QUALITY AND SAFETY IMPROVEMENT PLAN
(Version 2.3)

United Lincolnshire Hospitals NHS Trust

Introduction

The purpose of this plan is to define, at a high level, the Quality and Safety Programme and the continuing quality and safety improvement journey ULHT is making, including improvement goals that ULHT will work towards over the next 12 months. The plan includes all of the Compliance Notice requirements and MUST DO recommendations in the CQC Quality Reports. The plan is broader than the specific CQC requirements/recommendations and includes longer-term pieces of work that the trust is pursuing to improve overall quality and safety across the organisation.

The plan outlines the Trust's overall ambition to improve quality and safety. The plan includes a number of key milestones and these will be reported on at the weekly quality and safety Improvement Programme Board and monthly at the 2021 Programme Board, Quality Governance Assurance Committee and Trust Board. The milestone dates are all the end of the month unless a specific date is recorded. A separate monthly overview report will be produced to demonstrate progress against milestones and improvement goals. The dates in the plan below will not change unless specifically agreed by the Quality and Safety Improvement Programme Board.

No	Quality and Safety Improvement Project	Outcome / Key Milestone	KPI Measure	Baseline	Dependencies Resource and Support	Executive Lead	Project Lead	3 Month Milestones (May/Jun/Jul)	Date	6 Month Milestones (Aug/Sep/Oct)	Date	9 Month Milestones (Nov/Dec/Jan)	Date	12 Month Milestones (Feb/Mar)	Date
QS01	Safety Culture	**Leadership:** Review of approach to leadership completed	% staff witnessing potentially harmful errors, near misses or incidents in the last month % staff reporting errors, near misses or incidents witnessed in the last month Fairness and effectiveness for reporting errors, near misses and incidents Staff confidence in reporting unsafe clinical practices	2016: 30% (Average) Median for Acute Trusts 31% 2016: 91% (better than average) Median for Acute Trusts 90% 2016: 3.62 (worst 20%) Median for Acute Trusts 3.72 2016: 3.6 (worse than average) Median for Acute Trusts 3.65		Martin Rayson	Helen Nicholson	Leadership Charter launched	Jun-17	Top 250 senior leaders identified	Aug-17	Completed a review of the current leadership (designed to equip leaders to deliver the supportive, compassionate leadership required, which underpins a consistent safety culture)	Nov-17	Top 250 senior managers completed Management Programme	Feb-18
										Senior Leadership Forum relaunched	Aug-17				
		Values: ULHT values embedded (safety is a key element)				Martin Rayson	Lucy Ettridge	ULHT values relaunched as part of the overall 2021 Programme	Jul-17	Activities to bring ULHT values to life defined part of the next stage for the 2021 campaign	Sep-17	"What do the values mean for our Team?" survey completed	Nov-17		
		Staff Charter: ULHT values and behaviours embedded through the staff charter				Martin Rayson	Helen Nicholson	Staff charter, building on values and outlining expectations of staff and behaviours, approved	Jul-17					Values and behaviours of the organisation embedded (using processes such as recruitment and performance management)	Mar-18
								Staff Charter launched	Jul-17						
		Freedom to Speak Out				Martin Rayson	Jayne Warner	New Freedom to Speak Out Policy agreed	May-17						
								Programme commenced to promote wide understanding of the Freedom to Speak Out Policy	Jul-17						

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		Instilling a Safety Culture in our temporary workforce: Demonstrate that our temporary workforce are engaged and trained to play a full part in the life of the Trust, able to work to the standards and values we expect (Key to Care" work in nursing)				Michelle Rhodes (Nursing) Martin Rayson (Other Staff)	Debrah Bates (Nursing) Helen Nicholson (Other Staff)	Key to Care Project proposal refreshed with involvement from agencies	Jun-17	Key to Care launched	Sep-17	Refreshed general induction commenced	Nov-17		
								Key to Care Implementation plan developed with involvement from agencies	Jul-17	General induction reviewed and designed to deliver robust training covering safety requirements for all temporary staff	Oct-17				
QS02	Governance	**Trust Board Assurance:** Assurance Committee structure, processes and upward reporting in place				Neill Hepburn	Jayne Warner	Reviewed external assurance recommendations at Board Development session	Jul-17	Terms of Reference and modus operandi revised	Aug-17			Revised arrangements evaluated	Mar-18
										Revised processes implemented	Oct-17				
		Trust Board Assurance: Refreshed structure and process in place for Trust Board meetings				Neill Hepburn	Jayne Warner	Reviewed format, timing and style of Board Meetings at Board Development session to strengthen assurance and challenge	May-17	Revised arrangements for Trust Board Meetings implemented	Sep-17			Revised arrangements for Trust Board Meetings evaluated	Mar-18
		Trust Board Assurance: Information to support Board assurance, monitoring and planning reviewed				Neill Hepburn	Jayne Warner			Agreed formal content of Board performance dashboard by service line at Board Development session	Aug-17				
										Performance dashboard by service line in place	Oct-17				
		Integrated Governance Structure and Process			NHS I funding for External Review of Governance function and structure	Neill Hepburn	Jeanette Hall	External Governance Review completed and received.	May-17	External review of Trust proposals completed	Aug-17	Revised structure and process for integrated governance completed	Jan-18		
								Approach to integrated governance designed and agreed by Trust Board	Jul-17	Recruitment process for key posts within the revised structure completed	Oct-17				
								Implementation plan with agreed timescales for Integrated Governance approach in place.	Jul-17						

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		Clinical Governance Processes (including specialty governance, clinical audit, lessons learned, mortality reviews)				Neill Hepburn	Jeanette Hall	Review of specialty governance assurance mechanism completed (QPIC)	Jun-17	Specialty governance processes and monitoring arrangements reviewed and strengthened	Aug-17	Implementation of revised specialty governance arrangements completed	Nov-17	Specialty governance arrangements evaluated	Mar-18
								Revised specialty governance assurance mechanism in place (formerly QPIC)	Jul-17	Started implementation of revised speciality governance arrangements	Sep-17				
										All speciality have had a meeting in line with standard agenda	Oct-17				
		Risk Management				Neill Hepburn	Jeanette Hall	Risk Management strategy, policies and procedures refreshed	Jun-17	Risk management training tool kit developed	Aug-17				
								Corporate risk registers cleansed and validated	Jun-17	Schedule for cyclical audit of corporate and operational risk commenced	Sep-17				
								Datix project plan in place	Jun-17						
								Datix business case and specification to up-date the system submitted for approval	Jun-17						
		SI Backlog	Number of SIs		NHS I funding for resource to reduce backlog	Neill Hepburn	Jeanette Hall Victoria Bagshaw	Resources identified to clear the backlog of SIs	May-17	SI backlog completed	Sep-17				
		Duty of Candour	% of patients /relatives informed of notifiable safety incident % of staff trained in duty of candour Benchmarking to assess accuracy of recording		Links to Training and Competencies QS09	Neill Hepburn	Jeanette Hall	Duty of Candour monthly reporting to Quality Governance Committee Assurance Board commenced	May-17	50% of patients / relatives informed of notifiable safety incident	Aug-17	65% of patients / relatives informed of notifiable safety incident	Dec-17	95% of patients / relatives informed of notifiable safety incident	Mar-18
								Being Open Policy refreshed and launched	Jun-17			75% of all staff completed Duty of Candour Training	Dec-17	95% of all staff completed Duty of Candour Training	Mar-18
								Duty of Candour training module approved	Jun-17						
								Roll out plan for Duty of Candour training commenced	Jul-17						
								Duty of Candour intranet site in place	Jul-17						

