	31/12/18	Med	**07/701/19** The division has a robust process in place	Complete
				Surg	**07/701/19** The division has a robust process in place	Complete
				Family	**03/01/19** The division has a robust process in place	Complete
5.1	A training requirement assessment for training inside /outside the Organisation to be completed	Divisions	~~16/11/18~~ 31/03/19	Med	**17/10/18:** The ward level matrix being produced to support with the delivery of the trajectory will be used to identify training requirements	On Track

					19/10/18 Trust wide learning and development needs template to be completed by 16/11/18 **21/11/18** Division is still compiling this 31/01/19 External requirements have been identified by the CNO**. These will be reviewed by the DCNs and profile confirmed, Internal provision for Stat & Man training has been confirmed**	
				Surg	**19/10/18** Trust wide learning and development needs template to be completed by 16/11/18 **21/11/18** Division is still compiling this 31/01/19 External requirements have been identified by the CNO**. These will be reviewed by the DCNs and profile confirmed, Internal provision for Stat & Man training has been confirmed**	On Track
				Family	**19/10/18** Trust wide learning and development needs template to be completed by 16/11/18 **21/11/18** Division is still compiling this 03/01/19 The Division has completed the assessment for training for outside the Organisation. Internal training has been discussed 31/01/19 External requirements have been identified by the CNO**. These will be reviewed by the DCNs and profile confirmed, Internal provision for Stat & Man training has been confirmed**	On Track
5.1	All Divisions will implement the Clinical Supervision Policy	Divisions	31/12/18	Med	**07/701/19** The division has a robust process in place	Complete
				Surg	**07/701/19** The division has a robust process in place	Complete
				Family	**07/701/19** The division has a robust process in place	Complete
5.1	Compliance with life support training (80% of appropriate staff) will be achieved	Divisions	31/12/18	Med	**17/10/18:** Ward level matrix being developed to include all mandatory training and appraisals rates. To include improvement trajectory to meet Trust targets and demonstrate sustainability. **07/01/19** Need current compliance 31/01/19 Compliance is currently improving and is at 76%	Overdue
				Surg	**06/11/18** – division is On Track to deliver **07/01/19** Need current compliance 31/01/19 Compliance is currently improving and is at 77%	Overdue
				Family	**26/10/17.** This is monitored using a local spreadsheet and a trajectory is being used to ensure compliance **03/01/19** The division has achieved the target 31/01/19 Compliance is currently improving and is at 75%	Overdue
5.1	A demand and capacity exercise will be undertaken to ensure there are sufficient training places available	DoP	8/11/18	**18/11/18** An updated forecast for training for next year's has been produced and there is sufficient capacity to ensure training spaces. The HoCO is working with the SMT/Ops Directors to targeted staff who are 'out of date' in a more specific way. The HoCO and the CN are considering the content and frequency of Statutory and Mandatory Training.		Complete
5.1	An assessment of the requirements to support emergency situations at AWMH will be undertaken and agreed	HoOC	8/11/18	**17/10/18:** The assessment for AWMH has been completed by the HoOC but requires sign off by the CN **16/11/18:** assessment received by the Chief Nurse. This action will be closed, any new actions will then be added if required		Complete
Evidence Notes						

Requirement Infection Control	**Source**	**Status**	**Outcomes/Process/Evidence**

6.1 Preventing, detecting and controlling the spread of infections, including those that are health care associated, are managed effectively.	MED /SURG MUST DO 29A R12		**Outcomes:** • **90% compliance with Hand Hygiene audit (CQC Dashboard)** • **<5% of repeat Hand Hygiene audit failures** • **compliance with BBE/PPE audit** **Process** • **Revised standards of dress policy** • **BBE/PPE Audit**
6.2 The risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated are managed effectively.	MED/SUR MUST DO S29A R12		**Evidence :** • **Additional assurance to be gained through scheduled deep dive.** • **DPR and Divisional Governance Meeting minutes** • **Trust Wide Induction programme**

Ref	Action	Who	Due	Update		Status
6.1	The cleaning schedule for EDs will be reviewed	HoUC	19/11/18	**17/10/18:** Cleaning schedule has been reviewed and revised to reflect the increase in patient flow. Disposable cleaning equipment is going to be used in order to prevent and control of infection by allowing cleaning to happen at any time of the day. Domestic services including deep cleaning/HPV is available 24/7/365 **07/01/19** The cleaning schedule was not seen to be adequate a the Peer Reviews – cleaning audits to be revisited		Overdue
6.2	An announced review of areas identified in the S29A report will be revisited by the IPC	IPC	~~31/12/18~~ 10/01/19	**03/01/19** Peer reviews are planned to be completed by 10th Jan – all actions will have been checked and validated by then		On Track
6.2	The Standards of Precaution Policy will be reviewed to ensure that there is clear guidance on the Bare Below the Elbows and the use of PPE and ensure implementation	IPC/ CN/CMO	18/11/18	**07/11/17.** The standards of dress policy will be issued to all new starters once it has been through PAG,. This will be going back out to consultation and will be a Jan'19 PAG. The Standard precautions policy has been reviewed and some minor changes are being made but not in relation to BBE and PPE as these were already clearly laid out in the policy. The BBE and PPE message will be included in the Comms Plan.		Complete
6.2	Statutory and Mandatory compliance with Hand Hygiene will be reviewed at DPRs , any resulting Remedial Action Plans put in place and actions reviewed at DPR	Divisions	23/11/18	Med	**17/10/18:** In development with Ward score card and has been added to all revised DPR and Divisional Governance Meeting agendas.	Complete
				Surg	**23/10/18** has been added to all revised DPR and Divisional Governance Meeting agendas.	Complete
				Family	**26/10/18** this will be added to the DPR agenda	Complete
6.2	Additional BBE and PPE audits will be implemented – and will differentiate between medical / other clinical staff	IPC	~~31/01/18~~ 31/03/19	**07/11/18** BBE and PPE audits are in development and will be implemented via Audit R by the end of Jan 05/02/19 New audit tool for BBE and PPE audits will be trialled in Mar 2019 alongside the quarterly hand hygiene audit		On Track

Evidence Notes

Requirement Safe Staffing	Source	Status	Outcomes/Process/Evidence
7.1 The trust must ensure that there are a sufficient number of suitably qualified, staff deployed throughout the emergency department to support the care and treatment of patients.	U&EC MUST DO S31		**Outcome:** • **80% compliance with Statutory and Mandatory training**

	R15 2015 report		• **Compliance with S31 conditions** • **Compliance with standards in Safer Staffing Report** **Process** • **Paediatric Competencies in OPDs**
7.2 The trust must ensure that there are sufficient numbers of suitably qualified staff competent to care for children on duty in the emergency department at all times. In accordance with the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012).	U&EC MUST DO S31 R15 2015 report		**Evidence:** **1. Vacancy rate ED (CQC Dashboard)** **2. DPR and Divisional Governance Meeting minutes** **3. Paediatric trained nurses in OPD** **4. S31 reports** **5. HR / Workforce Reports to Board** **6. Safe Staffing reports** **7. Peer Review Reports** **8. Management of Children SOP**
7.3 There are adequately trained and skilled nursing staff at all times to meet the needs of patients (includes: There are sufficient adequately trained and skilled staff on all wards to meet the needs of the patients accommodated. / There are sufficient adequately trained and skilled staff on elderly care wards to meet the needs of the patients accommodated.)	MED/SURG MUST DO R15 2015 report		
7.4 The trust should consider implementing a lead for mental health in the department	U&EC SHOULD DO		
7.5 The trust should consider implementing a lead nurse for children's emergency care at Royal Hampshire County	U&EC SHOULD DO		

