



DRAFT QUALITY AND SAFETY IMPROVEMENT PLAN (V0.8 31 May 2017)

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 progress report will be produced to demonstrate

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)		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	2016: 30% (Average) Median for Acute Trusts 31%		Martin Rayson	Helen Nicholson	Leadership Charter launched	Jun-17	Top 250 senior managers identified , , Senior Leadership Forum relaunched	Aug-17	Completed a review of the current leadership (designed to equip leaders to deliver the supportive, compassionate leadership required, which underpins a		Top 250 senior managers completed Management Programme	Feb-18
			% staff reporting errors, near misses or	2016: 91% (better than average)		Martin	Lucy	ULHT values relaunched			Aug-17	consistent safety , culture) "What do the values	Nov-17		
		Values: ULHT values embedded (safety	incidents witnessed in the last month	Median for Acute Trusts 90%		Rayson	Lucy Ettridge	as part of the overall 2021 Programme		Activities to bring ULHT values to life defined part of the next stage		mean for our Team?" survey completed	Nov. 17		
		is a key element) Staff Charter: ULHT values and behaviours embedded through the staff charter	Fairness and effectiveness for reporting errors, near misses and incidents	2016: 3.62		Martin Rayson	Helen Nicholson	Staff charter, building on values and outlining expectations of staff and behaviours, approved	Jul-17	for the 2021 campaign	Sep-17			Values and behaviours of the organisation embedded (using processes such as recruitment and	
			Staff confidence in reporting unsafe clinical practices	3.72 2016: 3.6 (worse than average)				Staff Charter launched	Jul-17					performance management)	Mar-18
		Freedom to Speak Out		Median for Acute Trusts		Karen Brown	Jayne Warner	New Freedom to Speak Out Policy agreed	May-17	,					

	Quality and				Denondensies										
	Safety	Outcome /			Dependencies Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No	Improvement Project		KPI Measure	Baseline	Support	Lead	Project Lead		Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date		Date
No	Project	Rey Willestoffe	Krivieasure	3.65	Зирроге	Leau	Project Lead	Programme commenced to promote wide understanding of the Freedom to Speak Out Policy			Date	(NOV) Dec) Jan)	Date	(res) Mai)	Date
			1				<u> </u>		Jul-17						
		Instilling a Safety Culture in our temporary workforce: Demonstrate that our temporary workforce are engaged and				Michelle Rhodes (Nursing) Martin Rayson (Other Staff)	Debrah Bates (Nursing) Helen Nicholson (Other Staff)	Key to Care Project proposal refreshed with involvement from agencies		Key to Care launched					
		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)						Key to Care Implementation plan developed with involvement from agencies	Jun-17	General induction reviewed and designed to deliver robust training covering safety requirements for all temporary staff					
										Refreshed general					
										induction commenced	Nov-17	7			
QS02	Clinical	Trust Board		1		Vovin Turnor	launo	Reviewed external		Terms of Reference and					
Q302	Governance	Assurance: Assurance Committee structure, processes and upward reporting				Kevin Turner	Warner	assurance recommendations at Board Development session	Jul-17	modus operandi revised	Aug-17	7		Revised arrangements evaluated	Mar-18
		in place								Revised processes	0.14				
		Trust Board Assurance: Refreshed structure and process in place for Trust Board meetings				Kevin Turner	Jayne Warner	Reviewed format, timing and style of Board Meetings at Board Development session to strengthen assurance and challenge	May-17	implemented Revised arrangements for Trust Board Meetings implemented	Oct-17			Revised arrangements for Trust Board Meetings evaluated	Mar-18
		Trust Board Assurance: Information to support Board assurance, monitoring and planning reviewed				Kevin Turner	Karen Brown		,	Agreed formal content of Board performance dashboard by service line at Board Development session Performance dashboard by service line in place	Aug-17	7			

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	Safety	0.1			Dependencies	Formation		2 Barrath Ballantana		C B C with B C lock was		O B G and b B G land and a		42 Barrath Ballanana	
NI-	Improvement	Outcome /	KPI Measure	Baseline	Resource and	Executive	Dunia et Land	3 Month Milestones	Data	6 Month Milestones	Data	9 Month Milestones	Data	12 Month Milestones (Feb/Mar)	Date
No	Project	Integrated Governance Structure and Process	Refilitedsure	Daseille	NHS I funding for External Review of Governance	Neill Hepburn	Project Lead Kevin Turner	(May/Jun/Jul) External Governance Review completed and received.	Date May-17	(Aug/Sep/Oct) External review of Trust proposals completed		Revised structure and process for integrated governance completed	Date Jan-18		Date
		T TOCCSS			function and structure			Approach to integrated governance designed and agreed by Trust Board Implementation plan with agreed timescales		Recruitment process for key posts within the revised structure completed			3410		
								for Integrated Governance approach in place.	Jul-17						
		Clinical Governance Processes (including specialty governance,				Neill Hepburn	Kevin Turner	Review of specialty governance assurance mechanism completed (QPIC)	Jun-17	Specialty governance processes and monitoring arrangements reviewed and strengthened		Implementation of revised specialty governance arrangements completed	Nov-17	Specialty governance arrangements evaluated	Mar-18
		clinical audit, lessons learned, mortality reviews)						Revised specialty		All speciality have had a meeting in line with standard agenda Started	Aug-17				
								governance assurance mechanism in place (formerly QPIC)	Jul-17	implementation of revised speciality governance arrangements	Sep-17				
		Risk Management				Kevin Turner	Karen Sleigh	Risk Management strategy, policies and procedures refreshed Corporate risk registers cleansed and validated	Jun-17	Risk management training tool kit developed Schedule for cyclical audit of corporate and operational risk	Aug-17				
								Datix project plan in place Datix business case and	Jun-17	commenced	Sep-17				
								specification to up-date the system submitted for approval	Jun-17						
		SI Backlog	Number of SIs		NHS I funding for resource to reduce backlog	Hepburn	Michelle Rhodes	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		Links to Training and Competencies QS09	Neill Hepburn	Karen Sleigh	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

