RAG Key
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On Track to deliver
Some issues
Not on track

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MED	Medical Care
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Number
MD - Must Do
SD - Should Do
IA - Immediate Action

This Month	Nov-17
Status	Lockdown 23/11/17

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No	Recommendation	Core Service	Site	Exec Sponsor	Responsible Lead	Implementer	Agreed actions	Deadline	Assurance required, embedded and tested	This month's progress against timescale	Status
	Immediate Actions following announced inspection										
IA001	Compliance action - Regulation 18 We were concerned to see high staffing vacancies in some areas and the reliance on medical locums and temporary nursing staff to keep services safe. It was noted that in some areas the nurse staffing templates had not been reviewed against increasing patient dependency.	TRU	Both	Victoria Maher	Alex Brett	Workforce team	Continually review medical staffing templates	Oct-17	1. Reviewed templates 2. Evidence of review and action in minutes of meetings 3. Monthly paper to Workforce committee and Quality & Safety (Q&S) 4. Included on Trust Board agenda 5. Finance confirmation regarding budgets	VM/EB - Care groups producing medical workforce plans to be presented at Execs in Sept 17. As at 17/11 Awaiting a date for care group medical directors to present their plans to Execs	Some issues
							Recruitment and retention paper for medics	Oct-17		The Care groups are working to align recruitment plans to workforce plans and also develop new roles to address shortages. Recruitment remains a particular issue due to local complexities in some areas and national shortages. Plans are aligned to business and financial plans that articulate the needs from now and define 1, 3 and 5 years. As above	
							Reduction of locum use for medics	Dec-17		All locums are now booked through direct engagement. Locums are specifically covering vacancies and difficult to recruit to posts. Care group workforce plans and associated recruitment plans outline more sustainable solutions not withstanding significant medical gaps and hard to recruit to posts	
							Continually review nursing staffing data at executive rapid review meetings	Jul-17		Monthly safer staffing paper to Q&S. Six monthly nurse establishment review at board (last undertaken Aug-17) Roll out of safe care	
							Recruitment and retention paper for nursing	Sep-17		Discussed at Trust board - further discussions to agree long term strategy at execs	
							Strengthen governance and escalation of risk of workforce issues from ward to board	Apr-18		Workforce committee reports risk escalation to board and undertakes a deep dive into care groups at every meeting; workforce issues also discussed at confirm and challenge with each care group monthly	
							Identify long term recruitment and retention strategy	Sep-17		The Care groups are working to align recruitment plans to workforce plans and also develop new roles to address shortages. Recruitment remains a particular issue due to local complexities in some areas and national shortages. Plans are aligned to business and financial plans that articulate the needs from now and define 1, 3 and 5 years.	
							Cease reliance on off framework agency registered nurses and strengthen bank and substantive staff utilisation	Dec-17		Agency T&F group have a comprehensive action plan. NHSI support in place. Tier 5 reliance has stopped and use of tier 1&2. Bank campaign launched. Recruitment process streamlined and TRACS System implemented. Recruitment events for nurses and midwives in place	
							Inclusion within SSP programme	Aug-17		Yes - care group workforce plans aligned to finance in place defining workforce needs and development at 1, 3 and 5 years	
IA002	Compliance action - Regulation 15 The mortuary at the Princess Royal site is in a poor state of repair, we found consumables considerably out of date, the department was unsecure (unlocked) and in need of a deep clean.	EoLC	PRH	Neil Nisbet	Debbie Jones	Sheila Fryer	Deep dive of the mortuary at PRH	Dec-16	1. CQC review during unannounced revisit of area 2. Capital planning meeting minutes	Complete H&S - Mortuary included in regular audit schedule and first one September 17	Delivered
IA003	The theatre storage facilities at Royal Shrewsbury were also in a poor state. There were no cleaning schedules, and the ceiling had broken or missing tiles and there were stains suggesting water damage. Ceiling tiles were also missing from along the corridor patient pass through on their way to theatre.	SUR	RSH	Neil Nisbet	Carolynne Scott	SCG HoN	Deep dive to address actions	Dec-16	1. CQC review during unannounced revisit of area	CQC revisited and noted replaced ceiling tiles had water marks on them. See SUR action plan for tx action AA001	Delivered

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IA004	The mortuary at the Princess Royal site - A hoist needed to lift deceased patients had been broken since October.	EoLC	PRH	Neil Nisbet	Debbie Jones	Sheila Fryer	Deep dive of the mortuary at PRH	Sep-17	1. CQC review during unannounced revisit of area	Broken hoist – One of the 2 hoists available requires replacement wheels. This was reported promptly and would have been fixed (prior to the inspection) except that the wrong sized wheels had been ordered. In the meantime, the standby hoist is being used whilst the repair to the other hoist is expedited. The new wheels were fitted in early January 2017	Delivered
	Must do actions										
MD001	All patients brought in by ambulance are promptly assessed and triaged by a registered nurse. A suitably qualified member of staff (DR/ANP/RN) triages all patients, face to face, on their arrival in ED.	ED	RSH	Debbie Kadum	Colin Ovington	Matron	Review process	Oct-17	1. Roster review and sign off 2. Observation and testing of process	Streaming process now in place. Ambulance H/O trial commenced 11th October, now implemented	Delivered
							Implement changes	Nov-17		1 minute brief to be circulated regarding changes	
MD002	Compliance action - Regulation 18 There are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients. *IA001 addressed the issue of reviewing the templates and initial implementation of Safecare (see action for detail)*	TRU	Both	Deirdre Fowler	Helen Jenkinson	Ceri Adamson Kath Preece Lynn Atkin	Implement Safecare electronic system	Dec-17	1. Check and audit Safecare	Trial of 4 wards commences in September. Training programme being delivered. Roll out to general wards due to be complete by end December 2017	On Track to deliver