Ref	Action	Who	Due	Update	Status
7.1	In areas where children are looked after (ENT/Ophthalmology / Dental) Divisions will ensure that staff have the appropriate qualification/ competency	Family Division	31/03/19	**26/10/18** All OPD areas have dedicated paediatric waiting areas. At the BNHH site children attending Ophthalmic and ENT clinics are accompanied by paediatric nurses. Dermatology clinics are not supported by paediatric trained nurses currently. There is a plan to explore the possibility of a dedicated children's clinics which could then be supported by paediatric nurses. At the RHCH site children attending Ophthalmic and ENT clinics are accompanied by paediatric trained nurses. At the AWMH site there is currently no paediatric trained nurse support at present. The possibility of having an annual paediatric competency assessment for the OPD nursing team at AWMH is being discussed **15/11/18** Paediatric competencies are being developed for all OPD areas	On Track
7.1	A review of staffing number and skill mix for EDs will be undertaken, using support from 'Buddy Trust' data	ED	14/12/18	**07/01/19** This has been completed	Complete
7.2	ED must ensure that suitably qualified staff are on duty	ED		Please see actions in 1: Condition 5	Complete
7.3	A work force plan will be developed to include: • Workforce Recruitment/ Retention - linking with the OD strategy • An annual review of staffing levels by the CNO / Divisions • An automatic review when additional beds are opened • A review of roster compliance • The approval process for capped and high cost agency use • An operational policy to be followed by the Matron of the Day when opening additional beds at short notice including a risk assessment.	CN	~~30/11/18~~ ~~19/12/18~~ 08/04/19	31/01/19 the workforce review for nursing has been completed, additional plans / workforce models will be included in the business planning cycle which is due for completion on the 8th April	On Track
7.4/5	The paediatric lead nurse role will be considered as part of the development of the Paediatric Assessment Areas	Family Division	8/11/18	**26/10/18:** There is a Clinical Lead / Matron for Paeds across both sites who provides oversight, guidance and leadership when required	Complete
7.4	The department will consider the role of a lead nurse for MH	ED	21/11/18	**18/11/18** The lead for MH issues has been included on the HOUC job description and is the nominated lead	Complete

Evidence Notes

Requirement - Endoscopy	Source	Status	Outcomes/ Process/ Evidence
8.1 Safety Checklists were not fully completed for endoscopy procedures	MED MUST DO S29A R12		**Outcome** • **0 breaches of MSA in endoscopy** • **100% compliance with WHO checklist** **Process** • **MSA Policy**
8.2 Endoscopy patients were not treated in a single sex environments	MED MUST DO S29A R10		**Evidence** • **MSA breaches reported at DPR** • **DPR and Divisional Governance Meeting minutes**

Ref	Action	Who	Due	Update	Status
8.1	All areas will be 100% compliance with the WHO checklist in accordance with the Policy	Med	31/12/18	Endoscopy to confirm that amended checklist that is being used is JAG accredited and is identified in the Policy **07/01/19** This will be validated during the Peer Review Visit on 10th Jan **15/1/19** WHO checklist is in place and monitored by OSM / Matron	Complete
		Maternity	31/12/18	**26/10/18:** Compliance with the WHO checklist is monitored quarterly and has just been completed for Q2. The division will complete a spot check audit against step 5 within the quarter rather than wait until Jan for the next results. This will be reported to the divisional governance meeting **15/11/18** Maternity to confirm that the amended WHO check list in place is compliant with the policy **03/01/19** this has yet to be completed	Overdue
8.2	Breaches of the single sex lists will be reported at DPR	OD S	2/11/18	**17/10/18:** All breaches are now reported via Business Intelligence and reported to Board , as part of the Board papers there have been no breaches in endoscopy	Complete
8.2	The MSA Policy - complete approval and sign off process	CNO	30/11/18	**15/11/18** Policy due at PAG in November and includes best practise for all areas. **21/11/18** Policy approved	Complete

Evidence Notes
JAG accreditation achieved in December 18

EFFECTIVE			
Requirement - Outcomes	**Source**	**Status**	**Outcomes/Process/Evidence**
9.1. The trust must ensure patient audit outcomes are routinely shared with all staff in the emergency department and appropriate actions taken where results do not meet national standards.	U&EC MUST DO R17		**Outcome** • **Governance meetings in EDs how evidence of sharing outcomes/ learning of audits** • **Regular review of local and national audit outcomes,** **Process** • **Review of Audit R** • **Standardised Agendas for DPR**
9.2 The trust should ensure the emergency department participate in more clinical audit to be able to evidence care is being provided in line with national recommendations and best practice.	U&EC SHOULD DO		**Evidence** • **DPR and Divisional Governance Meeting framework and minutes** • **M&M meeting notes for ED** • **Annual audit programmes in each division** • **PSEEG actions meeting notes** • **ED Improvement plan** • **ED audit programme**

Ref	Actions	Who	Due	Update		Status
9.1	A review of Audit R will be undertaken	CNO	16/11/18	**21/11/18** This has been completed by the CNO and the Matrons will now review the use of Audit R in individual areas, The information for Audit R will be used in the Peer Reviews and on the CQC dashboard. The CN has also changed the way in wich the data is presented to Board		Complete
			19/12/18	5/12/18 – Matrons have reviewed the Audit R questions. CNO to update Audit R tool for implementation.		Complete
9.1	The requirements, outcomes and improvement plans in relation to National and local audit programmes will be discussed and agreed routinely at Divisional Governance meetings and reported to PSEEG on a quarterly basis	Divisions IADG/ AMD's	31/12/18	Med	**07/01/19** The DCN will be taking action to ensure robust processes are in place	Overdue
				Surg	**03/01/19** The division has a robust process in place	Complete
				Family	Division have confirmed that these are now part of the DRP agenda	Complete
9.1/2	Divisions will confirm the process of agreeing local audit programmes and the way in which they will be monitored	Divisions	16/11/18	Med	12/11/18 the Division is compiling a Divisional process to identify where audits are taking place, this plan will be monitored at DPR **07/01/19** The DCN will be taking action to ensure robust processes are in place	Overdue
				Surg	**06/11/18** Ward folder will include a Quality Project section where outcomes and actions will be managed and monitored and then reported to DPR. All wards will have this in place by 01.01.19 Consultant teams have individual clinician who oversee audits **03/01/19** The division has a robust process in place	Complete
				Family	**26/10/18:** There are Clinical Audit Leads for Women's Health and Children's services who determine the local audit programme	Complete
9.1/2	Audits and outcomes will be shared as a standard agenda item at DPRs and remedial action plans agreed where results do not meet national standards	Divisions	~~16/11/18~~ 19/12/18	Med	**21/11/18** This is now on the DPR Agenda **07/01/19** The DCN will be taking action to ensure robust processes are in	Complete

	Standard Agenda Item at Governance Meetings in addition to DPR				place	
				Surg	**06/11/18** Ward folder will include a Quality Project section where outcomes and actions will be managed and monitored and then reported to DPR. All wards will have this in place by 01.01.19 **03/01/19** The division has a robust process in place	Complete
				Family	**26/10/18:** The Clinical Audit Leads report back findings, outcomes and action plan requirements at the Governance meetings, **21/11/18** Division are waiting for Trust Wide guidance to then relaunch how the meetings works **03/01/19** Division have confirmed arrangement for monitoring actions/ remedial action plans	Complete
9.1/2	For ED specifically – in relation to both requirements the actions, above will apply	ED	16/11/18	**17/10/18:** A review of the governance framework has resulted in the development of an annual audit programme, as the beginning of an improvement programme A lead consultant has been identified to ensure that audits are completed, findings shared and appropriate actions taken		Complete