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QS03	Sepsis	Achieve 2017/18 CQUIN milestones (audit of 50 patients each month in A&E and 50 inpatients each month who meet the sepsis criteria)	Achieve 90% for sepsis screening within 60 mins	80% (April 2017 for A&E and emergency admission wards)	1)Staff completing sepsis bundle when patients score NEWS of 5 or more 2) Sepsis eBundle will enable all NEWS ≥ 5 to be pulled for audit which may initially show a deterioration of our current compliance which is more of a snapshot (50 /50 as per CQUIN requirement) 3) Sepsis Practitioners to provide support, guidance and training as required	Neill Hepburn	Adam Wolverson	Consistently achieved 80% or greater for each month	Jul-17	Consistently achieved 90% or greater for each month	Oct-17	Consistently achieved 90% or greater for each month	Jan-18	Consistently achieved 90% or greater for each month	Mar-18
			Achieve 90% for IVAB within 60 mins	85% (April 2017 for A&E and emergency admission wards)	1)Staff completing sepsis bundle when patients score NEWS of 5 or more 2) Sepsis eBundle will enable all NEWS ≥ 5 to be pulled for audit which may initially show a deterioration of our current compliance which is more of a snapshot (50 /50 as per CQUIN requirement) 3) Sepsis Practitioners to provide support, guidance and training as required	Neill Hepburn	Adam Wolverson	Consistently achieved 80% or greater for each month	Jul-17	Consistently achieved 90% or greater for each month	Oct-17	Consistently achieved 90% or greater for each month	Jan-18	Consistently achieved 90% or greater for each month	Mar-18

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		eCOBs and sepsis eBundle to be live and utilised on all adult admission and inpatient wards	All adult admission and inpatient wards using eCOBs	All admission/inpatient areas, aside from A&E Lincoln, are currently live	1) ICT training 2) Staff competence and confidence using the system 3)A&E Lincoln going live with web-v as planned	Neill Hepburn	Adam Wolverson	All inpatient wards are live with eCOBs	Jul-17	Reinforce eCOBS use, identify and mange arising issues	Oct-17	A&E Lincoln are final area to go live	Jan-18		
			All adult admission and inpatient wards are live with the sepsis eBundle	All admission/inpatient areas, aside from A&E Lincoln, are currently live	1)ICT training 2)Sepsis Practitioners supporting training 3)Staff competence and confidence using the system 4) A&E Lincoln going live with web-v as planned	Neill Hepburn	Adam Wolverson	Sepsis eBundle rolled out to all inpatient wards	Jul-17	Reinforce eBundle use, identify and mange arising issues	Oct-17	A&E Lincoln are final area to go live	Jan-18		
		eCOBS and sepsis eBundle to be live and utilised on all paediatric inpatient wards	All paediatric wards to be live with eCOBS	No paediatric wards currently live	1)ICT package development and training 2) Staff competence and confidence using the system	Neill Hepburn	Adam Wolverson	Ongoing development of eCOBS package	Jul-17	eCOBS package developed	Oct-17	Ward training of eCOBS and roll out commenced	Jan-18	All paediatric inpatient wards live with eCOBS	Mar-18
			All paediatric wards to be live with Sepsis eBundle	No paediatric wards currently live	1) ICT package development and training 2) Sepsis Practitioners supporting training 3) Staff competence and confidence using the system	Neill Hepburn	Adam Wolverson	Ongoing development of sepsis eBundle	Jul-17	Sepsis eBundle package developed	Oct-17	Ward training of sepsis eBundle and roll out commenced	Jan-18	All paediatric inpatient wards live with sepsis eBundle	Mar-18
		eCOBS and sepsis eBundle to be live and utilised on all Maternity inpatient wards	All maternity wards to be live with eCOBS	Labour Ward and Maternity Ward live at Pilgrim; Bardney and Nettleham Wards live at Lincoln	1) ICT training 2) Staff competence and confidence using the system	Neill Hepburn	Adam Wolverson	Ongoing development of eCOBS package	Jul-17	eCOBS package developed	Oct-17	Ward training of eCOBS and roll out commenced	Jan-18	All maternity inpatient wards live with eCOBS	Mar-18

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			All maternity wards to be live with Sepsis eBundle	No maternity wards currently live	1) ICT package development and training 2) Sepsis Practitioners supporting training 3)Staff competence and confidence using the system	Neill Hepburn	Adam Wolverson	Ongoing development of sepsis eBundle	Jul-17	Sepsis eBundle package developed	Oct-17	Ward training of sepsis eBundle and roll out commenced	Jan-18	All maternity inpatient wards live with sepsis eBundle	Mar-18
		Ensure robust process for monitoring and reporting performance to support continued and sustained patient safety	Trust Wide electronic audit of ALL at risk patients	Unable to utilise accurately Trust Wide at present so not baseline	1) eCOBS and Sepsis eBundle will enable all at risk patients to be pulled for audit which may initially show a deterioration of our current compliance which is more of a snapshot 2) All areas going-live with eCOBS and eLearning as planned 3) Structured process being followed to ensure timely admission to eCOBS system and accurate reflection of actual screens being undertaken				Jul-17	1) Manual check of electronic data performed by Sepsis Practitioners - no false positives but false negatives due to identified process problems in A&E Depts 2) Meetings with A&E leads conducted and process mapping undertaken and clear improvement plans implemented 3) Meetings held with A&E Lincoln re Web-V go live	Oct-17	1) Ongoing review of A&E performance in relation to allocation of patients 2) A&E Lincoln planned go live with eCOBS and sepsis eBundle 3) Aim to convert to sole use of electronic audit data with expectation that transition may see a drop in compliance temporarily	Jan-18	Trust Wide utilisation of electronic data for general compliance audit and CQUIN purposes.	Mar-18
			Monthly Review Template completion and submission of IR1s	14 IR1s completed in April 2017 and 6 were still open pending investigation	1) Timely and comprehensive completion of "review templates" 2) Staff completing IR1s as appropriate 3) Ward sisters reviewing all IR1s and acting on them 4) Sepsis practitioners reviewing templates to identify themes	Neill Hepburn	Adam Wolverson	Sepsis Practitioner have completed IR1s for all non compliance with sepsis screening / treatment during audit	Jul-17		Oct-17	1)Introduction of review templates to identify themes and possible harm 2) Provide guidance of harm classification for IR1 completion	Jan-18	Continuation of lessons/ themes shared as identified from review templates and IR1s	Mar-18

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			Completion of Harm Reviews for any patient with a NEWS ≥ 5 where sepsis screen/treatment not completed within 60 mins and patient outcome is an ICU admission or death	No base line data currently available	1) Accurate and timely identification of these patients 2) Time pressures of Adam Wolverson's responsibilities	Neill Hepburn	Adam Wolverson	Developed and agreed proforma for Harm Reviews and agreed Harm Review Process	Jul-17	Completed Harm Reviews for any NEWS 5 or above where sepsis screen/treatment not completed and patient outcome is an ICU admission or death	Oct-17	Sepsis Practitioners have reviewed themes and identified training needs for non compliance of sepsis screening / treatment and shared lessons with staff	Jan-18	Continuation of lessons/ themes shared as identified from IR1s	Mar-18
		Ensure comprehensive education, training and development is available	Mandatory completion of eLearning for front line staff	91% have completed their eLearning	1) Staff having time to complete the eLearning	Neill Hepburn	Adam Wolverson	90% completed eLearning by July 2017	Jul-17	95% completed eLearning by October 2017	Oct-17	Sustaining 95% or greater	Jan-18	Sustaining 95% or greater	Mar-18
			Staff specific eLearning modules for front line paediatric and maternity staff	91% have completed adult eLearning - no baseline for specific modules	1) Development of specific modules 2) Ensure relevant staff aware of specific additional modules 3) Staff having the time to complete the eLearning	Neill Hepburn	Adam Wolverson					Development of specific modules and ensuring relevant staff aware of requirement	Jan-18	90% completed by 31/03/2018	Mar-18
			Sepsis Link Nurse / User Group Forum established	Ward managers asked to identify at least one individual to attend and represent each area	1)Staffing levels may not allow for staff to attend training 2) 2018 dates disseminated early to try increase likelihood of attendance	Neill Hepburn	Adam Wolverson			1) Link Nurse information folders produced and potential dates for this year sent 2) Dates for 2018 agreed early to help managers roster attendance	Oct-17	Initial introduction meeting to be conducted and purpose of meeting outlined	Jan-18	Quarterly meetings to be conducted going forward with expected minimum one attendee from each clinical area	Mar-18
		Sepsis Boxes available on all adult inpatient wards	One Sepsis Box to be on each adult inpatient ward	None on adult inpatient wards but are on A&E / Admission Units	1)Pharmacy bags being developed and ordered 2)Meropenum stock levels	Neill Hepburn	Adam Wolverson	All adult inpatient wards to have one sepsis box	Jul-17	Awaiting pharmacy bags and agreement from microbiology re use of Meropenum	Oct-17	Sepsis Box contents revised, no longer to include abx or fluids - contains all practical equipment and paperwork for bundle completion. To be disseminated to adult and maternity wards w/c 18/12/17 and then to paediatric wards early in the New Year	Jan-18		
		EMAS to screen and treat red flag sepsis	EMAS screening, taking blood cultures and administering IVAB for red flag sepsis prior to admission to A&E	Not currently underway so baseline data available	EMAS training and protocol development	TBC	Jon Chippendale	Developed protocols	Jul-17	Implemented training for EMAS staff. A&E staff trained with new process.	Oct-17	EMAS commenced protocol for screening and treatment of red flag sepsis prior to admission to A&E	Jan-18		

