Annex A: WSFT Improvement Plan - Status Summary Report

Version date: 24th July 2020

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	1. Implement Trust-wide staff engagement project to elicit feedback to inform decision-making, including establishment of a BAME Staff Network. 2. Establish an executive team development programme, including 360. 3. Utilise the medical engagement scale to better understand and support improvement for the factors underpinning clinical engagement. 4. Establish a staff psychological support service to enhance well-being support for our teams. 5. Provide an organisational development update to the Board.	Stephen Dunn	Jeremy Over	Green	30.11.20	On track for completion Nov 20 based on QA Meeting with Jeremy Over. Update 29.06: - "What Matters to You" survey 1400 had over 1,400 responses in terms of learning from our staff's experience of Covid-19 - Beter Working Lives survey being undertaken by Paul Molyneux - BAME staff network established and first meeting held - A review policies is happening to ensure a more compassionate approach reflecting a just and learning culture - Investment in Staff Psychology services agreed and led by Emily Baker to support staff through Covid-19 - Freedom to Speak Up Guardian position out to recruitment -Link also with relevant items in related plans eg Duty of Candour (Plan 10) **Update 13.07.20: Additionally re-instated daily executive and senior nurse and doctor walkabouts and feeding back to staff more regularly in comunications.** **- JO to plan feedback process from IPB Membership to achieve consensus in terms of 'what does assurance and evidence of embedding mean' for Plans 1 & 2 given measuring outcomes / culture improvements ref culture**
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	30.11.20	On track for completion Nov 20 based on QA Meeting with Jeremy Over. Update 29.06: See 1 above. - Freedom to Speak Up Guardian position out to recruitment **Update 13.07.20:** **- Interim FTSU Guardian in place whilst recriutment process completes. Important right person recruited and supported to lead developments hence Nov end date.** **- Additional actions to be added to plan to ensure required improvement happens**
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.	1. Review of current incident pathways and their compliance to highlight areas for improvement. Include the outcome of this review in the design of new pathways as an integral element of the implementation of the Patient safety & improvement framework (PSIRF) 2. Ensure all divisions are supported to achieve these outcomes through the central patient safety / clinical governance team	Susan Wilkinson	Lucy Winstanley	Red	31.10.20	Overall RAG progression Amber subject to PSIRF implementation which has now recommenced. Trust is an early adopter of national PSIRF programme. **Update 09.07.20:** Overall RAG moved to Red. Plan's 3 and 4.3 will be re-drafted for submission and review at the next SRO Improvement Cluster meeting to ensure that specific actions in the plans can be progressed and deivered within the constraints of: 1) The national PSIRF programme 2) Trust review of Patient Safety and Quality **Update 13.07.20: Trust is an eary adopter of national PSIRF Programme which has been paused due to the pandemic. Progressing the work internally and not depending on national PSIRF programme for completion but moved to Red due to Covid-19 delays**

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4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Lucy Winstanley	Red	31.10.20	**Update 25.06.20**: See Plan 4.1 for line for line updates. Plan moved to Red RAG. - Assigned leader of actions on secondment. Update will be provided at next SRO Cluster re backfill arrangements - One audit software package to be selected in July. -Divisional national audit participation meeting cancelled in June (CSEC) -Defining Clinical Governance Manager role is part of Trusts Patient Safety & Quality Work. Definitions around central and divisional governance functions required. -Interim divisional clinical audit requirement – escalated as an agenda item **Update 13.07.20: Resource available to provide backfill and actions should progress quickly when post filled and so end date 31.10.20 stands.**
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Green	31.10.20	All ME Officers in post. MEs all recruited, some start dates have been delayed and plans are in place to manage service pending all being in post. **Update 13.07: Plan 4.2 will be reviewed in detail at the next cluster which has been arranged in line with project lead's availability. Overal green with some actions complete but will need further assurance and a forensic examination.**
4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Red	31.10.20	See No 3