Evidence Notes

Requirement -Incidents	**Source**	**Status**	**Outcomes/Process/ Evidence**
10.1 The trust should ensure there is a positive incident reporting culture where staff get appropriate and timely feedback	MED/SURG SHOULD DO		**Outcome** • **Maintain Middle quartile position in number of incidents reported of NRLS** • **100% of low level/no harm incidents closed by 25 days** • **98% mod (not SIRI) incidents to be closed by 60 days** • **100% of cardiac arrest calls reported as incidents and reviewed** • **100% of SIRIs have included patients and family in setting terms of reference (where possible)** • **Learning in ED is evidenced in M&M meetings** • **Number of incidents in ED is monitored**
10.2 The trust should ensure reported incidents are fully investigated with all opportunities for lessons learnt to be identified and fed-back to staff in an appropriate and timely way (This is also linked to a requirement in the well led domain as a should do)	U&EC R31		
10.3 The trust must ensure staff in the emergency department report all clinical and non-clinical incidents appropriately in line with trust policy.	U&EC MUST DO R1		
10.4 Incident investigations are completed in a timely manner and the patient or family are involved in the setting of terms of reference and are informed of the outcome of the investigation before it is signed off as complete	MED/SURG SHOULD DO		**Evidence** • **Number of unclosed incidents by Division (CQC Dashboard CQC Dashboard)** • **Incidents in ED** • **DPR and Divisional Governance Meeting minutes** • **No. of open SIRIS >60 working days (CQC Dashboard)** • **Evidence of lessons learnt disseminated** • **Minutes of SERG/PSEG** • **Commissioning Briefs from Sis** • **M&M Meting notes for ED**
10.5 The trust should ensure that there is an effective process of investigating robustly and for ensuring any learning points are disseminated and communicated to staff in a timely way (This is also linked to a requirement in the well led domain as a should do)	U&EC MUST DO S31 R17		
10.6. The trust must ensure that learning from incidents is shared with all staff in the emergency department to make sure that action if taken to improve safety	U&EC MUST DO		

Ref	**Action**	**Who**	**Due**	**Update**	**Status**

10.1	Trust wide campaign to raise awareness and promote a positive incident reporting culture with a focus on 'Being Open' and the requirements of DoC.	IADG	30/04/19			On Track
10.1	All Low/no harm incidents will be closed with in 25 days	Divisions	31/03/19	Med	Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline	Split Req
				Surg	Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline	Split Req
				Family	Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline	Split Req
10.1/ .2	All moderate incidents (non SIRI's) and below) open more than 60 working days will be closed against an agreed trajectory	Divisions	~~31/12/18~~ 31/03/19	Med	**17/10/18** Given the number of incidents to be addressed the division has identified that it requires 8 weeks to clear the backlog **07/01/19** The number of open incidents is reducing but not yet all completed Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline	On track
				Surg	**06/11/18** On Track to achieve **07/01/19** The number of open incidents is reducing but not yet all completed Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline	On track
				Family	**26/10/18:** The Division is working to the original set date and significant numbers will have been closed. **03/01/19** The Division have identified that they will not be able to close all Mod incidents in Maternity as these require a full RCA. They will close all low/no harm incidents Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline	On track
10.1/2 /4	SIRI's open more than 60 days as at 1 November 2018 will be closed against an agreed trajectory	IRCM / Divisions	~~31/12/18~~ 31/03/19	Med	**07/01/19** The number of open SIRIs is reducing but not yet all completed	On track
				Surg	**06/11/18** On Track to achieve **07/01/19** The number of open SIRIs is reducing but not yet all completed	On track
				Family	**03/01/19** The Division have identified that they will be unable to close SIRIS as they are subject to HSIB investigation	On track
10.1-6	Review the Reporting, Managing and Learning from Incident Policy and ensure clear guidance in line with national guidance / best practice regarding: • Reporting of incidents • Effective processes for investigating • Expected timeframes and process for closing incidents • Management of SIRI's • Involvement of patients and families • Methods for disseminating learning / lessons learnt	IADG/IRCM /CN	~~31/12/18~~ 30/6/19	**15.1.19** An initial workshop has taken place to discuss the process and management of SIRIs. The new Quality Committee meets for the first time in Feb and will influence the way in which the process and reporting is taken forward.		On track
10.1-6	Review of SIRI process and SERG with recommendations for improvement	IADG / IRCM/ AMD/CN	31/01/18			On Track
10.1	All resuscitation calls will reported as incidents and will be subject to post resus audit and feedback	HoOC	31/12/18 31/03/19	**24/11/18** : confirmed as an action, HoOC will monitor incidents and review compliance 31/01/19 HoOC will report back to CQC Action meeting in March		On Track
10.3	The reporting of incidents in ED will be monitored	OD M	17/11/18	**17/10/18:** The number of incidents raised is being monitored at governance meetings and is also		Complete

				included on the Trust Wide CQC dashboard. Incidents are discussed at ED Governance meetings	
10.3	ED will identify an effective process to ensure that incidents are investigated robustly	HoUC	31/11/18	**12/11/18** The ED will implement the trust incident investigation policy	Complete
10.6	The ED department will confirm the current arrangements that ensure learning from incidents is shared with all staff in the emergency department	OD M	9/11/18	**24/10/18** The weekly ED Governance meetings have been established with ToRs and set agenda	Complete

Evidence Notes

Requirement- Mandatory Training for ED	**Source**	**Status**	**Outcome/Process/Evidence**
11.1. The trust must ensure all staff in the emergency department are supported to attend mandatory training in key skills in line with the trust target.	U&EC MUST DO R12		**Outcome** • **95% of staff have completed mandatory training** • **80% of relevant staff trained in APLS.AIMS/PILS** • **90% of stable medical staff training in APLS** **Process:**
11.2. The trust must ensure staff in the emergency department are supported to attend the relevant level of safeguarding training in line with the trust target.	U&EC MUST DO R12 2015 report		**Evidence** • **ED Mandatory and Statutory training compliance** • **DPR and Divisional Governance Meeting** • **S31 Reports**

Ref	**Action**	**Who**	**Due**	**Update**	**Status**
11.1./ 2	Staff from ED supported to attend mandatory training including safeguarding training to achieve 80% compliance with mandatory training	ED)	31/12/18	**17/10/18:** Ward level matrix being developed to include all mandatory training and appraisals rates. To include improvement trajectory to meet Trust targets and demonstrate sustainability. Monitored DPR / DGM.	Overdue

Evidence Notes

Requirement – Training	**Source**	**Status**	**Outcome/Process/Evidence**
12.1. Systems are in place so staff receive appropriate support, training and appraisal to enable staff to carry out their duties safely.	MED/ SURG MUST DO R18		**Outcome** • **80% of staff have completed Stat and Mand training** • **95% of staff have had their annual appraisal** **Process** • **Stat and Mand training review**
12.2. The trust must ensure staff, looking after children in the emergency department, are appropriately trained in paediatric immediate life support (PILS) and advanced paediatric life support (APLS).(Includes The trust must ensure medical staff, looking after children in the emergency department, are appropriately trained in paediatric immediate life support (PILS) and advanced paediatric life support (APLS).)	ED MUST DO S31		• **Compliance rate (CQC Dashboard)**

Ref	**Action**	**Who**	**Due**	**Update**	**Status**

12.1	Achieve 80% compliance with Statutory and mandatory training across divisions	Divisions	31/12/18	Med	**17/10/18** On Track to achieve **07/01/19** Need current compliance – 31/01/19 Compliance for Dec was83%	Complete
				Surg	**06/11/18** On Track to achieve **07/01/19** Need current compliance 31/01/19 Compliance for Dec was82%	Complete
				Family	**26/10/18** On Track to achieve **03/01/19** this has been achieved 31/01/19 Compliance for Dec was80%	Complete
12.1	Review of Statutory and Mandatory training to confirm the programme and frequency of component parts	CN / AD TWD	31/12/18	31/01/19 Review has been completed		Complete
12. 2	This requirement has been addressed in a number of actions in 5.1 above as well as in the responses to the S31 action plan	HoUC	Weekly	**24/10/18** This action is reported weekly		Complete
Evidence Notes						

Requirement – Consent	**Source**	**Status**	**Outcome/Process/Evidence**
13.1 Staff obtain consent and adhere to the principles of the Mental Health Act 1983 and the Mental Capacity Act 2005.	MED MUST DO R11		**Outcome** • **95 % of appropriate staff have received MHA Training** • **95 % of appropriate staff have received MCA Training** • **95 % of appropriate staff have received Safeguarding Training** **Process**
			Evidence • **MCA training numbers** • **Compliance with safeguard training** • **Training requirement rep0rt to MH and Capacity Committee**