MD003	Compliance action - Regulation 18 Review its medical staffing to ensure sufficient cover is provided to keep patients safe at all times. IA001 addressed the issue of initially reviewing the templates. This action relates to the ongoing review)	TRU	Both	Victoria Maher	Edwin Borman	Alex Brett	Review at a granular level within each care group	Mar-18	1. Job planning review complete	Specific work is being undertaken at a granular level in each care group to review the medical workforce requirements across all services- this is being done by the Care Groups, led by the medical directors and work should be reaching fruition in the next week (Sept) to share with the CEO, Execs and the Medical Director. Care group plans will be scrutinised at Confirm and Challenge and the Care Group Boards. E-job planning commissioned as a tool to enable full review of all job plans.	On Track to deliver
MD004	All staff are up to date with mandatory training	TRU	Both	Victoria Maher	Mary Beales	Mary Beales	Revised SSU targets agreed by September 2017 Workforce Committee and Trust Board based on current programmes	Nov-17	1. Board papers approved 2. Risk Mgmt Matrix approved by both Committees 3. Notes of Confirm and Challenge meetings demonstrate SSU monitoring and result and Care Group actions result in Trust targets met 4. Reduction of avoidable non-attendance figures	Paper drafted and submitted to October Workforce Committee and approved for onward transmission to Trust Board on 30/11/2017. *Deadline revised from Sep-17 to Nov -17*	Some issues
							Risk Mgmt training matrix revised and approved by Education Sub-Committee and Workforce Committee	Jan-18		Revision of Trust Matrix in progress. Operational pressures may delay responses from clinical areas but targeted for submission to January 2018 Education Sub-Committee and Workforce Committee *Deadline revised from Nov-17 to Jan-18*	
							Care Group SSU improvement actions formulated and monitored at Confirm and Challenge	Oct-17		Confirm and Challenge meetings held monthly – ongoing focus on SSU compliance	
							Non-attendance rates (wasted places) at SSU to be recorded by Corporate Education and reported to Care Group HRBPs monthly for follow up with operational Managers with the aim of reducing avoidable wasted places	Nov-17		Monthly report of non-attendance developed and added to November 2017 Workforce Assurance reports. Monitoring of trends commencing.	
							Review feasibility of protection of study leave during peak activity	Oct-17		Trust entering increased activity period and attempts are being made by operational managers to relocate staff from study days and the Deputy Director of Nursing has had to intervene to keep on track	

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MD005	Compliance Action Regulation 11 All staff have an understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments are completed, when required - Mental capacity documentation had not been always completed for defined ceiling of treatment decisions - Nurses understanding of the Act was inconsistent	TRU	Both	Edwin Borman	Graeme Mitchell	Edwin Borman	Formal communication (global email/1 minute brief/message of the week) reminding staff of their requirements relating to mental capacity act	Sep-17	1. Improvement in Audit results 2. Lesson plans reviewed 3. Evidence of review and action in minutes of meetings	Email to be sent by end of Sept 17	On Track to deliver
						Tracey Lloyd Brenda Maxton	Include a refresh on consent/MCA in FY1/FY2 teaching session by patient safety team	Nov-17		FY1's completed Sep-17 FY2's have DoL's in Nov-17 which covers MCA. TL has done an RCA with emphasis on mental capacity which has been approved. V Redmond is trying to organise the next wave of training for permanent staff with the Trust Solicitors.	
						Helen Coleman Helen Venn Helen Hampson Tracey Lloyd	Ensure nurses attend various forums: Band 6 Masterclass (oct-17) 3 yearly update (Dec-17) Stat training (receive update in CPR section regarding DNAR - Sep-17) Shared learning presented at NMF (Tracey)	Dec-17		Band 6 masterclass scheduled for October Resus lesson plans for medical & registered staff updated to include MCA Corporate Education lead to review feasibility of including within 3 yearly update for RN's	
						Robin Long Brenda Maxton	Update doctors at medical/surgical clinical governance meeting on DNR's	Nov-17		Chair of Medical Governance will provide updates - scheduled for Oct/Nov 2017. USCG rescheduled for December CGE due to time constraints. Patient Safety Advisor to include in Safer Times which is circulated to all governance groups in Scheduled Care. *Deadline revised from Nov-17 to Dec-17 (on the agenda for December)*	
						Edwin Borman	Organise CPD event for MCA/DoL's training for Doctors and Nurses/Midwives*	Apr-18		Trust solicitors, Hill Dickinson have offered to deliver the training. Awaiting confirmation of date *To maximise attendance training to be scheduled outside of winter months	
						Helen Hampson	Safeguarding intranet page will signpost to MCA/DoL's app	Dec-17		Work in progress	
						Julie Lloyd	Review RaTE self-assessment question to ascertain knowledge & understanding following training	Sep-17		Question on Mental Capacity added	
						Angela Hughes	Check understanding & knowledge as part of Exemplar Programme	Oct-17		Added to list of requirements for next version update. Incorporated into the next version update	
						Jules Lewis	VMI methodology to review EoLC documentation (streamlined)	Feb-18		Workshop has taken place and documentation streamlined	
						Jules Lewis	EoLC/Palliative care team to meet with Hospital @ Night team and design a training pack which will include EoLC plan and out of hours support	Jan-18		As at Nov update, EoLC Facilitator is meeting with Hospital @ night team December 2017	
						Sally Allen	Audit compliance relating to completion of documentation	Sep-17		Audit complete, Lead Resus officer due to present results at CGE Oct-17	
						Edwin Borman	Review results of audit at CGE and create appropriate action plan	Dec-17			
						Sally Allen	Audit compliance relating to complete of MCA and DoL's form	May-18			
						Sally Allen	Strengthen the governance of CGE and Quality & Safety committee to challenge and monitor progress of all the above actions via Trust CQC action plan	Mar-18			
						Angela Hughes	Communicate need for compliance at NMF	Sep-17		Communicated at NMF Sept-17	