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - complaints are monitored and reviewed to drive service improvement.	1. Undertake NHSE&I patient experience framework assessments across the whole Trust 2. Review of divisional reporting of actions and learning from complaints, including accurate recording of service improvement linked directly to changes as a result of feedback	Susan Wilkinson	Cassia Nice	Complete	31.10.20	Project Status Amber as audit of improvement actions required. Patient Experience Managers for Complaints and PALS in post together with Patient Experience Administrator. Update 23.06.20: 5/6 points in the plan ready for submission and approval at Implementation Board to move from Black (complete) to Blue (BAU. All these actions complete with no further monitoring required. - Business case for patient experience and PALS roles approved. - All postholders in place and positions are permanent. Point 6 should remain Black (complete) to allow time to evidence attendance and outcomes from divisional Board meetings. **Update 13.07.20: Actions complete but not yet BAU ready. Continued monitoring required. Complaints are reducing but the team needs to be in place to continue to monitor to ensure KPI's are still being met.**
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	31.10.20	Status green as work on track for completion by October 2020. Elements of work are complete i.e. Just Culture training carried out by Trust solicitors. Further tasks to embed a just and learning culture in the Trust are now starting up (post Covid-19). **Update 29.06:** -Review Mersey Care re Just and Learning model. - Mersey Care HRD booked for a 5 o'clock club - Reviewing investi+S15gation toolkit undertaken by project team / linclude investigation recording system updates in plan. October completion date reflects time to complete the investigation toolkit. Update plan with PMO before next SRO Cluster **Update 13.07.20:** **- Slot to review plan with PMO agreed** **- Merseycare NHS HR Director presenting at next 5 O' clock Club**

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6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Design process for follow up booking 2. Recruit two new members of staff in TAC for all ward booking follow ups. Write SOP for Endoscopy. 2. Update all relevant Standard Operating Practices for Follow Ups and Surveillance. Write SOP for Endoscopy. 3. Identify and deliver any training needs within each specialty and Endoscopy 4. Design process for virtual surveillance booking of patients 5. Clinic Patients Missing Follow Ups - e-Care work 6. Prepare Communications piece for Green Sheet/Staff Briefing 7. Agree Go-Live date and communicate to all relevant parties	Helen Beck	Angela Price	Red	31.3.21	Processes in place. QA review also ascertained that Covid-19 holding statement and clear plan are also in place to pause safely. Actions are therefore essentially complete. Update 25.06: Overall status RAG moved to Red as plan needs to be re-focussed. Agreed action AP/CA to meet PMO to update. Update 09.07: Action completed. Revised plan prepared with Holding Statement for review at July SRO Improvement Cluster. **Update 13.07.20: Most of actions were done but now a different landscape with Covid-19 and the number of patient appointment cancellations. HB meeting with teams regularly and is obtaining frequent reassurance but further assurance required. The team is pulling together a status report of supporting evidence re: lists and actions as part of move back to business as usual operational process. Key issue is size of backlogs and capacity is less than previous to undertake the work. Surveillance programmes have been paused. Pathways still in place.** **- HB to provide assurance (detailed information) at next IPB 10.08.20**
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Amber	31.12.20	Overall RAG iAmber. Is clear plan but are resourcing issues and some of face to face actions cannot be completed during pandemic. - RTT Reporting workstream mainly complete. - Theatres Information workstream has continued and is on track. - RTT Training and Data Quality work streams paused due to resourcing issues and pandemic given requirement to be on site **Update 23.06:** - RTT Reporting – Mainly complete but cannot turn Blue as embedded before Trusts October update complete with testing evidence, which should resolve issues of remaining manual work arounds. - RTT Training – Looking to provide remote training for staff working from home. NY / HK are working to see how can be done electronically. This is an action to add to the plan. For administration staff it may be as simple as running same meetings via Teams. For Clinical Forums may record, demonstrate and provide PowerPoint online learning quiz. - Data Quality - DQ actions will be further progressed subject to resources and needs further discussion with SRO Theatres Information – Dashboard in place but cannot turn Blue as embedded until the dashboard can be used and tested under more normal circumstances post Covid-19 as not all theatres are open presently. - **Update 13.07.20: Outstanding workarounds do not present significant risk and will be resolved over next quarter. Out to advert for DQ Manager and so plan should turn green at next cluster**
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Green	31.12.20	**Update 23.06:** Overall RAG green. Whilst Community project implementation heavily impacted by pandemic, IT been able to facilitate other postive developments including remote working, which were not planned prior to Covid-19. Work recommenced on community integtation from June 20 and on track for December 20 completion. RAG may move to Amber subject to level of co-operation with NELCSU regarding migration around which there is a significant risk. Mike Bone to inform group if RAG needs to change.