Ref	**Action**	**Who**	**Due**	**Update**		**Status**
13.1	Training analysis for MHA and MCA to confirm: • Roles / numbers of staff who require MHA training • Roles / numbers of staff who require MCA training and a trajectory for training compliance	Divisions / DOD M / AD DWT/ CMO/ CNO	~~30/11/18~~ 31/01/18	MCA	**31/01/19 Head of Safeguarding (HoS) has confirmed roles that require MCA training and this will be part of Stat and Man training for next year. Sufficient places and resources are available to meet the needs of Divisions**	On Track
				MHA	**MHA training to be resourced from SHFT**	
13.1	Training programme to be confirmed – including material/frequency/assessment of competence for MHA and MCA	DOD M / AD DWT /CMO / CNO	31/12/18	MCA	**07/01/19** The Divisions need support with this requirement, **31/01/19 Head of Safeguarding (HoS) has confirmed training programme** including material/frequency/assessment of competence for MHA and MCA	Complete
				MHA	**07/01/19** The Divisions need support with this requirement I31/01/19 this has yet to be confirmed	Overdue

13.1	Required staff to attend training for MCA (in line with agreed trajectory)	Divisions	31/03/19	Med	**07/01/19** The Divisions need support with this requirement I31/01/9 this will become part of sat & man training for 19/20	On Track
				Surg	**07/01/19** The Divisions need support with this requirement I31/01/9 this will become part of sat & man training for 19/20	On Track
				Family	**07/01/19** The Divisions need support with this requirement I31/01/9 this will become part of sat & man training for 19/20	On Track
13.1	Required staff to attend training for MHA (in line with agreed trajectory)	Divisions	31/03/19	Med	**07/01/19** The Divisions need support with this requirement	On Track
				Surg	**07/01/19** The Divisions need support with this requirement	On Track
				Family	**07/01/19** The Divisions need support with this requirement	On Track
13.1	The Chief Nurse will consider the wider requirement for a Mental Health Campaign and identify actions to achieve this	CN	31/12/18			Overdue
13.1	The MH Committee will provide leadership including : • Approving the training programme for MHA and MCA • Monitoring compliance against agreed trajectory for Safeguarding / MHA / MCA training • Risk management	DOD M /CMO	31/03/19			On Track
Evidence Notes						

CARING – please note that a number of the actions also relate to the environmental actions in Infection Control (6)

Requirement – Dignity and Respect	Source	Status	Outcomes/Process/Evidence
14. 1 the trust must ensure that patients receive person centred care and treatment at all times.	U&EC MUST DO		**Outcome** • **100% of wards/care units will have an individual improvement plan** • **80% compliance with Dementia Training** • **Dementia champions in each ward relevant area** • **0 breaches of MSA** **Process** • **Equality and Diversity Policy** • **Mixed Sex Accommodation Policy**
14.2 The trust must ensure that patients are treated with dignity and respect at all times.	U&EC MUST DO		
14.3 The trust must ensure the environment is suitable to meet the needs of all patients, including those presenting with acute or chronic health conditions.	MED/SURG MUST DO R15		
14.4 That patient care and treatment are appropriate, meet their needs and reflect their preferences, (including the needs of patients living with dementia.)	MED/SURG MUST DO S29A R9		**Evidence** • **DPR and Divisional Governance Meeting minutes** • **FFT Responses (CQC dashboard)** • **Peer Review reports** • **Inpatient Survey results** • **Ward Improvement Plan** • **MSA Board Report** • **Non clinical bed moves for LD/MH and dementia patients** • **Findings from** Privacy and Dignity Thematic Review
14.5 Care and treatment is provided taking into account of people's privacy and dignity at all times, including relevant protected characteristics	MED/SURG MUST DO S29A R10		

Ref	Actions	Who	Due	Update		Status
14.1/5	An Equality and Diversity Policy (to include all characteristics) will be developed and will include: • Standardised Equality Impact Assessments • The development of an inclusivity programme • The requirement for each ward to have an Privacy and Dignity improvement plan	CNO/DoP OD M	~~31/12/18~~ 31/03/19	**17/10/18:** Med Div undertaking service profile / audit for equality delivery. Divisional Governance Team to track progress of completion and remedial action required 31/01/19 A Privacy and Dignity Thematic Review is planned for the 11th March. Findings will be reported to Exec Oversight Committee		Partially Met
14.1	Each Matron will develop a local improvement plan to address privacy and dignity issues within their area, taking into account FFT and Inpatient Survey results where appropriate	CNO/CM's	31/12/18	**31/01/19 70% of Matrons have submitted their ward improvement plans**		Partially Met
14.1/5	Confirm compassionate care training is within divisional training plans and within Trust training and development priorities for 2019/19.	Divisions /AD TWD	31/02/19	Med	**07/01/19** This will be taken forward by the DCN	At Risk
				Surg	**06/11/18** There is no divisional training plan – this will need to be taken forward by new DCN	At Risk
				Family	**26/10/18:** This already happens in Maternity	Complete
14.1/5	MSA policy - complete approval and sign off process Compliance reported at DPR and Board	CNO	30/11/18	**17/10/18:** Trust has undertaken a further review to assess which areas Trust-wide require measures to ensure compliance with the mixed sex guidance and has taken appropriate actions where identified, with a mechanism in place for reporting future breaches. To date BI have not had to report any MSA breaches .The Trust have been invited to join NHSI regional Mixed sex collaborative to review current guidelines **21/11/18** MSA Policy approved and breaches are reported at Board		Complete
14.1/5	All Divisions will confirm the quiet and private areas accessible to them. This list will then be made available on the Intranet	Divisions	14/12/18	Med	**07/01/19** There are private areas within the Division but they are not know to all or on the Intranet	Partially Met
				Surgery	**07/01/19** There are private areas within the Division but they are not know to all or on the Intranet	Partially Met
				Family	**03/01/19** All areas have quiet and private areas, - not yet published on intranet	Partially Met
Evidence Notes						

RESPONSIVE			
Requirement- Accessible Information	**Source**	**Status**	**Outcomes/Process/Evidence**
15.1 The trust should ensure action is taken to fully embed the accessible information (AI) standards	U&EC SHOULD DO		**Outcome** • **The trust has a trajectory to ensure it is compliant with AI standards** • **Process** • **Accessible Information Strategy**
			Evidence • **Key standards implemented in ED**

Ref	Actions	Who	Due	Update	Status
15.1	Develop an Accessible Communication Strategy	IADG	~~31/12/18~~		On Track

			31/03/19		
15.1	The early implementation of key standards for AI in ED will be included in the ED Improvement plan	DOD M HoUS	31/12/18	15.1.19 Hearing loops have been purchased for the department and will be installed once all the building works have been completed	On Track
15.1	Implement the requirements of the Accessible Communication Strategy	Divisions	30/6/19		On Track
Evidence Notes					

WELL - LED			
Requirement - Governance	**Source**	**Status**	**Outcomes/Process/Evidence**
16.1. There are effective leadership and governance processes for the delivery of safe and effective care.	MED / SURG MUST DO R17 2015 report		**Outcome** • **100% of Trust Policies are in date** • **100% of Divisional Policies are in date** • **95% of risks reviews are in date** • **Ward level dashboard are used to monitor quality of care and compliance** • **Governance meetings in unscheduled care** **Process** • **Per Review Scheme**
16.2. The trust must operate an effective governance process within unscheduled care.	U&EC MUST DO R17		**Evidence** • **Divisional DPR meeting minutes** • **Policy Spreadsheet** • **Peer Review Reports** • **Permanent DCNS in post** • **Ward /service level dashboards** • **PAG minutes**