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MD006	Up to date safety thermometer information is displayed on all wards	TRU	Both	Deirdre Fowler	Helen Jenkinson	Julie Lloyd	Review existing question on RaTE self-assessment to specifically mention safety thermometer	Sep-17	1. Improved compliance		On Track to deliver
						Angela Hughes	Include additional check within Exemplar	Oct-17		Exemplar v2.4 updated to include Safety Thermometer	
						Janette Pritchard	Include within IPC Quality Ward Walks (QWW)	Sep-17		QWW include a question to check safety thermometer is being displayed (areas checked 4 times a year/some twice)	
						Ceri Adamson/Kath Preece/Lynn Atkin	Matrons perform spot checks and review RaTE information	Dec-17		Communicated at NMF Sept-17	
MD007	Compliance Action Regulation 12 Ensure medicines are securely and appropriately stored at all times (PRH ED 'we saw missed temperature checks of refrigerators used for the storage of temperature sensitive medicines in the resuscitation room' added as a x Trust action)	TRU	Both	Edwin Borman	Bruce McElroy	Ceri Adamson Kath Preece Lynn Atkin Sara Jamieson	Act upon results of pharmacy audits and reinforce consequence of non-compliance (ward manager, matrons & governance meetings)	Dec-17	1. Improved compliance	To be included and reviewed as part of HoN preparation for confirm & challenge meetings. Included on NMF agenda Sept-17 W&C - spot checks undertaken, TRAKKA cupboards installed & medicines stored appropriately	On Track to deliver
							Pharmacy audit action plans in place and monitored	Dec-17		To be included and reviewed as part of HoN preparation for confirm & challenge meetings	
						Ruth Dudgeon Vicky Jefferson	Rolling program for Ward and clinical Areas Storage and Security Audits, established with an extended series on monthly audits concerning the security and storage of medicines.	Sep-17		All results currently being collated and will be provided to Care Group Nursing Teams, Matrons, Ward Managers, Nursing and Midwifery forum and the Patient Safety Team in September 2017 to robustly implement any actions required.	
						Ruth Dudgeon Vicky Jefferson	Quarterly updates from pharmacy to NMF regarding issues of compliance scheduled	Sep-17		First presentation by pharmacy Sept-17	
						Ward Managers	Add agenda item to monthly ward meeting template	Sep-17		Updated template, communicated at NMF (Sept) and updated to intranet	
						Ceri Adamson SCG HoN Lynn Atkin Sara Jamieson	Review RaTE for medicines management compliance and identify issues	Dec-17		Communicated at NMF Sept-17	
						Angela Hughes	Medicines management - Exemplar Standard	Aug-17		Wards must scores 100% on last quarterly CD audit and Score 100% on at least 1 of the last 3 rolling monthly medicine management audits* with no more than 1 failed question on each of the remaining audits to gain the minimum of Silver award	
MD008	Medication refrigerator temperatures are recorded daily and appropriate action is taken when temperatures fall outside accepted parameters	MED	RSH	Edwin Borman	Bruce McElroy	Ruth Dudgeon	All wards and clinical areas storing medicines will be audited to ensure they have suitable equipment, appropriate records and are aware of exception reporting and actions if out of range.	Sep-17	1. Improved compliance	Extended monthly audit program finalised and in place by the end of August 2017. All wards and clinical areas have completed additional audits reviewing both room and fridge temperature monitoring and recording. All results currently being collated and will be provided to Care Group Nursing Teams, Matrons, Ward Managers, Nursing and Midwifery forum and the Patient Safety Team in September 2017 to robustly implement any actions required.	On Track to deliver
						Ruth Dudgeon Vicki Jefferson	If not in place calibrated dual areas thermometers will be provided, along with register and training information	Oct-17		Thermometers procured and delivered to ward and clinical areas September 17. All areas identified in the audit as requiring calibrated thermometers have been provided them along with recording documentation and escalation guidance. In newly identified areas and areas undergoing a change of use medicine storage will be assessed for suitability by pharmacy and provided thermometers where required	

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						Angela Hughes	Question included on RaTE self-assessment & Exemplar	Dec-16			
						Ceri Adamson SCG HoN Lynn Atkin Sara Jamieson	Monitor and act upon RaTE results	Nov-17		**USCG** - Daily checks of fridge temperatures to be monitored by matrons. Daily checklist completed by Ward Manager. To check this is completed Dec 2017	
						Ceri Adamson SCG HoN Lynn Atkin Sara Jamieson	Consistent improvement in pharmacy audits from baseline	Jun-18			
MD009	Compliance Action Regulation 12 Relevant learning from incidents is shared across all departments for all its sites	TRU	Both	Deirdre Fowler	Dee Radford	Sam Carling	To identify and then implement an effective way of sharing learning from incidents across all staff groups across the Trust (Ward level/Clinical Governance/Care Group and Trust)	Dec-17	1. Rapid review ToR & presentation 2. Improved quality of incident reporting and evidence of learning	Review of governance and learning opportunities complete. The process will require Care Groups to ensure that learning from incidents is shared robustly through existing governance processes with all staff and that changes in practice are identified, monitored and measured through audit, patient and family feedback and incident reporting. Rapid review meetings commenced Sep-17 Commenced learning at CGE through the sharing and discussion of an incident that has learning applicable to all care groups and that is presented alongside a complaint that has similar themes	On Track to deliver
							Draft Quality Strategy in development (Trust paper to outline proposed changes and opportunities for the management of incidents and cascade learning)	Nov-17		Included on Q&S Committee Meeting 23/11/17 then to Trust Board *Wording of action amended and deadline revised from Sep-17 to Nov-17.*	
							Roll out of executive rapid review weekends - All moderate/severe harm incidents (focus on learning/grading/DoC)	Sep-17		First meeting on 08 September. Meetings held weekly	
							Commission bespoke RCA training - external provider	Nov-17		One day Essentials of Effective Investigations 12 October Two day Effective Investigation Workshop 21/22 November Company also happy to provide Exec/Board briefing – date to be confirmed.	