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9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	1. Develop business cases for Orthopaedics, Ophthalmology, General Surgery and Gynaecology 2. Business Cases to include up to date demand and capacity models, outline plans and costings to reduce current backlog, whilst balancing demand to enable the services to meet the national standard. 3. Continue to update Action Plans for all other specialities on a monthly basis 4. Review and monitor plans at new RTT steering group meeting with the ADO's, Weekly Access Meeting and Cancer PTL Meeting 5. Develop comprehensive action plan for Endoscopy now demand and capacity exercise complete for review at new bi-weekly Endoscopy oversight meeting	Helen Beck	Hannah Knights	Red	31.3.21	The Overall RAG is green as there is a clear plan and a realistic completion date but the work has been impacted by Covid-19. Clear plans being developed as part of Corvid recovery phase 3. Update 25.06: Overall RAG status moved to Red. Plan needs to be re-focussed. HK/AB to update plan. HK to prepare Covid-19 Holding Statement **Update 09.07.20: Covid-19 Holding Statement prepared. Revised Plan pending for review at next SRO Improvement Cluster.** **Update 13.07.20: The demand and capacity work was initially completed but since then capacity has reduced and there is uncertainty regarding future demand. Recovery of elective activity post Covid-19 is likely to take 2 - 3 years. The priority is diagnostics and cancer first and then 18 week waits.**
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Red	31.10.20	Overall RAG is Amber as Duty of Candour work is integral to PSIRF Implementation (see No 3). All actions therefore switched to Amber with end date 31.10.20. The Trust Board has maintained oversight of compliance and addressed performance issues as part of ongoing incident review process. The revised plan will be presented at the Quality Group in July to agree the next steps with a key group of stakeholders. **Update 23.06.20:** Overall RAG moved to Red. Plan will be recalibrated for submission at the next SRO Improvement Cluster. The revised plan will be presented at July Quality Group to agree next steps with a key group of stakeholders. Similar with Plan 3 and 4.3, Plan 10 is subject to the development of the Trusts Patient Safety and Quality Agenda which is reporting at TEG 20th July. **Update 13.07.20: Another plan wrapped up in PSIRF and again not taking eye off the ball. More updates to follow next month.**
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	31.7.20	Assurance testing being undertaken for most recent executive (acting) and NED appointments. **Update 29.06:** No. items in plan to be increased to reflect delivery. **Update 09.07.20:** HR met with PMO. Plan has been updated **Update 13.07.20: The small number of identified gaps within personal files have been of senior appointments have been rectified. Adequate processes are now in place.**
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Amber	31.05.21	Overall RAG Amber as mandatory training has continued for new starters but not for existing staff for duration of pandemic. Through a risk based approach the current Mandatory Training Recovery Plan is presently being reviewed as work is being restarted. **Update 29.06:** Plans will be updated re Covid-19 and second recovery plan for Mandatory Training. - Revised Plan will be presented at TEG July 20. - Mandatory training to be reviewed with W&C division - Issue is that PROMPT training needs to be mandated **Update 13.07.20: Long date (31.05.21) due primarily to capacity with limited access to education centre due to pandemic. Requires e-learning development. End date will be reviewed and may come forward but dont want to over promise.** **- Plan to mandate PROMPT Training is in place.**

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13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff which are non-compliant 9) Add to perfect ward 10) Monitor through weekly compliance audits and regular communications with ED staff re changes and be proactive with feedback re further changes	Susan Wilkinson	Ian Pridding	Amber	31.8.20	Overall RAG is green and on track. Patient safety checks being included on perfect ward app. Overall RAG moved to Amber. Awaiting compliance data report from Information Team (expected Mid July) regarding Patient Safety Checklist compliance as technical issues now resolved. Accurate compliance data will provide the levers to drive improvement through 1:1's or via the line managememt structure as it will be clear who is / not completing the Patient Safety Checklist. All relevant aspects of compliance will be added to the Perfect Ward App - A poster will be produced for the ED department for patients to view which presents the idealogy behind the Patient Safety Checklist and the Trusts commitment to it. - The first five parts of the plan are complete and are ready for submission to the IB for approval in July. **Update 13.07.20: Key actions due to complete in July including accurate compliance reports from the information team so may turn green at next cluster**