Ref	Action	Who	Due	Update		Status
16.1/2	Review arrangements for Board and Sub Board level meetings	CN	31/01/19	**31/01/19 This has been completed and new committees meet for the first time in feb**		Complete
16.1/2	Develop Quality Peer review process and accreditation scheme	CN / CNO	14/12/18	**03/01/19** Peer Review scheme in place, visits confirmed until end of March		Complete
16.1/2	Recruit to senior Divisional Head of Nursing roles for Medical Division and Surgical Division	CN / DODM/ DODS	31/12/18	DDNM in Post DDNS start Jan 2019		Complete
16.1/2	Introduce standard terms of reference and agenda items for divisional governance and performance meetings down to ward / business unit	DOD's / DGL's	30/11/18	Med	**07/01/19** The Division has confirmed this is in place	Complete
				Surg	**07/01/19** The Division has confirmed this is in place	Complete
				Family	**03/01/19** Division has confirmed that this is now been implemented	Complete
16.1/2	All out of date policies to be reviewed and updated	DGL's / PAG	31/3/19	Med	**07/01/19** The Division has confirmed this is in progress	On Track
				Surg	**07/01/19** The Division has confirmed this is in progress	On Track
				Family	**03/01/19** Division has confirmed that this is now been implemented	Complete
16.1/2	Review risk management arrangements at Divisional level to ensure risk is discussed and risk registers reflect the dates risks are reviewed and updated and	DOD's /DGL's	31/3/19	Med	**07/01/19** The Division has confirmed this is in progress	On Track
				Surg	**07/01/19** The Division has confirmed this is in progress	On Track

	new risks added			Family	**03/01/19** Division has confirmed that this is now been implemented	Complete
Evidence Nots						

Requirement - FPPR	**Source**	**Status**	**Outcome / Process/ Evidence**
17.1 The trust must ensure that all FPPR checks are carried out at appointment and reviewed on an annual basis and that evidence of these reviews is documented	Corporate MUST DO R5		**Outcome** • **All Directors will have an in date FPPR check** • **100% compliance for the checking of all Directors** • **Individual files for all Directors** **Process** • **FPPR Process** **Evidence** • **Annual Report to Board**

Ref	**Action**	**Who**	**Due**	**Update**	**Status**
17.1	All FPPR checks have been carried out and a new process has been implemented	CS	10/10/18	**17/10/18:** These separate component parts of the system have now been brought together under one system overseen by the Company Secretary. Each director has had a new file set up which is held by and maintained by the Company Secretariat Office. In terms of any new director appointments, the Company Secretariat Office will direct the HR department to carry out all necessary appointment checks on the director and will receive copies of the evidence of each check being completed satisfactorily.	Complete
17.1	The Company Secretary will continue to conduct the periodic on-going searches and collate the annual self-assessments and will store evidence of the completion of these on the single file per director	CS	10/10/18	**17/10/18:** The Company Secretariat Office now holds all files and information previously held by the HR department, has reviewed any gaps in files and is working with the HR department to complete any such gaps.	Complete
17.1	An annual review will be conducted by the Company Secretary to ensure that files are complete, in addition to the annual self-assessments., and will be reported to Board each May	CS	30/06/19		On Track
Evidence Notes					

Requirement – Confidential Information	**Source**	**Status**	**Outcome/Process/Evidence**
18.1 Patient confidential information is handled appropriately in clinical areas	**MED/SURG s29A R10**		**Outcome** • **90% compliance with IG audits in relation to WhiteBoards** **Process** • **Data Security and Protection Policy** **Evidence** • **IG Compliance audits** • **Matrons Message** •

Ref	**Action**	**Who**	**Due**	Update	**Status**
18.1	Interim message with guidance for staff to be issued by CN	CN	~~17/11/18~~ 19/12/18	**18/11/18** The Trust position on Whiteboards going forward is that they will display patient names but via consent so if the patient objects to this, then the Whiteboards will only show initials. **21/11/18** CNO to ensure that guidance is included in the Comms Plan **5/12/18** – CNO to confirm guidance is issued **03/01/19** Guidance has been provided and included in Trust comms	Complete

18.1	Agree standards for the handling of patient information (PID) in clinical areas and ensure these are reflected in the Trust Information Governance Policy (now Data Security and Protection Policy)	CNO / DPO	31/12/18	Policy is due at PAG in November **21/11/18** Policy approved at PAG. Messages to be included in Comms plan	Complete
18.1	Review content of Data Protection training and ensure standards are included	CNO/DPO	**31/12/18** **28/02/19**	**31/01/19 this could not be completed until the Policy was approved but has been confirmed**	Complete
Evidence Notes					

Requirement – Duty of Candour	**Source**	**Status**	**Outcomes /Process/Evidence**
19.1 There is training and support for staff to support understanding and application of the Duty of Candour (DoC)	**MED/SURG SHOULD DO**		**Outcome** • **100% compliance with 3 stages of DoC for closed incidents** **Process** • **Being Open Policy** **Evidence** • **Being Open Policy** • **Training and education material** • **Stat and Man Compliance matrix** • **TNA for Stat and Man**

Ref	**Action**	**Who**	**Due**	Update	**Status**
19.1	Trust policy review and update to reflect the statutory requirements of 'Duty of Candour' and principles of 'Being Open'	IADG	31/12/18	**15.1.19** Policy has been approved by PAG	Complete
19.1	Develop training and education material and resources in relation to Duty of Candour and principles of 'Being Open'	IADG	~~31/12/18~~ 01/01/19	**15.1.19** Draft training material is in development , and training will be available from April	On track
19.1	Training needs analysis of mandatory training to include DoC	IADG / AD TWD	31/12/18	**15.1.19** This is linked to the wider action around stat and Man training.	Overdue
19.1	Implementation plan with trajectory for the delivery of training programme for Duty of Candour	IADG / AD TWD	31/12/18	**15.1.19** This is linked to the wider action around stat and Man training.	Overdue
Evidence Notes					

Trust Wide Actions		**Source**	**Key Performance Indicators**
There are a number of actions the Trust will be undertaking that have been identified within the reports: These not counted in the overall count			
20.1	Improve the timeliness of complaint responses: The report noted that complaints were not always responded to in a timely manner	Final Inspection Report	**Complaints performance** % responded to within 25 working days / timeframe agreed with complainant will be captured on the CQC dashboard
20.2	Theatre Productivity: The report noted that Theatre utilisation rates were poor, staff thought this was due to various factors including the way theatre lists were organised, lack of equipment, last-minute patient cancellations and staff availability.	Final Inspection Report	**Quality Priorities reports to Board**
20.3	Bed Moves The report noted that in both Medicine and Surgery there was a high number of non-clinical bed moves, including at night, with some patients moving two or more times. This could impact on patient's continuity of care and their well-being, especially where vulnerable patients were moved.	Final Inspection Report	Patients moved more than 3 times will be presented on the CQC Dashboard
20.4	Length of Stay: (LOS) The final inspection report noted that the Length of Stay in Medical non-elective patients, average length of stay was 8.6 days,	Final Inspection Report	

	which is higher than the England average of 6.4 days. In addition in the Surgery Evidence appendix there are a number of comment around LOS in Orthopaedics for Hip fractures being in the bottom 25% of Trusts, The average length of stay for all non-elective patients at Royal Hampshire County Hospital was 7.2 days, which is higher compared to the England average of 4.9 days, and patients undergoing major bowel resection had a post-operative length of stay greater than five days.		
20.5	Seven Day Working The inspection report noted that the Trust did not have a strategy for implementing clinical standards for seven-day working in Medicine and Surgery – in that not all services in the surgical departments were offered seven days a week. Services that did operate mostly had limited capacity.	Final Inspection Report Surgery Evidence Pack	**Seven Day Working Strategy presented at Board**
20.6	Health Promotion The report noted the limited access to Health Promotion information in ED	Final Inspection Report	
20.7	Harassment, bullying or abuse The report noted that whilst the national staff survey reported that the percentage of staff experiencing harassment, bullying or abuse in the last 12 months was the same as other acute trust, we heard from various staff groups and whistle blowers who contacted us during our inspection, raised concerns that there was a culture of bullying and harassment which the trust had recognised but needed to address. It did note that he board were reported to be committed to addressing. It also said that within Medicine; creating a positive culture was not given sufficient priority. There were problems with bullying and harassment across services. Managers did not always take action to address staff behaviours that were not in line with the trust values.	Final Inspection Report	
20.8	QI Methodology The report notes that while the trust had a quality improvement (QI) strategy dated 2018-20, that identified the principles for QI and had recently launched a quality improvement academy. There was no trust wide methodology that all projects used. There were not effective structures, processes and systems of accountability in place to support the delivery of the trust's strategy and quality, sustainable services. We were not assured that patients were sufficiently protected from avoidable harm. However it did also note that There were already a number of QI in progress with others at the consideration stage. While this was a relatively new development it did demonstrate that the trust were committed to focusing on continuous learning and improvement. And There were QI champions to support the QI programme and the trust had introduced a QI training programme. This was a relatively new development and therefore we could not assess its impact.	Final Inspection Report	**QI Strategy**