							Quality Performance Report includes themes	Aug-17		The Quality Performance Report has been designed to provide a quarterly thematic review of quality and safety metrics.	
MD010	Ensure patient information leaflets can be provided in languages other than English (RSH ED)	TRU	Both	Deirdre Fowler	Graeme Mitchell	Andrena Weston	Publicity in ED & OPD informing staff/patients how to access language services	Dec-17	1. Annual report to E&D 2. Six Monthly written report to Q&S	Outpatient leaflets are currently being designed and these will be sent to Absolute to translate into several languages. This action is linked to the below	On Track to deliver
						Graeme Mitchell	Communicate, audit and report on outcome (Equality & Diversity Group)	Dec-17			
						Andrena Weston	Key information/signage displayed in Polish and review OPD letters to see if a sentence can be provided on how to access alternative languages	Dec-17		Absolute interpreting services to translate main outpatient and inpatient letters into several languages. Request made to PAS team to update system to enable first language to be selected. Once received translated letters will be added to database to enable correct selection. They will also complete a survey to ascertain which are the most common languages used. Booking and scheduling have been informed of changes. Site survey being undertaken by estates regarding appropriate signage needed.	
						Rebecca Houlston	Top 10 most frequently used leaflets in ED made available in Polish	Feb-18		Currently in contract negotiations with company (held corporately) and until resolved we are unable to request additional supplies	

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						Rebecca Houlston	Ensure ED staff know how to access the SaTH communication handbook (hard copy provided to every department in 2017)	Sep-17		Complete	
MD011	Patient medical records are kept secure in all areas at all times (Areas highlighted Surgery RSH & Medicine PRH)	TRU	RSH	Deirdre Fowler	Helen Jenkinson	Ceri Adamson Kath Preece Lynn Atkin Sarah Jamieson	Remind staff about importance of correct storage of medical records	Oct-17	1. Improvement in compliance	Secure notes trolley in place on Gynae Poster circulated to all care groups to circulate/display within teams	On Track to deliver
						Jill Stretton	IG lead to audit Surgery RSH & Medicine PRH	Jan-18		IG lead confirms in progress with organising dates	
						Ceri Adamson Kath Preece	Review & address any issues highlighted in audit	Mar-18			
MD012	Ensure that it meets the referral to treatment time (RTT) for admitted pathways for surgery	SUR	Both	Debbie Kadum	Sara Biffen	Carolynne Scott	Action plan to recover	Sep-17	1. Improvement in compliance	Action plan in place which is presented at CQRM Full recovery trajectory in place. Detailed in trust operational plan. Currently on target for delivery at end of September 2017. Caveat to this is a fragile ophthalmology service/workforce. 17/11/17 Assistant Chief Operating Officer confirming this has consistently been delivered since Sep-17 at 93.88%	Delivered
MD013	Application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist is improved in theatres	SUR	RSH	Edwin Borman	Tony Fox	Mark Cheetham	WHO checklist revised to include signature	Sep-17	1. Improvement in compliance	Complete	On Track to deliver
							Record prelist briefings	Sep-17		Complete	
							Rolling programme of Human factor training	Sep-17		Complete	
						Victoria Maher	Observational report/recommendations from Human factor training (Trevor Dale)	Mar-18		Internal baseline assessment (not shared widely) of where the organisation is currently against the principles of human factors to help identify how best we allocate resource to HF training - Report due October, position to agree focus November	
						Mark Cheetham	Introduce integrated theatre documentation	Nov-17		New documentation presented at NMF Oct-17	
MD014	Theatre recovery staff have completed advanced life support (ALS) training as per national guidance	SUR	Both	Deirdre Fowler	Kath Preece	Katy Moynihan	Trajectory plan to ensure all recovery staff trained to ALS level to enable 1 ALS nurse per shift	Jun-18	1. Roster assurance	Theatre manager booking staff onto available capacity, limited places	Some issues
MD015	Ensure all staff complete accurate paper and electronic records in a timely manner to document patient care and treatment, including early warning scores (PRH - Paper records were not always completed accurately or in a timely manner. Electronic patient information boards were not used consistently by all staff, which meant patients were not always seen in priority order of need)	ED	PRH	Edwin Borman	Colin Ovington	Rebecca Houlston	Whiteboard SOP to be signed off by clinical lead and nursing lead	Oct-17	1. Improvement in compliance	Shared with all current staff and is part of induction for new starters	Some issues
							Audit of documentation at PRH following discussion at clinical governance	Oct-17		Completed – outcome fed back to leads and patient safety lead for Unscheduled Care.	
							Quarterly internal audit to check compliance for both paper and electronic records	Apr-18		ECDS implemented 1st October creating the need to higher level validation of records undertaken on a daily basis which has increased time taken to complete from 1.5 minutes to 6 minutes. Currently takes place via daily checks following the implementation of ECDS on a selection of CAS cards and regular review of electronic information. Will revert to quarterly checks once ECDS has embedded.	
						Andrena Weston	Identify a schedule of cleaning & displayed	Dec-16		R&D responsible for stores; Floors & general environment theatres. Quality checks undertaken weekly - any issues escalated to Head of Procurement.	