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QS04	GI Bleed Service	Policy				Neill Hepburn	Emma Coulson Koshy Jacobs Jonathan Thomas-Thompson	Out of Hours GI Bleed audit commenced	May-17	Out of Hours GI Bleed audit commenced	Oct-17	Audit findings reviewed	Nov-17		
								Audit findings reviewed	May-17						
								Out of Hours Upper GI Haemorrhage Policy for Pilgrim Hospital approved by CESC and launched trust-wide	May-17						
		Out of Hours GI Bleed Rota (Pilgrim)				Neill Hepburn	Emma Coulson Koshy Jacobs Jonathan Thomas-Thompson	Review of current on call rotas and job plans completed	Jun-17	Option for Out of Hours GI Bleed Service model agreed	Aug-17				
								Costed options for delivering an Out of Hours GI Bleed Rota, including "do nothing" developed	Jul-17	Milestones for next stage agreed	Aug-17				
QS05	Airways Management (NIV Pathway)	There is a NIV pathway in use across Lincolnshire	Number of recorded Datix and Si's. % of appropriate patients who follow the NIV pathway.	Baseline 360 Assurance audit being undertaken.	Engagement from community colleagues.	Michelle Rhodes	Jenny Hinchliffe	Consultant lead for Pilgrim identified to chair the Project Group	Jun-17	Community wide Pathway review group established	Aug-17	Community wide pathway implemented across Lincolnshire	Jan-18	Community wide pathway compliance audit completed	Mar-18
								Project Group to review the internal system and process for airways management established	Jul-17	Implementation plan, based on the community wide pathway review, in place	Sep-17				
								Baseline audit of pathway for patients admitted requiring NIV completed and issues defined	Jul-17	Implementation plan, based on the findings of the baseline audit, in place	Sep-17				
										Review of Community NIV pathway completed	Oct-17				
QS06	Mental Health and Learning Disabilities	Environmental risk assessments completed in all acute admission wards, ED and Paediatrics	Environmental risk assessments			Michelle Rhodes	Jennie Negus	EDs have repeated initial risk assessments	Jun-17	Requirements of acute admission wards and paediatric audits have been addressed	Sep-17	EDs, acute admissions wards and paediatrics have repeated environmental risk assessments	Dec-17		
								Requirement of ED re-assessment have been addressed	Jul-17			Requirements of all environmental risk assessments addressed	Jan-18		
								All acute admissions wards and paediatrics have completed an initial environmental risk assessment	Jul-17						
		Staff on acute admissions wards, EDs and Paediatrics are knowledgeable and know how to assess and manage the risk of self-harm	Ward assurance metrics Number of SI and incident relating to patients self-harming			Michelle Rhodes	Jennie Negus	50% of relevant staff have undertaken Ligature risk and self-harm training	Jul-17	90% of relevant staff have undertaken Ligature risk and self-harm training	Oct-17				

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		Clinical staff understand the requirements of the administration and care of patients detained under the Mental Health Act (Core Learning)	Number of staff who have completed Mental Health training (target 90% of relevant staff)		Core Learning requirements Training and Competencies (QS09)	Michelle Rhodes	Jennie Negus	Training needs analysis completed identifying which staff require training	Jun-17	50% of identified staff have completed training and self-assessment proforma	Oct-17	90% of identified staff have completed training and self-assessment proforma	Dec-17		
								Pre and post training self-assessment proforma designed	Jun-17						
		Clinical staff understand how to respond and care for patients who require clinical holding or restraint	Number of staff who have completed clinical holding or restraint training (target 90% of relevant staff)		Links to Chemical Restraint Policy Training and Competencies (QS09)	Michelle Rhodes	Jennie Negus	Clinical Holding and Restraint Policy developed and launched	Jun-17	50% of identified staff have completed clinical holding and restraint training	Oct-17	90% of identified staff have completed clinical holding and restraint training	Dec-17		
								Clinical holding and restraint training needs analysis completed	Jun-17			Existing policy reviewed and amended where necessary as a result of staff training	Dec-17		
								Clinical holding and restraint training developed	Jul-17						
		Clinical staff understand the new Learning Disabilities pathways	Compliance against Learning Disability pathway			Michelle Rhodes	Jennie Negus	Resource folders available on all wards	Jun-17	Commenced presenting case reviews to Mental Health and Learning Disabilities Strategy Group	Aug-17				
								LD specialist nurses commenced attending Matrons and Sisters meetings	Jun-17	Ward based training completed on all wards	Sep-17				
								Revised LD Pathway launched during LD awareness week	Jun-17						
								LD patient story presented at June Trust Board Meeting	Jun-17						
		Care and practice is informed and influenced by patient and staff feedback			Speciality Governance Meetings	Michelle Rhodes	Jennie Negus	Process developed and commenced for all Mental Health related incidents to be reviewed by the Deputy Chief Nurse, Safeguarding Team and Security Management	Jul-17	Case reviews, including learning from incidents, available to share and discuss at Specialty Governance Meetings	Aug-17				
								Commenced reporting of each review to the Mental Health and Strategy Group	Jul-17	Mechanism to flag Mental Health and Learning Disability patients within existing feedback data (complaints, PALs, FFT) agreed	Aug-17				
								The mechanism to identify Mental Health and Learning Disability patients on Medway has been agreed	Jul-17	Commenced discussions regarding Mental Health and Learning Disability patient feedback at the Patient Experience Committee	Sep-17				
										Mental Health and Learning Disability staff are notified in order to attend patient in a timely way	Sep-17				

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QS07	Safeguarding	There is a vision, strategy and robust governance across adult and children's safeguarding (Dec17)	Staff understand the Trust SG duties and the vision for 2017-2020. Annual report available. Audit plan in place.	Strategy drafted. Adult operational meetings held quarterly.	SG team capacity	Michelle Rhodes	Jenny Hinchliffe	Safeguarding strategy developed	Feb-17	The self-assessment of regulation 13 has been completed and will be repeated every quarter	Aug-17	There is an updated organisation Statement of Intent for safeguarding	Dec-17		
								There is a monthly Operational committee for adult safeguarding established	Mar-17	Named professionals for safeguarding received 3 monthly supervision	Aug-17	A safeguarding audit plan is developed and agreed	Dec-17		
								The safeguarding risk register has been reviewed and updated as required	Mar-17	Trust Safeguarding annual report for 16/17 produced and presented to Trust Board	Sep-17				
								Safeguarding MCA & DOLS audit tools piloted	Jul-17	Children's Act Section 11 self assessment completed	Sep-17				
								Safeguarding service improvements reviewed with support from CCG	Jul-17	Risk register reviewed and updated by Adult safeguarding operational meeting, children and young people operational meeting and integrated safeguarding committee	Sep-17				
										Safeguarding Team and capacity and job descriptions reviewed	Sep-17				
										Safeguarding strategy embedded within the organisation	Sep-17				
										Staff engagement plan to implement safeguarding strategy in place	Sep-17				
		Safeguarding policies have been reviewed, updated and relaunched across the organisation (Jan18)	All polices are updated, relaunched and available on the intranet.	Existing policies in place.		Michelle Rhodes	Jenny Hinchliffe	The dignity in care policy has been reviewed and updated as required	Jan-17						
								The revised dignity in care policy has been relaunched and is embedded across the organisation	Apr-17						
								The MCA and DoLs policy has been reviewed and updated as required	Jun-17	The revised MCA and DoLs policy has been relaunched and is embedded across the organisation	Sep-17				
										The safeguarding children and young people policy has been reviewed and updated as required	Sep-17	The revised safeguarding children and young people policy has been relaunched and is embedded across the organisation	Dec-17		
										The management of allegations against people who work with children policy has been reviewed and updated as required	Sep-17	The revised management of allegations against people who work with children policy has been relaunched and is embedded across the organisation	Dec-17		