Ref	Action	Who	Due	Update	Status
20.1	Divisions and customer care to develop and implement a recovery plan with targeted interventions and trajectory for improvement Internal audit (RSM) of learning from complaints and serious incidents	IADG/Divisions	30/04/19	**17/10/18:** Actions should include process of formal learning from complaints 31/01/19 Response rate is also discussed at SMT	On Track
20.2	The Theatre productivity programme to identify actions to be taken to improve productivity	Quality Priority Lead	28/3/19	**17/10/18:** Report noted sub – optimal use and capacity at AMWH Rise in cancelled ops for non-clinical reasons. Board will be updated in March 06/11/18 This action is being overseen by the Theatre Steering Group – programme plan to be included 31.01.19 Oversight of this action is by the Theatre Productivity Board	On Track
20.3	Actions from the Quality Priority to reduce unnecessary bed moves for non-clinical reasons to be identified	COO	31/1/19	**17/10/18:** Report noted patients who were moved twice and late discharges Board will be updated in March **06/11/18 : Site flow and management arrangements to be clarified by 24/12/17. Action plan in place by 31/1/19 to include** • A review of admission criteria for wards to ensure patients are admitted to the right ward at the right time • Plan to ensure that discharges happen earlier in the day to create right beds in right places • An education programme with appropriate staff to ensure that they all understand criteria/ vulnerable patients • Identification of patients who can be moved to include clinical risk assessment – pilot	On Track

				being undertaken on E1. / identification by physicians out 'outliers' • Operational flag to be discussed with BI – daily report/ flag on EPR where patients have been moved multiple times for non clinical reasons 31/01/18 report presented to Board identifying number of patients with LD/Dementia and MH issues who were moved more than one, however this includes clinically appropriately moves. Further work being done with BI to see if exclusions can be applied. Going forwards the Quality Committee will receive reports on bed moves.	
20.4	Actions to reduce the LOS in medicine, T&O (specifically hip fractures) and Surgery (post major bowel resection) to be identified		TBC	**06/11/18 for hip fractures:** A peer review has been commissioned regarding #NOF and it has been recognised that we need more Othrogeriatric input. Adverts are out but there is a national shortage of these skills so unlikely to fill all posts in the near future. We are working on a reconfiguration of orthopaedic services but that is proving unexpectedly challenging so will not be achieved in the near future. However these actions link to the GIRFT and #NOF reports.	On Track
20.5	Actions to implement 7 day working plans to be identified	CN	TBC	**Actions to be agreed** **31.01.19 Seven Day Working Strategy presented to Board on 30.01.19**	On Track
20.6	Actions to improve access to Health Promotion in ED to be identified	HoUC	TBC	**17/10/18:** This should also be linked to the Risky Behaviour CQUIN which has deliverables in Q4 – smoke free hospital / alcohol and Quit 4 Life	On Track
20.7	The impact on the Culture Change Programme on bullying and harassment to be identified	DoP	31/3/19	**17/10/18:** Impact on bullying and harassment, with Comms between Teams (matrons and OSMs) • Creating a positive culture • Staff drive to challenge systems and processes • Learning and changes	On Track
20.8	Specific milestones for the QI Programme to be identified	CNO	TBC	**Actions to be agreed:** **31.01.19 The Trust has secured additional 'Buddy Funding' some of which will be used to provide QI training for all Matrons so that it can be used in the implementation of their Ward Improvement Plans**	On Track

Requirement Well Led Action Pan. Executive Actions – these will not be counted in the overall figures

Outcomes:

- **Board are clearly sighted on and assured about the management of key risks**
- **There is clear accountability and demarcation for the quality agenda between executive portfolios**
- **There is clear floor to Board visibility of quality performance**
- **Capital planning process is appropriately prioritised on the basis of clinical risk**
- **Exception reporting to SMT to allow for early escalation of quality concerns**
- **Improved interface between estates and clinical services**
- **Review of Board Papers in April 2019 demonstrates sustained improvements in terms of well led actions**
- **Board Report in May 19 will articulate improvements identified in Board papers and areas for further review.**

Ref	Action	Who	Due	Update	Evidence	Status
21.1	Senior leaders did not demonstrate understanding of the current challenges to quality and sustainability	CNO	January 2019 reports	1) Monthly report to both Exec Comm and Board on new red risks (either newly identified or newly escalated to red status) Minutes of meetings to be more explicit in recording discussions on current challenges Complete. Minutes are now more explicit. 22.01.19first new Bard meeting in January, Board to review action in April to ensure the action is embedded	Board Minutes	On Track
21.2	Not assured that the executive leadership have	Chairman	January 2019	Set up Quality sub committee of the board TORs drafted. First meeting to be in Jan 2019.	TOR for Quality	On Track

	sufficient focus on quality and safety			22.01.19first new Bard meeting in January, Board to review action in April to ensure the action is embedded	Committee	
21.3	Ensure fully compliant with FPPR Regulations	Company Secretary	By end of November	Bring all under control of Company Secretariat, such that HR are given specific tasks to complete. This has been completed	Please see above	On Track
				Complete any evidence gaps in existing director files Update 1 DBS and some 2018/19 appraisals to finalise.		On Track
				Company Secretariat Office to conduct annual review and deliver annual statement of compliance to the Board Going to November board		On Track
21.4	Senior leaders did not take action to address known risks identified by frontline staff	CNO	January 2019 reports	See action under 1) above. The new section in the monthly governance report should actions to be taken and a due date for the action. Reported against once complete. 22.01.19 first new Board meeting in January, Board to review action in April to ensure the action is embedded	Minutes of Governance Reports	On Track
21.5	Continue improve the quality of reporting, including more analysis of data to explain spikes and changes	All Execs	January 2019 reports	1) Better triangulation of reporting, both at Trust level and at specialty/ward level – a dashboard to be produced 2) All reports to Board to have a clear front sheet, summarising the key points of the data in the paper 3) Greater focus on the "so what" of the data. 22.01.19 first new Board meeting in January, Board to review action in April to ensure the action is embedded		On Track
21.6	Clarify which reports are presented at other committees and groups to facilitate sharing of information	Chairman & CEO	January 2019 meetings	Review of Executive meeting structure and implementation of Quality and Workforce Committees Update: Proposal going to November Executive Committee 21.1.19 – Company Secretary to produce Organogram ensuring clarity of reporting structure		On Track
21.7	No BME members of the Board	Chairman	March 2019	NED recruitment expected in 2019 Continue to ensure that all avenues are explored to reach BME population aware of Hampshire demographics. Update: Clinical NED JD drafted. Aiming to advertise by end November. Searching for BME candidate. 22.01.19please see update on this action below		On Track
21.8	Clinical leadership model is medically led, with insufficient nursing input and does not encourage joint working	CNO	January 2019	Julie Dawes reviewing nursing leadership model – recruiting divisional heads of nursing. Family division already have a senior paed nurse and senior midwife. Update: Interim divisional heads of nursing recruited – on in post, one due to start. Permanent structure under review. 22.01.19please see update in TW action plan UoR		On Track
21.9	Limited evidence of open constructive challenge at board level, with no assurance that all options considered and decisions not dominated by individuals	Lauren Wagner	Immediately	NED recruitment expected in 2019 Continue to ensure that all avenues are explored to reach BME population aware of Hampshire demographics. Update: Clinical NED JD drafted. Aiming to advertise by end November. Searching for BME candidate. 22.01.19please see update on this action below		On Track
21.12	No NED with a clinical background, meaning an absence of clinical challenge	Chairman	March 2019	Julie Dawes reviewing nursing leadership model – recruiting divisional heads of nursing. Family division already have a senior paed nurse and senior midwife.		On Track