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken	Susan Wilkinson	Dona Bowd	Green	31.08.20	Overall RAG green. Daily recording in place on wards with matron rounds then checking completion through Perfect Ward App. **Update 08.07.20:** Plan essentially complete with 7/8 items immediately ready for approval at IB to move to Blue (BAU) as room and fridger temperature planned improvements are embedded and monitored. Item 8 on the plan is to add room and fridge temperatures to the Perfect Ward App **Update 13.07.20: Findings related principally to ED and Maternity but this is an area again where the Trust has taken the opportunity to review organisation wide. 7/8 actions complete and internal checks confirm compliance but still need ongoing assurance to 31.08.20.** **- Also, central temperature recording system maybe something to look at in new building. Central collation system required and so monitoring assurance needs development.**
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Green	31.07.20	Paper format - Infection prevention to revisit plan to meet with IT re replicating updated electronic forms on to the online checking system. **Update 08.07.20:** Plan essentially complete with 5/6 actions to review and improve resuscitation equipment and medication checklists ready for submission to IB for approval. The last remaining item on the plan is to customise the online checklist template on e-Care for all ED areas for individual resus trolleys. This work has been impacted by Covid-19 and the ED Matron will pick up again with IT to complete this action. **Update 13.07.20: Similar to plan 14, majority of actions complete with one key item to complete in July 20 and again to work on centralised log for monitoring.**

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16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	<u>Controlled drugs and storage of patients own mediciation</u> 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance <u>Ambient room temperatures</u> 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	Amber	31.10.20	Overall RAG green. Actions mainly complete - wards reported broken lockers repairs made by facilities. Audit of compliance being implemented through PerfectWard App to embed practice through leadership of Heads of Nursing Update 08.05.20: Overall plan moved to Amber. Actions complete with exception of mock inspection re medicines management (medicines storage). However, holding statement prepared re actions that need to be added to the plan for delivery so that plan be embedded: Holding statement 08.07.20: No guarantee actions in plan mean that problems around the safe storage of medications will not recur: - Further communications required to ensure message is getting across to relevant ward staff, including managers and matrons, to ensure the actions are being implemented consistently across the organisation. - Appropriate monitoring arrangements will also need to be in place if the plan is to move to Blue (BAU). - Consideration should be given as to whether any of these processes could be automated. These actions should be added to the revised baseline plan before the next SRO Improvement Cluster meeting **Update 13.07.20: Additional items added to plan. SW meeting with SWh to review actions in plan to achieve BAU.**
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process. Ad hoc audits will be undertaken by WSG and MS with findings reported to HRD on a quarterly basis	Jeremy Over	Holly Randall / Helen Beard	Green	31.12.20	Overall RAG green with one remaining amber action: HR to check with CDS what is focus on OLM. Assurance process to be agreed. Update 29.06: New WSP Manager starts 1st July '20. Status of plan reviewed and updated with new actions assigned given departure of manager. **Update 13.07.20: New WSP Manager in post with detailed updated action plan for implementation.**