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MD016	Compliance Action Regulation 15 Ensure maintenance and cleaning schedule in place for : - Theatres storeroom - Mortuary	SUR	PRH	Neil Nisbet	Carolynne Scott	Katy Moynihan/Alan Jackson	Audit programme to monitor performance: IPC/H&S	Oct-17	1. Improvement in compliance	**IPC Quality Ward Walk** in theatres biannually - July results 71%, theatre manager advised (dust on trolleys/clinical waste bags stored behind bed spaces) **H&S** - ED/Theatres/Mortuary included in regular audits and first one scheduled for September 17 - Rescheduled for Nov 17 **Theatres -** areas outside the operating theatres are monitored monthly by facilities, this will be increased to bi-monthly from Oct-17 then back to monthly if no concerns as per guidelines **Storeroom -** Cleaning schedule completed daily and regular checks are carried out. Plan in place to review results at the end of December 2017 **Mortuary** – facilities will monitor monthly from Oct-17 then back to monthly if no concerns as per guidelines	On Track to deliver
MD017	Compliance Action Regulation 15 Ensure equipment in theatres is repaired or replaced as required to ensure it is fit for purpose and keeps people safe	SUR	RSH	Neil Nisbet	Carolynne Scott	Andrena Weston	Implement robust process	Jan-17	1. Improvement in compliance	Process in place to report all broken/faulty equipment, add to Datix and Medical Engineering who keep an up to date asset register and RAG rate all assets.	Delivered
MD018	Compliance Action Regulation 12 Ensure that midwives consistently prescribe medicines given in labour, in line with Nursing and Midwifery Council practice standards. Ludlow MLU specifically	MGY	MLU	Deirdre Fowler	Sarah Jamieson	Anthea Gregory-Page	Staff communication on NMC requirements on prescribing medicines in labour	Jan-18	1. Improvement in compliance 2. Evidence of embedded practice	Memo circulated to staff regarding responsibility and accountability in accordance with NMC rules Sept-17	On Track to deliver
						Jacqui Bolton	Reduce number of PGD's (patient group directives) and revert to midwives exemptions (do not require prescribing)	Jan-18		Exception list identified correlated with PGD reduction. Policy circulated to HoM, Director QNM and Pharmacy (*Deadline revised from Nov 2017 to Jan 2018 due to limited number of Safer Medicines Committee Meetings-Dec)*	
						Anthea Gregory-Page	Midwifery advocates to spot check and action non-compliance with midwives	Apr-18		To commence January 2018	
						Rachel Lloyd	Audit midwives compliance on prescribing and recording medicines in labour (prescription sheet)	Mar-18		Documentation of medicines to be audited within the Care of Women in Labour Audit	
MD019	Ensure accurate monitoring of the maternity escalation policy for all areas including Wrekin MLU.	MGY	Both	Deirdre Fowler	Sarah Jamieson	Anthea Gregory-Page	Escalation process to be reviewed and policy to be updated	Nov-17	1. Improvement in compliance 2. Evidence of embedded practice	Guidelines Midwife meeting with HoM 12/09/17 to review the guideline. *(Deadline moved from Nov 2017 - Jan 2018 due to limited number of Meetings for ratification)*	On Track to deliver
						Sue Watkins	Refine process for recording and monitoring Wrekin midwifery hours when consultant unit busy (initiate full escalation process)	Dec-17		Escalation forms in use	
							Ensure Wrekin MLU use central database for recording	Dec-17		Escalation forms monitored via central database at Maternity Governance	
						Jill Whittaker	Ensure Labour ward adhere to escalation process	Dec-17		Spot checks by Matron Complete reporting at Maternity Governance	
MD020	Stroke patients did not always receive timely CT scans due to availability and reliability of diagnostic imaging equipment	MED	PRH	Edwin Borman	Debbie Jones	Glen Whitehouse	CT scanner on risk register	Sep-17	1. Reduced downtime 2. Stroke patients reiving timely scans	Monthly review of risk register in place. Gold standard maintenance contract with remote diagnostics in place to ensure maximum uptime	On Track to deliver
							Overarching review of care pathway to streamline and make effective use	Apr-18			
						Graham Mills	Progression on west midlands peer review/stroke improvement plan	Apr-18		Stroke Improvement plan action 1.1 - all stroke patients receive a scan within 4 hours (1 hour target) due for delivery Oct-17	
						Glen Whitehouse	Plan for capital replacement	Sep-19		Replacement planned for 2019/20. Awaiting update from Radiology Manager.	