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										The self harm in children pathway has been reviewed and updated as required	Sep-17	The revised self harm in children pathway has been relaunched and is embedded across the organisation	Dec-17		
												The unexpected child death policy has been reviewed and updated as required	Nov-17		
												The revised unexpected child death policy has been relaunched and is embedded across the organisation	Jan-18		
										The DNA process for children with outpatient appointments has been reviewed and amended as required (included in safeguarding children and young people policy)	Aug-17	The revised DNA process for children with outpatient appointments has been relaunched and is embedded across the organisation	Nov-17	Audit of adherence to pathway completed	Feb-18
		There is a robust process for monitoring and reporting safeguarding performance	Safeguarding dashboard used and reports circulated.	Data collected and included in quarterly reports.		Michelle Rhodes	Jenny Hinchliffe	A safeguarding dashboard has been developed and launched	Mar-17	Children aged 14-16 years being cared for in an adult setting is monitored and reported monthly (risks assessed and safeguarding notified)	Oct-17				
								The use of sedation and rapid tranquilisation is monitored and reported monthly	Jun-17	Children who DNA outpatient appointments is monitored and reported monthly	Oct-17	Audit of use of sedation and rapid tranquilisation completed	Nov-17		
		Early Implementer of safeguarding assurance Tool						Request for ULHT to be early implementer for provider of safeguarding assurance tool submitted to NHSE	Jun-17	Training in the use of the safeguarding assurance tool completed	Sep-17	Provider Safeguarding assurance tool implemented	Nov-17		
		There is a comprehensive education, training and development offer	% of training sessions that have been refreshed/ updated. % of Board members who have received training. Training compliance against target.	Level 2 & 3 SG training, MCA & DoLS and prevent training.		Michelle Rhodes	Jenny Hinchliffe	Training targets are agreed and published for 2017/18	Mar-17	Tailored training for staff on the silver and gold on-call rota has been completed	Sep-17	Review of safeguarding training completed with support from CCG safeguarding team	Nov-17		
								Clinical supervision sessions are provided on all sites	Mar-17	Tailored training for Trust Board members delivered	Sep-17	Senior managers have undertaken a back to the floor session to monitor safeguarding in practice	Dec-17		
								The training offer is reviewed and revised as required	May-17	Additional training and support delivered to appropriately skilled staff available to support ward staff to undertake MCA and DoLS	Oct-17				

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								Tailored training is developed for staff on the silver and gold on-call rota	May-17						
								Plan in place to support ward staff to gain competencies in completion of MCA and DOLS	Jul-17						
QS08	Medicines Management (previously Medication Safety CQUIN)					Neill Hepburn	Victoria Bagshaw Colin Costello	Conference Call with Richard Seal, Neill Hepburn and Claire Pacey taken place Fri 02-06-17	Jun-17	Roll out of Implementation Plan commenced	Aug-17	Missed critical medicines implementation plan completed	Nov-17	Missed critical medicines re-audit completed	Mar-18
								Missed critical medicines implementation plan agreed	Jul-17	NHSI Medicine pathway mapping exercise commenced	Aug-17	Missed critical medicines audit completed	Dec-17		
								Scope for NHSI support with medicines management agreed	Jul-17	NHSI Pharmacy diagnostic deep dive completed	Aug-17	Further actions, based on findings of the audit, agreed	Jan-17		
										NHSI Medicine pathway mapping exercise completed	Sep-17				
										Next stage milestone plan in place for pharmacy and medicine pathway	Sep-17				
QS09	Training and Competencies	Core Learning	90% of staff who are up-to-date with core learning requirements (Excludes vacant posts and maternity leave)		Links to values QS01	Martin Rayson	Helen Nicholson	Review of core learning completed (stakeholder views used to confirm or amend existing requirements and current core learning defined)	Jun-17						
								Refreshed core learning package launched and promoted to staff	Jul-17						
		Core Learning Plus				Martin Rayson	Helen Nicholson			Project Plan for Core Learning Plus agreed	Aug-17	Training Needs Analysis completed	Dec-17	Competence and skills matrix created for key roles (linking training requirements identified in other parts of this plan)	Mar-18
														Mechanism for recording completion of core learning plus training in place including escalation process for non-compliance	Mar-18
QS10	Appraisal and Supervision	**Appraisal Rate**	Non-medical: Number of staff with at least 12 months service with the Trust who have had an appraisal in last 13 months (one			Martin Rayson	Helen Nicholson	80% recorded appraisal for all available staff	May-17					85% recorded appraisal for all available staff	Mar-18
								Executive letter sent to all managers outlining responsibilities in line with the Appraisal Policy	Jun-17						

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		Performance Management	month leeway). % of all staff with at least 12 months service with the trust. (Career break, external secondment and suspensions are excluded) Quality of Appraisal indicator in National Staff Survey			Martin Rayson	Helen Nicholson			Approach to Individual Performance Management reviewed	Oct-17	Performance Management Policy approved	Dec-17	Revised Individual Performance Management Approach (incorporating appraisal) launched	Apr-18
QS11	Out-Patients	**Health Records** Health records service is compliant, responsive and performance / quality issues have been reduced	Case note availability 98% Number of case notes merged / repaired Number of Subject Access Requests over 40 days	Case note availability 92% (May17) circa 180,000 case notes require merge and repair 384 Subject Access Requests over 40 days (Jan17)	Health Records Business Case approval Ability to Recruit approved numbers / skill mix to Health Records	Mark Brassington	Lee Parkin	Review processes and develop SOPs for Health Records	Jun-17	Health Records implementation plan (including recruitment and capital requirements)	Aug-17				
								Subject Access Request (SAR) Trajectories in place	Jun-17	Trust Wide SOPs for Health Record function launched	Sep-17				
								Case note merge and repair trajectory in place	Jun-17						
								Health Records business case refreshed	Jun-17						
								Health Records business case approved	Jul-17						
								Monthly case note availability audit commenced	Jul-17						
		Environment All Out-Patient facilities are fit for purpose	Part of QS17		Capital funding Part of QS17	Mark Brassington	Claire Hall	OPD capital requirements identified and prioritised	Jun-17	Capital projects for OPD priorities developed	Aug-17				
										Capital Projects for OPD priorities approved	Sep-17				
										Implementation plan for Capital Projects priorities commenced	Oct-17				
		Access, Booking and Choice Centralised ABC function with a fit for purpose structure and workforce	Centralised ABC Service		ABC Business Case approval	Mark Brassington	Lee Parkin	ABC business case approved	Jun-17	Phase 2 Implementation plan for centralised ABC function developed with milestones	Sep-17	Phase 3 Implementation plan for centralised ABC function developed with milestones	Dec-17	Centralisation of ABC function completed	Mar-18
								Phase 1 Implementation plan for centralised ABC function developed with milestones	Jul-17						