				Update: Interim divisional heads of nursing recruited – on in post, one due to start. Permanent structure under review. 22.01.19please see update in TW action plan UoR		
21.11	No mitigation to manage the risks if STP bids unsuccessful	CFO	April 2019	Plan being produced for application for capital loans 21.01.19 The Trust was successful with 1 Wave 4 Capital Bid for Orthopaedic Expansion and the relocation of Pharmacy in Winchester The planning process and more particularly culminating in April 2019 and more particularly the 5 year strategic plan in the summer will identify an intended capital plan and indicated those where we see funding and those that aren't funded. For those that aren't funded, we will have to decide on the funding route. The most likely is that we develop a business case for submission to NHSI. However, there is a long list of Trusts doing the same, and our major plans do not have strong financial paybacks so don't fit in the business case format very well. The other option is some sort of joint venture or managed service, but for major service developments this come uncomfortably close to PFI, which is no longer an accepted way of doing things after the November 2018 budget. Making the business case to NHSI means a delay of probably 18 months from here to the approval or turning down of the case. We have established a small team to look at the ED case, and I would expect some very valuable assessment of staffing implications to come within the next 2 months. But this work is very much pre-business case. And if the conclusion is an increase in our staff costs, then unlikely to make much of a business case		On Track
21.12	Unclear how strategic framework links to other strategies	CEO	April 2019	The 2019/20 planning process is different to previous years and divisional planning is aligned to strategic framework and overall strategy to be documented by April 2019. Strategic framework being embedded through 2019 planning 22.01.19There is a clear link to other strategies and the Senior Leadership team. Board to review action in April to ensure the action is embedded		On Track
21.13	Report said "Not all Board members demonstrated the Trust's values and their behaviour was not challenged"	CEO / Chairman	April 2019	1) Board development training programme 1) Exec training - B&H training 2) Implement reflective practice discussion at the end of every Board meeting, for people to feed back Update: Initial board development with RSM in October 2018. Sourcing board development partner .Exec training Scheduled for January , reflective practise discussion In place 21.01. Board to review action in April to ensure the action is embedded		On Track
21.14	Catastrophic risk of 25 on the risk register but unclear what additional action had been taken and if the mitigation had been reviewed to evaluate why it was not having the desired result	CNO/CMO	January 2019	Risk Committee are more rigorously reviewing risk ratings and articulation of risks. Better documentation of actions taken. Also see action under 1) above This risk has been down rated on review. CNO is reviewing risk management processes. 22.01.19Please see actions in TW action plan		On Track – Not counted in overall actions
21.15	Consider whether CQSC should be a sub-committee of the Board	CEO/Chairman/Company Secretary	January 2019	Agreed to establish a Quality Committee of the board. TOR drafted. First meeting in January 2018. 22.01.19CQSC to be disbanded and new Quality Committee in place		On Track
The following actions were identified in the RSM Audit and are not counted in the overall figure						
21.16	Role of Governor/NEDs/Executives should be	CEO/Chai	February 2019	1) Board development training programme		On Track

	clarified	rman/Co mpany Secretary		2) Further discussion with CoG the role of the Governor, with reference to the Code of Governance 3) Consider sub committee chairs reporting to Council of Governors rather than Execs presenting board papers. Update: Board development programme being sourced. COG / Board roles to be scheduled for January COG meeting 22.01.19Board to review action in April to ensure the action is embedded		
21.17	Succession planning to consider diversity matched to skills audit	Chairman	February 2019	Nominations Committee of the Board to meet to discuss succession planning Update NomCo Scheduled. Execs working through succession planning conversations.		On Track
21.18	Board impact could be strengthened via improvements in papers, focus on outcomes, adopting reflective practice (continuous improvement), restructuring the agenda and clarifying role and purpose of the Board	CEO/Chai rman/Co mpany Secretary	April 2019	1) RSM workshop held on 25 October attended by Board and Top team 2) See actions under concern 5 above 3) Look at ways to restructure the Board programme/agendas Update: Improved clarity of purpose of each paper that comes to board. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.19	The Trust should consider triumvirate operational management to improve the parity of esteem for non-medical leaders	CNO	January 2019	See action under 8 above		On Track
21.20	Improve the ability to hold to account via greater specificity of actions, membership of forums and clarity of roles and purpose	Company Secretary	April 2019	Implement use of a Board action tracker (see attached example) RSM Workshop on accountability in meetings Update: Action tracker drafted. Workshop held in October 2018. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.21	Development of a credible strategy, developed inclusively and supported by robust plans is required	CEO /CMO	April 2019	Clinical strategy position statement approved by Board Sept 2018 Working with Basingstoke & Deane Council on local planning Update: NHSE have offered funding to pull together the work done to date. 22.01.19Director of Strategy being recruited		On Track
21.22	The Trust needs to ensure that its developing strategy is aligned to wider system requirements	CEO/CMO	April 2019	Workshops with Governors and stakeholders on strategic development. Update: Workshop with Governors in November 2018 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.23	The Trust needs to provide greater clarity to divisions and staff around its future direction	CEO	April 2019	Via the planning process, see action under 12) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.24	The development of the Trust's OD strategy needs to incorporate the development points identified within RSM's review	DoP	March 2019	Review the strategy in light of the RSM comments Update: Review underway with Change Champions. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.25	The respective roles of Board members and Governors should be clarified	Chairman	February 2019	See action under 16) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.26	Operational reporting lines should be reviewed to support clear lines of accountability	CEO	March 2019	Under review Update: Discussion with Execs in November. No significant changes recommended.		On Track

21.27	Committee structure should be reviewed in response to the Trust's current challenges	Chairman /CWO	January 2019	Establish a Quality and a Workforce Committee Update: TOR both drafted. Committees will meet in January 2019. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.28	The Board, as a whole, should look to play a more active role in system working	Chairman /ACEO	March 2019	STP/LCS standing item at Board meetings NED meeting with Lay members Update: NED / Lay member meeting in November 2018. This needs to become a routine forum. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.29	Meeting agendas should be colour coded to identify key areas and timings should be included on agendas so that adequate focus is given to these key matters	CEO/Chairman/Company Secretary	January 2019	This recommendation has been interpreted to mean greater clarity on the purpose of the papers is required. All papers to include a clear articulation of their purpose. Update: Papers have a clearer articulation now. Need to continue to improve 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.30	Action plans should be realistic and followed up thoroughly along with potential impact of action not occurring	Company Secretary	March 2019	Implement action tracker for board and board sub committees Update: Action tracker drafted 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.31	In light of current challenges and absence of a strategy more horizon scanning of emerging national, sector and local issues is required	CEO	December 2018	Update: Monthly CEO report to Board now includes reporting on external issues Completed		On Track
21.32	Risk management should be a regular feature of operational management and Board discussions and help drive agendas		January 2019	See action under 1) above and to be included in DPRs. 22.01.19Please see actions in TW action plan		On Track
21.33	Need for more evidenced challenge		Immediately	See action under 9) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.34	Enhancements to data presentation including benchmarking, SLR, trend data, integration, forward looking and expansion of HR metrics to support the cultural journey		January 2019	See action under concern 5) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.35	IT resources need to be regularly assessed so that the Trust's ambitious IT agenda remains on course and is implemented successfully	Company Secretary / Chairman	January 2019	Consider increased frequency of IT reporting to Board 22.01.19To be discussed by Board and confirmed		On Track
21.36	Review the processes of how the Trust shares and utilises feedback from patients, staff and the public	ADG	January 2019	Patient experience and engagement strategy being produced Update: Schedule for approval at board in January 2019 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.37	Strengthen the current process of how the Trust interacts with third parties (engagement strategy)	HoC	January 2019	Engagement strategy being produced Scheduled for approval at board in January 2019 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.38	Focus on consistency of approach in performance managing all staff	DoP	January 2019	Leadership and OD strategy implementation Update: Strategy approved. Implementation underway. New appraisal system for March 2019.		On Track