						Graham Mills Glen Whitehouse	Business continuity plan in place (Equipment and also Stroke patients)	Oct-17		BCP for equipment in place; Debbie Holland developing BCP for stroke patients (in place by end Oct-17)	

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MD021	Ensure they are preventing, detecting and controlling the spread of infections, associated in the mortuary department by ensuring surgical instruments are decontaminated to a high level and there are arrangements in place for regular deep cleaning. Following our inspection the hospital arranged a visit from an infection control lead who recommended a washer disinfector to comply with HSE guidance.	EoLC	Both	Deirdre Fowler	Dee Radford	Sheila Fryer	Procurement of washer disinfector	Nov-17	1. Care group audit 2. Reported at care group board	Due to a gradual fall in the number of post-mortems being requested all post-mortem activity for the Trust will be transferred to RSH from October 16th 2017 Our DIPC, Dr O'Neill, has confirmed that a washer-disinfector needs to be installed at RSH, but there is therefore no longer a requirement to install one at PRH. The situation as at 30 August is that there are three potential models that could be used. Estates and CSSD are meeting with the mortuary staff in early September to identify where the equipment may be placed. Plan to have in place before the 16 October move. 17/11 Email to Sheila Fryer for an update	On Track to deliver
							Annual inspection by IPC team (Jan 2018)	Jan-18			
MD022	ED meets the Department of Health's target of discharging, admitting or transferring 95% of its patients within four hours of their arrival in the department (Part of Trust operational plan)	ED	Both	Debbie Kadum	Colin Ovington	Matrons	Work with Director of Transformation who is leading with ED development. Embed internal actions to improve patient flow: fit2sit/SAFER/bed realignment and frailty	Sep-18	1. AE Delivery board 2. Weekly Executive meeting 3. Sustainability Programme 4. Trust board	Weekly ED Improvement meeting in place to progress actions to improve performance. Update 17/11 (RH) Introduction of fit2sit, improved ambulance handover process and review of specialty input are all ongoing to help improve patient experience. GP streaming has also now been implemented at PRH since 28th October 17.	On Track to deliver
MD023	Review the arrangements for the care of children in the emergency department to ensure it reflects the Royal College of Paediatrician (RCP) standards	ED	Both	Edwin Borman	Jo Banks	Lynn Atkin	Review and recommendations to ED to be completed	Sep-17	1. AE Delivery board 2. Weekly Executive meeting 3. Sustainability Programme Trust board	Scheduled to be completed by end of Sept-17. 17/11 Email to Lead Nurse regarding September deadline	On Track to deliver
							Formulate plan based on recommendations	Dec-17		Formulate plan based on recommendations	
							Ensure RCP standards included within SSP programme	Sep-17		All our new buildings in relation to the SSP will be in accordance to the Department of Health's HTM (Health Technical Memoranda) and HBN (Health Building Notes)	
MD024	Compliance action - Regulation 15 Ensure sufficient emergency equipment is available to respond to emergencies ED 'the corridor was not fitted with oxygen or emergency equipment, and we saw ambulance staff using equipment they had brought from their ambulances to monitor patients'	ED	Both	Neil Nisbet	Rebecca Houlston	Ceri Adamson	Explore options for having an oxygen storage facility near the ED corridor	Oct-17	1. Care group board sign off	Estate/Matron have explored options **PRH -** Oxygen cylinders are secured to the wall just off the main corridor (where waiting crews are accommodated). **RSH** - Every A&E trolley has a large oxygen cylinder on the trolley which is checked daily. There is portable suction in Resus that can be used in the corridor but in the case of a patient deteriorating in the corridor the patient would be moved immediately into Resus. It would cause health and safety and fire issues to store equipment in the corridor. We have portable dynamaps to carry out observations in the corridor. Added to USC board for 28th September (AOB - Risk Appraisal and mitigating actions)	Delivered
							Inclusion within SSP programme	Sep-17		All our new buildings in relation to the SSP will be in accordance to the Department of Health's HTM (Health Technical Memoranda) and HBN (Health Building Notes)	
MD025	Staff have access to a translation service, and that all staff are aware of the service	ED	Both	Deirdre Fowler	Graeme Mitchell	Graeme Mitchell	Part of actions to address MD010	Dec-17		See MD010	On Track to deliver
	Should Do Actions										
SD001	All staff receive an annual appraisal	TRU	Both	Victoria Maher	Care Group Directors	Mary Beales	Review practicality of current targets	Sep-17	1. Cascade through governance process 2. Evidence of improvement in	Revised targets considered in a paper to October 2017 Workforce Committee and approved for forwarding to November 2017 Trust Board	On Track to deliver
							Review at board	Nov-17		For review and approval at November 2017 Trust Board as part of Workforce Committee report *Deadline revised from Oct-17 to Nov-17*	

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							Raise awareness to all staff of responsibility (1 minute brief)	Nov-17	performance	1 minute brief will be drafted and disseminated following decision at November 2017 Trust Board	
							Monitor through dashboard & education department	Sep-17		Process in place	
SD002	Audits of adult oxygen prescription & administration records are completed	TRU	Both	Edwin Borman	Bruce McElroy	Ruth Dudgeon Vicky Jefferson	Formal Communication by Medical Director regarding requirements to prescribe oxygen (Regulation 12). Monthly Audit program to be extended to review adult prescriptions and administration records for Oxygen Therapy, in addition to routine prescribing and record completeness audits.	Mar-18	1. Improvement in performance	In September the pilot audits will be developed for both sites. The pilot audits will commence in October 2017 (respiratory wards) and any deficiencies and resultant actions provided to the Care Group Governance meetings in November/December 2017. Inclusion into Medicines Management audit program across all wards and clinical areas in Quarter 4 2017/18 with any identified training support. Subsequently regularly audited on a rolling basis to assure continuing improvement. Support to be provided by Care Group Governance leads to fully support rapid implementation in response to any deficiencies and resultant action plans	On Track to deliver
SD003	Audits of adult 24-hour fluid balance charts are completed.	TRU	Both	Deirdre Fowler	Helen Jenkinson	Helen Coleman	CPF's & Corporate Nursing team to provide support and guidance to wards	Apr-18	1. Improvement in compliance		On Track to deliver