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		Innovation Progressed the implementation of digital solutions within OPD	Patient calling e-outcomes Net call clinic room e-booking		Completion of Medway Upgrade (Oct17) Business Case approval Centralisation of ABC service IT support / system interface	Mark Brassington	Lee Parkin	Roll out plan for patient calling at Pilgrim completed	Jul-17	Business case for patient calling at Grantham and other areas approved (based on funding available)	Aug-17	Trust Wide roll out plans for Electronic patient calling fully implemented	Jan-18	E-room booking plan implemented	Mar-18
								Business case for patient calling at Grantham and other areas submitted	Jul-17	Electronic Clinic room booking functionality plan developed	Sep-17				
								Roll out plan for net call completed	Jul-17	Roll out plan for patient calling at Grantham and other areas completed (subject to business case approval)	Oct-17				
		Constitutional Performance Standards	Delivery of constitutional standards recovery trajectories		ABC Business Case approval / implementation Clinical capacity	Mark Brassington	Neil Ellis	Constitutional standards recovery plans and trajectories in place	May-17	Implementation of demand management plan commenced	Aug-17				
								Harm review process in place	Jun-17	Harm review outcomes included in trust board report	Aug-17				
								Demand management plans with CCG support agreed	Jul-17						
QS12	**Infection Control Governance**	The risk register accurately reflects the risk to the organisation of the currently high levels of C Diff infection	Up to date IPC Risk Register	Risk of high incidence of C-Diff not on risk register		Michelle Rhodes	Penny Snowden / Jane Finch	Risk Assessment approved and uploaded to RR	Jul-17			Process in place to review & update risk register	Nov-17		
		Improved quality of SI investigations	Updated RCA Tool	RCA tool introduced in 2015			Jane Finch			Review and update RCA Tool ensuring that time to isolation is captured	Aug-17				
			Update SI process and documentation	Generic Template in place				Development of Learning Lessons Process		Review SI process to capture lessons learned	Aug-17	Produce and implement plan which incorporates lessons learned	Nov-17	Review lessons learned from previous 3 months SI and update plan	Mar-18
		Improved organisational learning	Reduction in lapses in care	0 successful appeal cases in 16/17			Jane Finch /IPC	Review process for development, dissemination and analysis of performance data	Jun-17	To ensure that each clinical area receives IPC monthly performance data	Aug-17				
							Jane Finch /IPC					Intranet site to be updated so that lapses in care reports can be uploaded	Nov-17	Review additional approaches to communicate incidents and learning	Feb-18
							Jane Finch	Thematic Review of the Cases reported this year with support from PHE.	Jul-17			Quarterly Learning Events to be arranged for IPC link practitioners based on thematic review	Oct-17		
		To ensure that the TB are sighted on IPC Performance including C.Diff	Reporting od IPC aligns to agreed governance process.	Upward IPC Committee Report is formulated.			Victoria Bagshaw			Appropriate reports produced routinely for identified meeting structure defined in ToR	Sep-17				

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		To ensure that clinical guidelines reflect contemporary practice	Updated approved clinical guidelines that refer to the management of IPC	Guidelines in operation reviewed in 2016			Jane Finch			Schedule for review of all and update of all clinical guidelines agreed by IP committee	Oct-17	Update of all clinical guidelines in line with agreed schedule	Ongoing		
		Reviewed IP governance Structure	Revised Terms of Reference for IPC, including appropriate documentation and membership to support the committee	Terms of Reference formulated in 2013			Victoria Bagshaw	Reviewed and Approved Terms of Reference	Jul-17	Attendance monitoring logs and scheduled work programme to be introduced.	Aug-17	Evaluate templates and amend accordingly	Jan-18	Appropriate information on updated process and structure DIPC annual report.	Apr-18
										Agenda of IP sub committees to be agreed and ToR updated	Sep-17	Attendance monitoring logs and scheduled work programme to be introduced.	Oct-18	Appropriate information on updated process and structure DIPC annual report.	Apr-18
												Escalate through line management for members with low attendance at IPC and sub groups.	Dec-18		
										Commence developing templates for IP committee.	Sep-18	To introduce a regular written report regarding patient feedback.	Dec-18		
			Completed and disseminated DIPC Annual Report	16/17 report completed			Victoria Bagshaw/ Jane Finch	Commence formulation of annual DIPC report	Jul-17	Complete and present to IP Committee, Quality Governance Committee, Trust Board the DIPC Annual Report	Oct-17	DIPC Report available on the Trust Internet site	Nov-17	DIPC 18/19 report commenced	Mar-18
							Victoria Bagshaw/ Jane Finch	Upload 16 / 17 DIPC report to the Trust's internet site	Jul-17						
			Improved reporting processes through the Governance Structure	Monthly IP performance reports			Jane Finch / Victoria Bagshaw	Commence monthly Progress Report on QSO Project 12 IP to the Quality and Safety Meeting	Jul-17	To present annual IP work plan which includes C Diff recover plan and QSO project 12 IP to infection prevention Committee	Aug-17	Continue to provide quarterly update to IP committee and QGC on progress made against plan	Jan-18	Provide end of year update of performance against the annual plan to IP committee and QGC	Mar-18
												To arrange a board development session on IP	Jan-18		
			Improved Monitoring processes of HCAI	Monthly report from IP Nurse			Jane Finch			Ensure that a mortality review is undertaken where applicable for all IPC related deaths	Aug-17	Process in place to incorporate Post CCG review of cases where agreed appropriate	Sep-17		
										Ensure that any delays in RCA's reviewed through Nursing Performance Meetings	Sep-17	Process in place to monitor required improvements through nursing performance	Oct-17	Review of any changes in trends identified through RCAs	Feb-18
							BS /jane Finch	To facilitate a peer review by the National CDI Lead to identify addition areas of improvement	Jul-17	Review Surveillance Report to aid improvement work	Aug-17	Ensure surveillance data is being used to identify further improvements	Nov-17		
											Sep-17	To introduce epi-curves into surveillance and outbreak data	Nov-17		
										MRSA screening process and data review to identify improvements		Data to be expanded to provide areas of non compliance so that improvement can be targeted		To monitor monthly performance on MRSA screening	Mar-18
												Develop a peer review process with CCG and other partners	Dec-17		

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		Increased compliance against the Code of Practice	Robust Self Assessment Tool in Place	Self assessment being undertaken quarterly			Jane Finch	Commence Gap Analysis of the Code of Practice	Jul-17	Gap analysis completed of the Code of Practice	Oct-17	Align 2017/18 IPC improvement programme with gap analysis	Nov-17	Monitor actions and improvements through IPC and reflect remaining gaps into the 2018/19 IP work programme	Mar-18
								To address saving lives audit submission with all Heads of Nursing	Jul-17	Develop an audit programme that ensures on-going monitoring of compliance and aids future self assessments	Oct-17	Monitor improvements and gaps at operational level through IP Committee and relevant subgroups	Nov-17		
							Penny Snowden	To inform IP committee of the Ward Accreditation Pilot findings in relation to IP	Jul-17	Develop an update report to be shared with IP Committee identifying areas of concern and action	Oct-17	To ensure that areas rated as red for IP are visibly supported by IP through increase audit and training	Nov-17	Regular receipt of WA report at IP Committee	Mar-18
		Policies reflect current evidence base	In-date evidence-based policy	Current policies are in date but does not reflect national guidance			Jane Finch			Develop a schedule to review and update all policies in line with evidence base	Oct-17	Policies updated in line with schedule monitored through IP Committee	ongoing		
			Evidence based policy on C.Diff	Current policy is in date but does not reflect national guidance			Jane Finch			Revise C diff policy in line with national guidance	In line with schedule				
			In-date Hand Hygiene Policy with illustrative guidance to assist understanding	Hand hygiene policy does not contain visual examples of how to wash hands or WHO 5 moments.			Jane Finch			Revise hand hygiene policy to include visual guides for hand hygiene practice	In line with schedule				
			In-date policy and SOP for toy cleaning and disinfection	No trust-wide policy on toy cleaning and disinfection			Jane Finch			Create toy cleaning policy/ SOP for use in all paediatric areas across the trust: submit to relevant committees for approval	In line with schedule				
	Gram Negative Bacteraemia	10% reduction across the health economy	Number of Gram Negative Bacteraemia reported Number of Contaminated Blood Cultures Data collected	The Trust aims to reduce Gram Negative Bacteraemia by 10% (YR1) and Contaminated Blood Cultures rates by 5% (YR1)		Michelle Rhodes	Jane Finch	Health economy Project Group established with ULHT involvement	Jun-17	Milestone Plan, based on audit findings, developed - ULHT working in partnership towards Health Economy solutions	Aug-17				
								Baseline audit completed	Jun-17	E-coli rates displayed on Trust Intranet	Aug-17				
												Communication plan in place reflecting internal and health economy plans	Dec-18		
							Jane Finch / BS?	Development and commencement of a programme of work to reduce blood culture contamination rates	Jul-17	To provide updates to the IP committee on progress made and to highlight challenges	Oct-17	To develop process for sharing lessons learnt from blood culture contamination and any associated RCAs and implement	Dec-17		