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Green	31.10.20	Overall RAG green. Weekly QA call through June with Project Lead. Update 25.06: Project progressing and on track. **Update 13.07.20: On track and has progressed despite Covid-19 and could potentially bring end date forward and present to Board for approval / BAU once the audit reports are presented by the team.**

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20	The trust must improve monitoring ambient room temperatures in drugs rooms.	1. MDT meeting to access temperature monitoring options available 2. Prepare baseline assessment of ambient temperatures in Clinical Area 3. Investigation cost associated with automated temperature monitoring equipment and Air conditioning 4. Ordering of Max/Min room temperature thermometers 5. Creation of Ambient temperature monitoring record book for clinical areas 6. Creation of Ambient temperature monitoring email address for wards to use to report temperature exclusions 7. Distribution of max/min room temperature thermometers to inpatient clinical areas 8. Ordering of second batch of Max/Min room temperature thermometers 9. Distribution of second batch of max/min room temperature thermometers to inpatient clinical areas 10. Creation of MedicBleep ambient temperature reporting message group 11. Creation of Perfect Ward monitoring tool for Ambient temperature monitoring 12. Completion of Risk Assessment of actions if high ambient temperatures recorded	Susan Wilkinson	Simon Whitworth	Complete	28.2.20	Overall RAG Black Complete. Trust Guidance now in place for managing adverse ambient temperatures - this is also a risk assessment tool. As an additional action, Perfect Ward App will be introduced to ensure compliance with requirement around recording temperature monitoring. Action implemented, assurance testing ongoing. **Update 08.07.20:** Plan 20 is Black (complete) only in context of implementing all actions in current plan. However, there remains a monitoring and reporting risk around ambient temperatures as the actions in the plan are manual. - The Implementation Board may therefore need to consider the introduction of a centrally monitored, continuously recording Ambient room temperature, fridge and freezer monitoring system for the Trust at a potential cost in excess of £100k, to switch the plan to Blue (BAU), for which a business case will be required. - This initiative would need to form part of the Buildings Management Systems strategy with Estates & Facilities monitoring and maintaining the alarms and to ensure that batteries do not expire. - Existing analysis suggests that other options, including air conditioning, are unrealistic given the associated cost and the current fabric of the building. **Update 13.07.20: Planned actions complete but need to understand from Board how much monitoring is required to move to BAU and adjust end date.** **- SW restated that compliance and action will not be dependent on centralised alarm system for maintaining temperatures.**
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	Complete	28.2.20	appropriate audit sample size. **Update 08.07.20**: The recommendation is that Plan's 21, 23, 24, 25 are submitted to the Improvement Board for approval to move the RAG from Black (Complete) to Blue (BAU) as a Clinical Quality Midwife has been appointed with responsibility for undertaking monthly audits. Sample sizes and audit dates are agreed and the findings are presented monthly at the Women's Health Governance Board and the Women & Children's Divisional Board going forward. **Update 13.07.20: Actions are complete. Midwife appointed to undertake audits. Need to see assurance results to progress through Board to move to BAU.** **- A maternity deep dive will be undertaken by KN, SW, LN, JR reporting back at next IPB with 3 months data as evidence**
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is mitigated through appropriate referral to the smoking cessation advisor. **Update 08.07.20: The RAG for Plan 22 cannot move from Black to Blue (BAU) given national stop on carbon monoxide monitoring assessments through pandemic.**
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing. **Update 13.07.20: See 21**
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing **Update 13.07.20: See 21**