						Angela Hughes	Include Fluid balance on masterclass for band 6	Oct-17		Included in October masterclass	
						Sally Allen	Audit of completion of fluid balance charts (clinical audit)	May-18		Included in audit planner for May-18	
SD004	Staff understand their part in responding to a major incident in their area	TRU	Both	Debbie Kadum	Sara Biffen	Stewart Mason	Recruit full time Emergency Planning and Resilience Officer (EPRO)	Jul-17	1. EPRO sign off	Fulltime EPRO in post since Jun-17	On Track to deliver
							Undertake live exercise	Jul-18		Scheduled to take place Jul-18	
							Commence table top exercises for all specialities	Dec-17		Process implemented with first exercise due to commence in Dec-17	
							Bespoke EP Awareness sessions to be offered at Ward/Department level	Jan-18		Away days/forums of 1-2 hour duration developed. RSH ED commenced with PRH starting in Dec-17. ED department scheduled to be complete by Jan-18	
							Develop bespoke business continuity plans for each service/ward/department and staff aware of content	Jun-18		Clinical areas will be the priority	
							Incident response folders in place for all ward areas with evidence that staff have read and understood the guidance	Mar-18		In progress	
SD005	Ensure agency staff competencies are monitored or assessed to ensure they were safe to work on the wards	TRU	Both	Deirdre Fowler	Helen Jenkinson	Liz Walton	Introduce robust process for reviewing competencies on induction	Oct-17	1. Evidence of a 'fit for purpose' contract 2. Improvement in compliance	Proposal presented at NMF Oct-17	On Track to deliver
							Governance incorporated into agency contracts	Apr-18			
						Ceri Adamson Kath Preece Lynn Atkin	Consistent practice of checking agency competencies on arrival to ward	Aug-18		**USCG** - Matrons to check comprehensive records kept	
SD006	Consider introducing competency frameworks for nursing staff working in surgical specialisms to ensure they had the right skills. (e.g. urology/vascular)	SUR	Both	Deirdre Fowler	Helen Jenkinson	Kath Preece	Extend work to cover other specialities	Jul-18	1. Improvement in compliance	Ophthalmology, Endoscopy, Tracheostomy in place already. HoN exploring other specialisms that require specific competencies	On Track to deliver
SD007	Wider learning from complaints is promoted as staff did not get to hear about complaints in other areas	TRU	Both	Julia Clarke	Julia Palmer Graeme Mitchell	Reps from Care Groups attending CGE	Learning report to be taken to CGE on a regular basis for dissemination amongst care groups	Oct-17	1. Evidence of review and action in minutes of meetings	Learning report is now a regular agenda item and has been presented at the September and October meetings	On Track to deliver
						Ceri Adamson Kath Preece Lynn Atkin	'You said, we did' posters in clinical areas to enable both staff and members of the public to be aware of changes	Jan-18		Plan to disseminate 'You said, we did' posters at the Governance meetings through November & December with implementation planned for 1 January 2018.	
					Care Group Directors	Julia Palmer	Reports at Care Group Board meetings and Governance Meetings to include details of learning	Oct-17		Reports to Care Board meetings now include details of learning. All learning from incidents & complaints in Women & Children's Care Group presented to Governance meetings & Care Group Board on a monthly basis.	

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					Graeme Mitchell	Julia Palmer	Develop closer links with Patient Safety team for triangulation of data and sharing of joint learning	Mar-18		Work has commenced through reporting at CGE and weekly rapid review meetings. Following meetings SCG share with all matrons and learning is taken through to CGE, NMF and Q&S committee.	
					Graeme Mitchell	Care Group Directors	Patient stories to be shared and discussed at the start of each Care Group Board Meeting	Dec-17		Scheduled Care to start using patient stories in November. Women and Children's to start from January as the November and December Boards are being used for Business Planning. Not had an update from other Care Boards yet.	
SD008	Regulation 12 Provide signage on the store room door containing portable Entonox to inform people that compressed gases are stored there.	MGY	Both	Neil Nisbet	Martin Foster	Anthea Gregory-Page	Ensure signage on room doors where Entonox cylinders stored Compliance to be monitored via Health & Safety Audit	Sep-17	1. Observational check	Areas have temporary laminated signs to denote gas storage. Permanent signs to comply with HTM have been ordered Emails sent to ward managers asking them to identify if any other areas that require signage stickers H&S audit updated to include question to check appropriate signage in place	Delivered
SD009	Any changes to medications are signed for appropriately	TRU	Both	Edwin Borman	Bruce McElroy	Ruth Dudgeon Vicky Jefferson	Monthly Audit program to be extended to review prescriptions and administration records to verify any changes are signed appropriately.	Mar-18	1. Improvement in compliance	The pilot audits will be developed for both sites. The pilot audits will commence in November 2017 and any deficiencies and resultant actions provided to the Care Group Governance meetings in January/February 2017. Inclusion into Medicines Management audit program across all wards and clinical areas in Quarter 4 2017/18 with any identified training support. Subsequently regularly audited on a rolling basis to assure continuing improvement.	On Track to deliver
							Review the Trust Prescription Writing Standards to consider emphasising the importance of recording and signing any change in prescriptions (increase awareness/compliance)	Mar-18		An initial review of the Trust Prescription Writing Standards is complete, no changes were required at this time. This was discussed at the Trust Safe Medication Practice Group. A further review is due in March 18 which will take into account the findings and actions from the pilot audits. *Deadline revised from Sep-17 to Mar-18*	
SD010	Consider using the maternity specific safety thermometer to measure compliance with safe quality care	MGY	Both	Deirdre Fowler	Sarah Jamieson	Angela Hughes	Working party to scope implementation and project plan	Dec-17	1. Audit in place	Implementation methods in consideration All metrics with the exception of 3 are currently collected elsewhere	On Track to deliver
						Julie Lloyd	Secure IT resources including RaTE	Jan-18			
						Julie Lloyd	Train staff and promote awareness	Feb-18			
						Sarah Jamieson	Maternity governance to review outcomes and formulate actions to address deficits	Apr-18			