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							Jenny Hinchliffe	Development and commencement of a programme of work to reduce CAUTI rates	Jul-17	To provide updates to the IP committee on progress made and to highlight challenges	Sep-17	To develop process for sharing lessons learnt from CAUTI project and any associated RCAs and implement	Dec-17		Mar-18
	Cleanliness of Environment	Cleanliness audit results are improved across all indicators	Average score in MiC4C Cleanliness audit results per site	Mar-17 audit data		Paul Boocock	Ian Hayden / Jane Finch / Victoria Bagshaw	NHS I IPC site visits completed	Jul-17	Milestone plan developed based on the findings of the IPC visit	Aug-17				
										Plan developed for trust-wide deep cleaning	Aug-17				
												Develop Trust Wide 'site assurance reviews' jointly by Lead Nurse for IPC, DCN/ deputy Chief Nurse, facilities lead	Oct-17		
		The Trust achieves compliance with cleaning targets across each clinical area	Mic4C cleaning scores are rated as green for each clinical area	Average cleaning scores by site: Pilgrim 85.82% (Amber), Grantham 91.55% (Green), Lincoln 81.17% (Amber)	Recruitment of additional housekeeping staff - separate project		Ian Hayden	Submission of second business case to draw down £300K of additional Funding	Jul-17	Ensure that all wards have a cleanliness improvement plan in place and that improvement is reported through the nursing assurance process and site IPC meetings	Sep-17				
							Ian Hayden / Jane Finch/ operational site lead	Review of clinical areas to ensure that the risk level for cleaning is accurate		Review cleaning procedures and schedules for isolation rooms meets guidance	Aug-17	Review side room provision	Nov-17	Introduce use of an isolation prioritisation tool to support appropriate side room usage.	Nov-17
										To develop a plan that focuses on very high risk (98%) and High Risk (95%) clinical areas to achieve compliance	Aug-17				
								HPV decontamination Units to be explored with on site demonstrations arranged	Jul-17	Develop a business case for the introduction of HPV or UV as part of a systematic deep clean process	Aug-17	Tender /procurement process commenced	Nov-17	HPV cleaning initiated as part of the deep clean and outbreak cleaning	Dec-17
										Milestone plan to be formulated in light of second business case with progress reported monthly at IPC committee	Aug-17				
										To review bed space cleaning process and documentation	Sep-17	Embed and monitor as per agreed practice. Issues report to HoN and through operational IP site meetings			
										Review Cleaning procedures including the use and availability of sporicidal wipes	Sep-17	To develop a process where site duty managers have a list of patients in side rooms and where isolation can be achieved through patient movement	Nov-17		
										To review the exit clean arrangement including the use of HPV or UV	Oct-17				
										To develop deep clean programme for Theatres including the use of HPV or UV.	Oct-17				
		Reviewed arrangements for Decontamination	Named Lead for Decontamination	IP Doctor current the Lead		Michelle Rhodes	SDJ	To identify a named lead for decontamination	Jun-17	Decontamination lead to review existing arrangements	Nov-17	Revised governance structure for decontamination	Dec-17	Decontamination annual report to inform DIPC annual report	Mar-18

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								To arrange decontamination lead training	Jul-17	Decontamination Lead to attend training	Nov-17	Improved reporting template for decontamination to the IP committee	Dec-17	Second Decontamination Lead to attend training	Jan-18
		The correct cleaning specification is in place for each clinical area	Trust Document outlining expectations regarding cleaning specifications	Cleaning manual in place		Paul Boocock	Ian Hayden / jane finch	Meeting to be arranged to agree cleaning specification e.g. PAS 5748	Jul-17	Agreement of Cleaning Specification and Ward Cleaning Schedules are updated accordingly	Sep-17				
										Review of risk level of cleaning for all clinical area and document on risk register as appropriate	Sep-17				
										To ensure that there is a training plan in place for all housekeepers to attend regarding cleaning and infection control prevention	Aug-17	Monitor and report adherence to training schedule to IP and operational site meetings	Oct-17		
										Teaching programme regarding cleaning specification to be formulated and implementation commenced	Sep-17	Training continues for Housekeepers and Supervisors	Jan-18	Training continues for housekeepers and supervisors	Mar-18
		Strong leadership and management of housekeepers	Line Management to be transferred to Facilities from Nursing	Currently being line managed by each ward sister		Paul Boocock	Ian Hayden	Business case for additional supervisors to draw down funding to be completed	Jul-17	Business case submitted	Oct-17	Transfer from nursing to facilities operational plan to be development and transfer initiated	Dec-17	Appraisals undertaken for all housekeepers with expectations regarding cleaning scores articulated	Mar-18
										To hold masterclasses with shift co-ordinators regarding their role in ensuring that the clinical area is clean	Oct-17				
		Matrons to undertake cleaning assessment with Facilities so that immediate action can be taken	Joint assessment increasing objectivity and consistency in scoring	Facilities undertake cleaning audit unattended		Michelle Rhodes	Heads of Nursing	To discuss at HoN meeting regarding that Matrons will need accompany facilities to undertake monthly cleaning audits	Jul-17	To formulate a SOP with facilities regarding Cleaning audits including the development of improvement plans that will be monitored through Nursing Assurance Framework and Site IPC meetings.	Sep-17	Monitoring of actions taken to improve cleaning scores at local level through the governance framework	Oct-17	compliance against cleaning standards to be included in DIPC annual report	Mar-18
										Monthly Trust Wide report on cleaning audits and improvement actions taken and planned to be written and submitted by Facilities to IPC	Sep-17				
								Initiate joint cleaning audits between facilities and matrons	Jun-17	Initiate joint cleaning audits between IP team, facilities and matrons	Nov-17				
		Hand hygiene decontamination points to assist with the WHO 5 moments of hand hygiene should be available	Increased compliance with hand hygiene	Audit results reporting less than 100% compliance		Michelle Rhodes / Paul Boocock	Jane Finch / Ian Hayden	Review of all cleaner's cupboard to ensure that there is appropriate hand decontamination facilities	Jul-17			Audit housekeeper hand hygiene & PPE compliance	Oct-17		

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		Regular meetings between site IP leads and Facilities to walk the floor ensuring that clinical areas are clean and that outstanding estates works are risk assessed	There is a robust oversight of the condition of the wards and level of compliance with criterion 2	Lack of a consistent approach across the Trust		Ian Hayden	Site IP Leads/Heads of Nursing	IP to review each clinical area to assess level of compliance against Criterion 2	Aug-17	Monthly scheduled meetings to visit ward and ensure that each ward has a snagging list that is progressing	Sep-17	Peer Matron Inspections of clinical areas to be introduced to provide challenge and objectivity	Dec-17	To introduce the 15 steps methodology using patient representatives	Mar-18
	Safe Environment of Care	Bare Below the Elbows	Compliance audit of bare below the elbows and dress code policy					Consultation on Dress Code Policy completed	Jul-17	Dress Code Policy revised	May-17	Revised Dress Code Policy launched with Comms plan	Oct-17	Review of compliance with dress code policy as per Comms plan	Dec-17
								Bare Below the elbows relaunched	Jun-17	Process for identification of compliance with BBE identified and implemented	Oct-17			Review of compliance with BBE reported to IPC	Dec-17
		To reduce closures to clinical wards through robust isolation of patients with infections	10% Reduction in the number of days wards were closed due to outbreak or PII's	Outbreak data	Business case for doors to bays	MB / PB		To submit a paper recommending bay doors to MEAU at Lincoln	Jun-17	To receive funding approval for bay doors for MEAU	Aug-17				
										To develop a business case for bay doors for wards at LCH to enable cohort isolation	Oct-17				
							Jane Finch	To ensure that the lack of bay doors is captured on the risk register for IPC	Aug-17						
		Appropriate use of antimicrobials	Scheduled weekly audits on hot spot wards and monthly in low prevalence areas	Existing audit data			SL	To discuss staffing for antimicrobial pharmacy team	Jul-17	Develop an audit schedule with junior medical staff	Aug-17	Report audit results to the CDI recovery group and monthly IP committee	Dec-17	Report audit results to the CDI recovery group and monthly IP committee	Mar-18
						Michelle Rhodes	BS	To discuss microbiology staffing resource with IP doctor	Jul-17	Report audit results to the CDI recovery group and monthly IP committee	Aug-17				
							SP			Reinstate antimicrobial ward rounds on each site	Sep-17				
							SL			To review CDI cases to date to review themes relating to Antimicrobial stewardship and develop response	Sep-17				
		Effective control of infection through robust management of outbreaks	Reviewed Outbreak Management Processes	Existing Infectious Outbreak Policy		Michelle Rhodes	Jane Finch	Reinforce correct sampling	Jul-17	Reinforce correct sampling	Oct-17	Reinforce correct sampling	Dec-17	Reinforce correct sampling	Mar-18
							BS?	Prompt Outbreak Meeting by DIPC on advice from Microbiologist team	Jul-17	Review of outbreak meetings completed	Sep-17	Review of SOP and guidance in line with policy when reviewed	In line with policy review schedule		
							Jane Finch			Review outbreak policy to ensure that it is evidence based	In line with policy review				
		Trust is compliant with Safer Sharps	Trust is full compliant with all sections of the HSE act	Trust is partially compliant			Jenny Hinchliffe	Programme to deliver compliance with safe sharps developed and in place	Jun-17	Paper to ET and IPC regarding progress made to date on Safer Sharps	Jun-17	Business Cases approved and implementation plan developed	Aug-17	Continuation of roll out of safer sharps in line with plan	Aug-17
								Appropriate Risk Assessments completed and identified on risk register where appropriate	Jul-17			Update all risk assessments	Jan-18		