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing **Update 13.07.20: See 21**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Complete	31.1.20	Action implemented, assurance testing ongoing **Update 07.07.20:** Plan No 26 can be submitted for approval at IB to move the RAG from Black to Blue (BAU). - Paper checking is no longer used in the department. The following checks were originally put in place: - F11 Ward Manager check daily - Labour suite co-ordinators to check daily - Service Manager to check weekly compliance in all areas A Clinical Quality Midwife has also been appointed with responsibility for overseeing checks **Update 13.07.20: Again actions virtually complete (31/34 guidelines prepared) and midwife in place to complete audit checks.**
27	The trust must ensure clinical guidelines are up to date.	1. Through the divisional leadership review and update all clinical guidelines and issue through the approval pathway 2. Put in place systematic system to support the management, reporting and monitoring of clinical guidelines across the Trust to ensure they are kept up to date	Susan Wilkinson	Divisional Triumvirate	Amber	31.10.20	Update 23.06.20: 29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support management of clinical guidelines. **Update 23.06.20: Clarity needed re divisional engagment via Tri**
28	The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets.	See No 9	Helen Beck	Helen Beck with ADOs	Red	31.3.21	See No 9
29	The trust must ensure diagnostic test results are available in a timely manner.	Review reporting arrangements for relevant diagnostics services. Ensure appropriate escalation procedures are in place for delays. Address the negative impact of COVID on diagnostic testing and reporting.	Helen Beck	Helen Beck	Red	31.12.20	Through the Board reports and divisional PRMs performance is monitored against 6-week diagnostics standards. Compliance was being delivered for all diagnostics other than endoscopy. The monthly PRMs also include radiology reporting times and prior to COVID the Trust was achieving good performance. There is an SOP in place to escalate imminent OPD appointments for which results are not available to prioritise them on reporting queue prior to the patients appointment. Monitoring systems are effective and in place. The diagnostic testing and reporting forms part of the phase 3 recovery plan for COVID -availability of additional resource will impact on timescale for delivery. Update 25.06.20: Covid has had a significant negative impact on diagnostic timeframes. A recovery plan is in development. Reporting times have improved due to reduced numbers of tests and is monitored through divisional PRMs. Covid-19 holding statement required as diagnostic timeframes have extended significantly under Covid-19 **Update 13.07.20: The Trust could have evidenced at the time of the CQC inspection that tests were available in a timely manner but the information was not requested. The landscape has now changed and Covid-19 has had a significant negative impact on diagnostic performance. Whilst reporting times have improved due to reduced numbers of tests which are monitored through divisional PRM's, a recovery plan is in place as diagnostic timeframes have extended significantly.**
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Angela Price	Red	31.03.21	25.06.20 Overall status Red pending collation of new documentation re COVID backlogs

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. Issue reminder to teams regarding the importance of undertaking pain assessments for end of life patients 2. Review of core template on SystmOne to ensure that it is fit for purpose 3. Written guidance on completion of core assessment template on SysmOne 4. Share written guidance with clinical teams 5. Identify SuperUsers to support training on the correct use of the core template and embedding within teams 6. Update staff via CREWS divisional quality report 7. Include audit of completion of Pain Assessment via Perfect Ward App	Helen Beck	Michelle Glass	Green	31.12.20	Overall RAG is Green with one Red item re Crews divisional quality report / Newsletter which has been reintroduced as part of Covid-19 recovery. Also one Green item is regarding providing evidence re use of Perfect ward App. Update 25.06: Should be at BAU embedded point. NSH action to provide update at next SRO Cluster. **Update 13.07.20: HB and MG seen early audits and should be able to give a recommendation by the next Board. Assurance that all available care plans will be completed and a huge amount of work has been done. MG confident would be embedded and progressed to BAU (Blue).** **- HB to present update at nexr IPB 10.08.20**
32	The trust must ensure all staff complete mandatory training including safeguarding training.	See No 12	Jeremy Over	Denise Pora	Amber	31.5.21	See No. 12