SD011	Ensure access to Woman's notes when women arrive at the MLU in labour so that staff have relevant information about the woman.	MGY	Both	Deirdre Fowler	Sarah Jamieson	Anthea Gregory-Page	Prompt on Medway (at completion of delivery records)	Oct-17	1. Monitor Dashboard	Prompt on Medway (at completion of delivery records)	On Track to deliver
							Memo to remind staff to complete a Datix if notes unavailable at time of delivery	Oct-17		Memo to staff to be sent	
							Add bookings of women without notes to the dashboard	Apr-18		Discussions with Data Analyst to add this metric to dashboard - planned for April 2018	
SD012	Ensure dying patients and their families are asked about their preferred place of death and that their wishes are recorded.	EoLC	Both	Deirdre Fowler	Graeme Mitchell	Graeme Mitchell	Progression against National End of Life national audit and delivery	Dec-18	1. Monthly written CGE report 2. Quarterly written report to Q&S 3. Improvement in performance on national audit 4. Palliative care recorded on Somerset	Not appropriate to include on fast track checklist, included on EoLC input form. EoLC team have started documenting PPC in the notes when they have the conversation	On Track to deliver
						Jules Lewis	EoLC input form to include Preferred Place of Care (at end of life)	Aug-17		Palliative care on Somerset register PDD EoLC plan checklist developed which asks staff to consider PPC (18/10)	
						Jules Lewis	More training on EoLC plan as questions are already included	Nov-17		18/10 Documentation workshop. Plan redesigned and checklist created. Ideas to be implemented over next few weeks/months	
						Emma Corbett	Raise awareness foundation 1&2	Mar-19			
						Graeme Mitchell	Raise profile of what matters to me @ NMF	Oct-17		Presented at NMF Oct-17	

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						Jules/Emma	1 minute briefs/chatterbox/screensaver	Jan-18	recorded on Somerset		
						Jules	masterclass briefings	Oct-17			
						Jules/Palliative care team	intranet page reviewed - palliative/EoLC	Jan-18			
						Emma Corbett	change audit proforma	Jan-18			
						Sally Allen	Re-Audit of documentation	Feb-18			
						Jules Lewis	Review provision of information regarding home care and increase awareness	Nov-17		PPC in end of life care plan. Stopping in Dec 17 handed over to new roles within the community. Close when handover occurs	
SD013	Risks in relation to EoLC are recorded on the risk register	EoLC	Both	Deirdre Fowler	Graeme Mitchell	Alan Jackson	Mortuary/EoLC to review current issues and identify any risk which require escalation to risk register	Sep-17	1. Up to date risks in place	Manual handling of bodies (Ref 1119) included regarding transfer of services to RSH	Delivered
						Jules Lewis	EoLC to review current issues and identify any risk which require escalation to risk register	Sep-17		EoLC Service (Ref 1270) added to register CQC report identified lack of palliative care consultant at time of inspection but this has since been resolved with recruitment of part time palliative care consultant (Emma Corbett)	
SD014	Hand washing facilities are available in the emergency department's corridor, to prevent patients; dignity being compromised when staff use hand basins in nearby cubicles	ED	Both	Deirdre Fowler	Ceri Adamson	Janette Pritchard	Ensure added to risk register	Oct-17		IPC have reviewed and a sink not required	On Track to deliver
							Develop plan to address (purchase/hire of portable sinks)	Nov-17	1. IPC audit/observations 2. Reduction in risk score on risk register	Discussed at water safety meeting (wk. 25/09/17) Dr P O'Neill confirmed legionella risk associated with portable sinks. Estates will explore options and provide costings to fit permanent WHB but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017). RSH ED Matron explained that there was no room in the clinical corridor to install a WHB and that each side room / bay had one fitted. IPC visited RSH with Matron and confirmed a change in how they now use the area and there is now a fit to sit assessment areas where blood can be taken and would not recommend a sink in the corridor. IPC attended PRH with Estates and there is room to fit WHB so will go ahead with work. Assurance Lead emailed Ops Lead to circulate comms to teams about being mindful of patients dignity as mitigation at RSH.	
							Inclusion within SSP programme	Sep-17		All our new buildings in relation to the SSP will be in accordance to the Department of Health's HTM (Health Technical Memoranda) and HBN (Health Building Notes)	
SD015	Review the exterior lighting and signage at ED to ensure members of the public are directed to the correct entrance.	ED	RSH	Neil Nisbet	Carol McInnes	Rebecca Houlston	Patient journey to be walked through to identify areas of improvement	Oct-17		Session to be arranged (Ops & Ward Manager). Update 17/11 Following a further review with POWYS further review is required right up to the mini island at RSH. To be completed wc 20/11/17 Estates are able to provide costings but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017).	On Track to deliver
							Act on recommendations from patient journey and further review	Dec-17		17/11 Awaiting confirmation from Ops to check review took place.	
SD016	Access to the emergency department children's waiting area is controlled	ED	RSH	Neil Nisbet	Jo Banks	Jon Simpson	Security Manager to scope requirements/costs	Sep-17	1. Risk assessment	SD016/17 combined - potential costs in excess of £5k. Review recommends key padded locks in place of 'press to exit', timer programmes, doors locked during quieter periods 11pm-1am, relocating relatives room. Estates are able to provide costings to fit permanent HWB but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017). 17/11 New action carried forward for business case	On Track to deliver

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							Review recommendations and agree plan	Apr-18		Associate Director of Estates confirms if work to go ahead paper/business case required to Capital Planning. Awaiting formulation of Business Case. Email sent to ED Manager	
SD017	Review the security of access from the public waiting area into the resuscitation, majors and minors patient treatment areas to ensure staff and patients are protected from avoidable harm.	ED	RSH	Neil Nisbet	Martin Foster	Jon Simpson	Security Manager to scope requirements/costs	Sep-17	1. Risk assessment	SD016/17 combined - potential costs in excess of £5k. Review recommends installation of opaque (safety) glass panel and key padded locks. Requires further discussion with wider team around any new risks introduced from potential changes and identify funding for any agreed changes. Estates are able to provide costings to fit permanent HWB but a business case will need to be submitted to capital planning by care group, suggests one combined one (SD014, SD015, SD016 & SD017).	On Track to deliver
							Review recommendations and agree plan	Apr-18		As SD016	