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								To contact CCG regarding the provision of patient's own insulin needles that they should be safer sharps	Jul-17						
		To improve practice through audit	Improved hand hygiene audit results through a more robust data collection process	Hand Hygiene audit compliance is 99.13% for June 2017			Jane Finch	Review and revise hand hygiene audit methodology	Aug-17	To review Hand Hygiene Audit Tool to ensure robust data is being captured	Oct-17	Implement campaign to improve compliance with hand hygiene	Oct-17	Monitor compliance with hand hygiene monthly	Oct-17
	Competent, Knowledgeable Practitioners	IPC Link Practitioners There is a cadre of competent IPC Link practitioners	Number of IPC Link Practitioners in all clinical areas % of trained IPC Link Practitioners (i.e. those that have attended core training)		Release of Link Practitioners to deliver plan	Michelle Rhodes	Jane Finch / CCG	Capacity and capability of IPC Link Practitioners reviewed (including training needs analysis) Review of current link practitioners including clinical areas and designations: identification of gaps in non-represented areas and professional groups.	Jul-17	IPC Link Practitioner implementation plan, based on review, in place	Aug-17	Focused monthly awareness raising by IPC Link Practitioners commenced	Nov-17		
										Review and update IPC link practitioner role description and responsibilities	Oct-17			Review impact of revised responsibilities	Mar-18
										Review communication channels with IPC Link Nurses and implement clear processes for communication of essential information	Oct-17				
										Schedule of quarterly IPC development days aligned to key priorities developed and implemented	Sep-17				
										IPC Link Practitioner folders in all clinical areas	Sep-17				
										Role of IPC Link Practitioners in IPC Outbreak management agreed and commenced	Oct-17			Review impact of revised responsibilities	Mar-18
		To drive improvement in IPC practice through greater clinical involvement	75% of staff are aware who their named IPC nurse is			Michelle Rhodes	Jane Finch / IPC Nurses	To assign each Infection Control nurse to a Clinical Directorate and associated wards	Jul-17					review impact of individual assignment	Jan-18
								To ensure that the ward staff receive feedback from the IPC nurses following their daily review of CDI cases	Jul-17			Develop and implement a process of lessons learned related to individual clinical areas	Nov-17		

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						Michelle Rhodes	BS			Microbiologists initiate undertaking ward rounds	Oct-17				
		To provide expert IPC advice to drive down CDI	Trust performs within or below the agreed monthly threshold of 4 cases			Michelle Rhodes	Jane Finch	Establishment of a C Diff recovery meeting	Jun-17	Monthly Progress reported to the IPC committee,					
		The senior nurses should ensure that all patients have stool chart which includes the Bristol Stool Chart	At Lead 90% compliance with the use of stool charts should be attained	No baseline data			Heads of Nursing	Compliance against metric monitored and discussed as part of nursing operational accountability processes	Jun-17			Evaluate effectiveness of documentation and process and implement appropriate changes or strengthen accountability requirement	Nov-17		
				New initiative			Heads of Nursing	Introduction of the Golden Hour - daily assurance visit	Jun-17	Implement a process to identify organisational 'lessons learned'	Oct-17			Review impact of golden hour on patient care and experience	Jan-18
		Effective daily site position communication processes between stakeholders during an outbreak of period of increased incidence	Reviewed communication process outlined in the Infectious Outbreak Policy	Infectious Outbreak Policy requires additional depth to outlining communication standards between stakeholders			Jane Finch			Agreement of communication channel during an outbreak of period of increased incidence	Aug-17	Review clarity of documentation used and revise accordingly	Nov-17		
												Review and implement a process for IPC on call/ daily advice during 'winter period'			
										Updated approved Infection Outbreak Policy as per schedule	Oct-17				
		All Matrons, Heads of Nursing and Ward Sisters are clear what their expectations are in relation to IPC	Tailored Training Sessions delivered	Masterclasses held in 2015			Penny Snowden	Accountability training sessions delivered to Staff Nurses and Deputy Ward Sisters	Jun-17	Formulation of training material and opportunities for local education through IPC link practitioners	Aug-17	PODCST of information related to IPC presented by an exec scheduled and recorded	Nov-17	5 day university of Lincoln course commissioned and actively	Dec-17
			Compliance against the IPC ward accreditation standard	New Initiative			Penny Snowden	Pilot of Standard completed	Jun-17	Implementation	Sep-17				
		There are clear role expectations for cleaning	Cleaning specifications to include roles	Out of date cleaning specifications in place			Heads of Nursing			Review of roles completed	Oct-17				
										To ensure that all staff are aware of how to check a mattress for fitness for purpose	Oct-17	Annual Mattress audit completed by TV team	Nov-17		
		All staff are up to date with IPC Mandatory Training	IPC training compliance	Non compliance with IP mandatory Training						Trajectory for compliance to be submitted by Matron to the site IPC committee and compliance monitored monthly upwardly reporting to the Trust IPC committee	Sep-17		All wards to have IPC performance data available to staff		
		All wards have a named link practitioner who meets role requirements	To ensure that all clinical areas have a IPC link practitioner promoting good practice	Inconsistent approach to IPC link practitioners			Jane Finch /Victoria Bagshaw	Metric in Ward Accreditation	Jun-17	To generate a database of practitioners	Sep-17				
										To arrange a series of masterclasses for IPC ambassadors to expand knowledge base	Oct-17	Hold first masterclass with a launch event	Dec-17		

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	Patient, Public, Staff Information	Effective patient information processes in place	Reviewed written and electronic sources of patient information				IPC nurse			Information on CDI, Norovirus, hand hygiene reviewed	Aug-17	Development of a leaflet on "outbreak of infection on this ward " Q&A	Sep-17		
										Templates developed for common CDI infection - outbreak and PII					
		Effective Public Media statements and information to the Public	Template statements developed				Communications			Updated Public Internet site on IPC	Oct-17	Updated IP intranet site where patient information can be sources	Sep-17		
			Evidencing Use of Social Media	Information process that requires structuring						Development of a IPC Communications Strategy	Oct-17				
		Effective internal communications so that all staff are aware of the challenge regarding CDI and their role in reduction of incidents	Implemented co-ordinated communication plan	Ad hoc Communications in newsletters			SS / ?WC? / Communications	Set up a meeting with Comms regarding formulating an internal Comms plan	Jul-17	Engage IP Link Practitioners in a CDI challenge	Aug-17				
							IP / Ward Sisters			Formulate a 100 day improvement challenge for IPC improvement and CDI reduction with Ward Sisters	Sep-17	Launch event for 100day improvement event aligned to infection control week	Oct-17	Evaluate impact and develop rapid improvement event for spring 2018	Feb-18
							IP / Ward Sisters			Commence 100 day challenge	Oct-17	Assist wards with implementation	Nov-17		
		Suitable accurate information on infections is available	Up to date information on infections is available in a variety of trust-approved formats for service users, visitors and those providing ongoing support or care	Leaflets available on external website are out-of-date and not in approved trust format		Michelle Rhodes	IPC nurse	Current available Trust leaflets are identified and available on Trust website	Jul-17	To develop and implement a schedule to review all patient and public information leaflets regarding infections	Oct-17	Leaflets are printed and distributed to patient areas as per schedule	As per schedule		
		The intranet and public website enable people to access appropriate information on how the Trust prevents and controls infection	Updated website	Out of date website		Jane Finch	IPC nurse	Identify an IPC nurse and lead from communication team who have continuous responsibility to review of intranet and internet sites	Jul-17	Commence review of internet and intranet IPC site and information	Oct-17	Suitable information is proactively uploaded onto Trust internet and intranet sites following review of policies / guidance /patient information	Oct-17	To ensure that the websites are pro-active for areas such as norovirus and include appropriate seasonal advice	Nov-17
		To provide information about infections to staff	A monthly information developed and cascaded	Nothing in place		Michelle Rhodes	IPC nurse			To develop a schedule of topic that will be covered and commence implementation	Aug-17	Consider innovative mechanisms to communicate IPC information to trust staff	Sep-17		
QS13	Reducing Variation in Clinical Practice	Diabetes - DKA Pathway	Compliance with the DKA pathway			Neill Hepburn	Bala Srinivasan	Medical Director contacted Leicester Team	May-17	DKA compliance audit completed	Oct-17	DKA compliance audit completed	Jan-18	DKA compliance audit completed	Mar-18
								Terms of Reference agreed	Jun-17						
								DKA pathway review commenced	Jul-17						