				22.01.19Board to review action in April to ensure the action is embedded		
21.39	The Board should consider the use of team brief and increased social media to increase visibility of Board working	Chairman	January 2019	Part of engagement strategy under 37) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.40	Embed QI methodology as business as usual	CNO	January 2019	QI strategy produced – accelerate implementation process Update: Bid to NHSI to increase resource into QI programme.		On Track
21.41	Review the agenda of meetings to include time for reflective practice	Company Secretary /Chairman	December 2018	Insert agenda item on reflective practice/meeting chairs to include it Update: To be included on agendas from December. 22.01.19Board to review action in April to ensure the action is embedded		On Track

Requirement - Use of Resources (These are not Regulatory /	**Source**	**Status**	**Key Performance Indicators**
The following actions were identified in the UoR report and are not counted in the overall figure			
1 Medical job plans are not linked to activity and they are not scrutinised by the Trust.	UOR		**Actions 1 –.4 will be led by the CFO and CMO** **Actions 18.5 -18.8 will be led by CFO**
2: Medical staff have a low reported DCC (Direct Clinical Care) rates.	UOR		
3: The trust does not fully understand its productivity gap in medical staffing or have a plan to address this.	UOR		
4: The trust does not systematically use Service Line reporting or Patient Level Costing to identify high cost areas in the trust.	UOR		
5: The trust has high pay costs per WAU in medical and nursing costs.	UOR		
6: The trust needs an updated estates strategy based on the output of the clinical strategy to address the material levels of backlog maintenance and maximise the benefit of future investment.	UOR		
7: The trust needs to improve monitoring and delivery of the pharmacy transformation strategy to ensure delivery of all identified efficiencies.	UOR		
8: The trust needs to improve procedures for dispensing of drugs on wards, as it currently spends well above most trusts in England on low cost drugs.	UOR		

Ref	**Action**	**Who**	**Due**	**Update**	**Status**
1- 4	Appoint Divisional Senior Nurses for Medicine and Surgery Division	CN	December 18	The Senior Nurse for Medicine is in post and interviews have been held for the Surgery post **22.01.19** Divisional Chief Nurses appointed for all three divisions	Complete
1-4	Review nursing grade mix across the hospital to optimise benefit of nurse leadership in wards	CN	April 19	**22.01.19** This will be completed as part of the business planning cycle	On track
1- 4	Act on conclusions of recruitment and retention Task and Finish Group	DOP		21.1.19 Over 100 interviews conducted with leavers from 2018 this data feeding in to Change agents & retention document – Work is going on in CNO office now on some things but you should ask Julie Dawes on this. Change Agents have entered the interview part of the investigation phase and are interviewing NEDs, and exec and other in senior team to further define what cultural change may be needed to support clinical quality	On track
1- 4	Work with NHSI productivity team on improving efficiency of rostering of	DoF	04/04/19	**22.01.19** productivity assessment are being built into the plan that is due to Board at the end of march and for submission on the 4th April	On track

	staff					
1- 4	Support the emerging work of Hampshire Isle of Wight STP on developing a Collaborative Bank	DoP	March 19	**22.01.19** a signed contract for all Trusts across the STP that will introduce a collative bank for all staff is expected by the beginning of March		On track
1- 4	Enhance the Theatres and Outpatients productivity work. Commit to expected timetable for scale of improvement. Ensure that there is not substantial downtime in Theatres over (for example) school holidays.	OD/CD Surgery	04/04/19	**22.01.19** productivity assessment are being built into the plan that is due to Board at the end of march and for submission on the 4th April		On track
1- 4	Implement Medirota as a general workforce system for medical staff under the leadership of Medical Directors and Clinical Directors	Divisional CDs	April 19	Surgery	Medirota/CLW fully implemented in surgery	**Complete**
			April 19	Medicine	**Awaiting update**	**On Track**
			April 19	Family	**Awaiting update**	**On Track**
1- 4	Make clear that Clinical Directors are responsible for individual Job Plans within their area of responsibility, including the agreement of the objectives of SPA time.		April 19	Surgery	Clinical Directors in Surgery are currently reviewing job plans in a rolling programme	**On Track**
			April 19	Medicine	**Awaiting update**	**On Track**
				Family	**Awaiting update**	**On Track**
1- 4	Differentiate activity in Orthopaedics between Winchester and Basingstoke sites consistent with GIRFT report, subject to sufficient capital investment being available			First stage of centralising of activity is planned, with Trauma and NOF activity being cared fro at BNHH and corresponding elective work to be carried out at RHCH		**On Track**
1- 4	In 2019/20 annual planning exercise, fully articulate activity plans with reasonable expectations of the capacity inherent in Job Plans.		March 19	Surgery	Capacity planning not yet complete	**On Track**
				Medicine		**On Track**
				Family		**On Track**
1- 4	In 2019/20 – 2023/24 Strategic Plan, establish expectations over continuous improvement in productivity and identify pathway articulation with Out of Hospital work	DoF	31/07/19	**The 5 year strategic plan for the Trust is expected by the end of July**		**On Track**
5	Estate and Property Strategy produced within annual planning process for 2019/20, which supports the clinical	DoF	April 19	**22.01.19Estates strategy is expected as part of the business planning process**		**On Track**

	strategy and will underpin work over the strategic plan period 2019/20 – 2023/24.				
6/7	Subscribe to Refine and Define service	DoF	December 19	Subscription complete	Complete
6/7	Review Pharmacy strategic improvement plan in line with developments since 2016, major estate opportunity in Winchester and the clinical strategy as part of 2019/20 annual planning	DoF/MD Families	April 19	**22.01.19 strategy is expected as part of the business planning process**	**On Track**
6/7	Review Pharmacy support for wards as part of ward skill mix review, and bring closer links with Procurement to ensure optimum buying policy	CP	16/11/18	**The pharmacy support action forms part of the TW action plan -** Review of pharmacy provision to be developed into a risk assessed implementation report . The report will include • Details of where the current gaps are • Priority of where support is needed • Immediate safety issues • Immediate actions to be taken • Identification of quick wins **22.01.19 review was completed and outcome will form part of the business planning process**	**On Track**
6/7	Fully utilise robotic dispensing and other innovations to reduce drugs and medicine going out of date.	DoF /CP	Dec 20	**22.01.19 Robot in place at BNHH, further developments at RHCHC , project expected to begin this year and will be fully in place by 2020**	**On Track**
8	**SLR and PLICs utilised as tools to compare resource allocations and signpost likely productivity improvements in 2019/20 annual planning and 2019/20 – 2023/24 strategic planning**	**DDoF**			**On Track**
8	**Establish Steering Group with intent to identify clear actions for improvement**	**DDoF**			**On Track**

Abbreviations			
Who	**Title**	**Who**	**Title**
CN	Chief Nurse	**DoP**	Director of People
COO	Chief Operating Officer	**DPO**	Data Protection Officer
AMD	Associate Medical Director	**CFO**	Chief Finance Officer
DOD M	Divisional Operations Director - Medical Services	**CS**	Company Secretary
DMD.M	Divisional Medical Director -Medical Services	**IRCM**	Interim Risk and Compliance Manager
DOD S	Divisional Operations Director - Surgical Services	**AD TWD**	Associate Director of Training, Wellbeing and Development
DMD S	Divisional Medical Director - Surgical Services	**TW**	Trust wide
DOD FCSS	Operations Director -Family &Clinical Support Services		
DMD.FCSS	Divisional Medical Director - Family &Clinical Support Services		
CNO	Chief Nursing Office		
IADG	Interim Associate Director of Governance		

HoUC	Head of Unscheduled Care		
DE	Director of Estates		
AD E	Associate Director of Estates	**Source**	**Description**
CEO	Chief Executive Officer	**S29a**	CQC Section 29a Warning Notice
CMO	Chief Medical Officer	**MUST DO**	CQC 'must do' action
CP	Chief Pharmacist	**S31**	CQC Section 31 Warning Notice
DGL	Divisional Governance Lead	**SHOULD DO**	CQC 'should do action
MED	Medical Division	**2015 Report**	Identified as Must /Should in 2015 comprehensive inspection report
SURG	Surgical Division	**'R'**	Regulatory Breach
U&EC	Urgent and Emergency Care		
CG	CaldIcott Guardian		
HoOC	Head of Operations & Compliance		

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