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								Further milestones agreed once scope and TOR in place with Review Team	Jul-17						
		Deteriorating Patient (Out of Hours)			P2 - Productive Hospital	Neill Hepburn	Pavlos Zafeiris	Review of current Hospital at Night service against Trust Board paper commenced	Jun-17	Review of Hospital at Night service completed	Aug-17				
										Further milestones , KPIs and Project Lead agreed based on recommendations from the review	Sep-17				
QS14a	Clinical Staffing - Nursing	Workforce Plan				Michelle Rhodes	Debrah Bates			Initial draft for Nursing and Midwifery workforce plan completed and circulated for consultation	Sep-17	Nursing and Midwifery workforce plan approved	Dec-17		
										Revised draft for Nursing and Midwifery workforce plan circulated for comment	Oct-17				
		Recruitment Process	Nursing Vacancy Rate			Michelle Rhodes	Debrah Bates	Generic job descriptions for band 2 and band 5 approved	Jul-17						
								Cohort recruitment plan in place for 2017-18	Jul-17						
								Standardised recruitment process in place for Nursing and Midwifery	Jul-17						
		Care Certificate All new HCAs will complete the Care Certificate and schedule in place for all existing HCAs	Number of HCA with Care Certificate (new and existing staff reported separately)			Michelle Rhodes	Debrah Bates			Plan for all current HCAs to complete Care Certificate developed	Aug-17	First Care Certificate presentation event taken place	Dec-17		
										All new starters from 01-09-17 are apprentices and will complete the Care Certificate	Sep-17				
		ACP and Workforce in conjunction with NHSI				Michelle Rhodes				Workforce plan developed with NHSI	Aug-17				
										Next step milestone plan in place	Sep-17				
QS14b	Clinical Staffing - Medical	Technical Solutions	Medical Vacancy rate (Trust target 12%) Ratio of substantive to agency staff		Links with NHS Employers and NHSI	Mark Brassington	Steve Anglin	Business case for Allocate system approved	Jun-17	Resources and Finance released for procurement of agreed solution	Aug-17	Implementation of consistency and review panels to reduce variation and embed job planning as business as usual	Jan-18	Analysis commenced of the job plans of agency staff to reduce variation and deviation from the 10 PA standard. Monitor proportion of job plans for temporary and substantive staff in specialities and clinical directorates	Mar-18
										Implementation plan and schedule for improved medical rotas commenced	Aug-17				
										Allocate software system implemented	Sep-17				

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		Job Planning monitoring	Percentage of job plans uploaded to Allocate as a proportion of total consultant and SAS Doctors Average number of PAs				Steve Anglin	Existing long term agency doctor job plans have been submitted for compliance checks	Jun-17	Achieve 80% completion of job plans uploaded to Allocate	Oct-17	95% of job plans are agreed and uploaded to Allocate. Started to use analysis from existing job plans for capacity planning reducing all job plans to within 12 PA (include on-call)	Nov-17		
												Milestone plan agreed to assess needs of the service against existing job plans for agency staff	Nov-17		
		Internal Bank system	Agency to Bank conversion % of medical staffing spend attributable to bank and agency		Allocate business case approval		Chloe Scruton	Medical agency staff reduced to a maximum of 10 PA's (excluding on-call)	Apr-17	Recruitment campaign and process for medical bank to include AHPs and surgical first assistant commenced	Aug-17				
								Internal bank rates agreed and standardised	Jul-17	Automatic registration for new starters in place	Aug-17				
										Process for compliance checks in place	Aug-17				
		Skill Mix			Medical Agency Project Resource required for medical input for assessment and implementation		Chloe Scruton	Scoping exercise completed	Jun-17						
								All medical rotas reviewed and efficiencies identified	Jul-17						
								Skill mix plan in place	Jul-17						
QS15	Medical Engagement	National Medical Staff Survey results			NHS I funding for Medical Engagement Survey	Neill Hepburn		Preliminary discussion taken place with E2P	May-17	Medical Engagement Survey closed, data analysed and report received	Aug-17				
								Data requirements completed	Jun-17	Survey results reviewed and action plan developed	Sep-17				
								Medical and Senior Management staff briefed prior to launch	Jun-17						
								Medical Engagement Survey launched	Jul-17						

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QS16	Strengthening Support for Pilgrim Hospital	Ward Accreditation				Michelle Rhodes	Penny Snowden	Ward Accreditation Project Group established	May-17	Pilot evaluated process and tool revised as necessary	Aug-17	Agreed posts from Business Case filled	Dec-17	Implementation schedule on track for all sites	Mar-18
								Visit to partner organisations (Salford / Pennine, Northampton) taken place	May-17	Ward Accreditation implementation schedule developed and agreed for all sites	Aug-17				
								Salford tool mapped to fundamental standards of care, CQC KLOES and nursing standards	May-17	Business Case for on-going implementation and sustainability of Ward Accreditation completed	Aug-17				
								Ward Accreditation operational guide in place	Jun-17	Business Case agreed	Sep-17				
								Placement visit schedule in place	Jun-17	Mechanism agreed and commenced to revisit wards	Sep-17				
								NHSI funding approved for 5 8A posts	Jun-17						
								8A Job Descriptions approved and recruitment commenced	Jul-17						
								Communication Strategy for Ward Accreditation developed and agreed	Jul-17						
								Ward Accreditation pilot commenced at Pilgrim (2 Wards) and Grantham (1 Ward)	Jul-17						
								Nursing Quality Assurance Framework in place to develop and monitor implementation plans	Jul-17						
		To provide a quality, safe service for cardio-respiratory patients with appropriately trained competent nursing staff				Mark Brassington	Michael Woods			Cardio-respiratory clinical strategy developed and agreed Clinical Model/SOPS Workforce Model Estates Plan	Aug-17	Business case approved	Nov-17		
										Business case developed including KPIs and dashboard (Including Gap analysis)	Sep-17				
										Implementation plan with milestones developed and agreed	Sep-17				
										Review further milestones for implementation agreed	Sep-17				
										Staff are engaged and consulted with regarding new service (including HR process)	Oct-17				

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		Clinical Directorate Infrastructure				Mark Brassington / Michelle Rhodes	Michael Woods / Penny Snowden	Additional senior support at Pilgrim hospital to delivery QSIP plan in place	May-17						
								Plan agreed for "fit for purpose" Clinical Directorate infrastructure	Jul-17						
QS17	Estates Environment					Paul Boocock	Claire Hall	Analysis of E&F requirements completed	Jun-17						
								Mechanism and process in place to bring together and prioritise all E&F work programmes	Jun-17						
								E&F priorities rationalise, costed and agreed	Jun-17						
								E&F work plan agreed and milestones in place	Jul-17						
	Fire Action Plan					Paul Boocock	Claire Hall	Requirement for business case for fire improvement works submitted to NHSI	Jun-17					Full compliance in line with enforcement notice at Pilgrim	May-18