lr	Safety mprovement				Banan dan dan										
	mprovement				Dependencies										
NO F		Outcome /	VDI Massaura	Deseller		Executive	Ductostional	3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones (Feb/Mar)	Data
	Project	Key Milestone	KPI Measure	Baseline	Support	Lead	Project Lead	(May/Jun/Jul)	Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan) 75% of all staff		95% of all staff	Date
1			% of staff					Being Open Policy				completed Duty of		completed Duty of	1
			trained in duty					refreshed and launched	Jun-17			Candour Training		Candour Training	Mar-18
			of candour					Duty of Candour				8			
								training module							1
			Benchmarking					approved	Jun-17						
			to assess					Roll out plan for Duty of							
			accuracy of					Candour training							
			recording					commenced	Jul-17						
			_					Duty of Candour							
								intranet site in place	Jul-17						
QS03 S	Sepsis	Sepsis CQUIN	Achieve 90%	99% (April	Staff initiating	Neill	Adam	Consistently achieved		Consistently achieved		Consistently achieved		Consistently achieved	
	•	Achieve 2017/18	screening for	2017 for	sepsis bundle	Hepburn	Wolverson	80% or greater for each		90% or greater for each		90% or greater for each		90% or greater for each	
		CQUIN milestones	sepsis	A&E and	when patients			month		month		month		month	
		(audit of 50		emergency	score NEWS of 5										
		patients each		admission	or more				Jul-17		Oct-17		Jan-18		Mar-18
		month in A&E and	Achieve 90% for	80% (April	Sepsis eBundle			Consistently achieved		Consistently achieved		Consistently achieved		Consistently achieved	
		50 inpatients each	sepsis 6 within 1	2017 for	will enable all			80% or greater for each		90% or greater for each		90% or greater for each		90% or greater for each	
		month who meet	hour	A&E and	new NEWS 5 or			month		month		month		month	
		the sepsis criteria)		emergency	more being										1
				admission	audited which						0				
			Achieve 90% for	wards)	will show a			Canadatanthua abiana d	Jul-17		Oct-17	Canadakan khi a ahdan ah	Jan-18	Canadatanthi addisinal	Mar-18
				85% (April	deterioration of			Consistently achieved		Consistently achieved		Consistently achieved		Consistently achieved	
			IVAB within 1	2017 for A&E and	our current			80% or greater for each		90% or greater for each		90% or greater for each		90% or greater for each month	
			hour		compliance			month		month		month		monun	
				emergency admission											
				wards)					Jul-17		Oct-17		Jan-18		Mar-18
		eCOBs to be live	All adult	90% of	ICT training			All wards are live with							
		on all adult	inpatient wards	wards are	Staff competent			eCOBs							
		inpatient wards	are using eCOBs	currently live	and confident										
					using the system										
					Stroke ward at										1
					PHB returning to										
					base ward										
					Obs and Gynae										
					ward at Pilgrim										
					moving to new										1
					building as										1
					scheduled				Jul-17						1

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	Safety	Outroms /			Dependencies	Forestine		2 Baruth Ballantanaa		C Bd a with Bdilanta was		O Baruth Bailestones		12 Nameth Milestones	
NIa	Improvement	Outcome /	VDI Massaura	Deselles	Resource and	Executive Lead	Duning the said	3 Month Milestones	Data	6 Month Milestones	Data	9 Month Milestones	Data	12 Month Milestones	Data
No	Project	Key Milestone Sepsis eBundle to		Baseline 50% of	Support ICT training	Lead	Project Lead	(May/Jun/Jul) Sepsis eBundle rolled	Date	(Aug/Sep/Oct) Sepsis eBundle	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
		be live on all adult			Sepsis			out to all inpatient		compliance audit					
			are live with the		T			wards		completed					
		inpatient wards	sepsis eBundle	currently live	training			warus		completed					
			sepsis ebuliule		Staff competent										
					and confident										
					using the system										
					Stroke ward at										
					PHB returning to										
					base ward										
					Obs and Gynae										
					ward at Pilgrim										
					moving to new										
					building as										
					scheduled				Jul-17	·	Oct-17				
		eCobs for	All paediatric	No	ICT training	1		Ongoing development		eCobs package		Ward training of eCobs		All paediatric inpatient	
		Paediatric wards	wards to be live	paediatric	Staff competent			of eCobs package		developed		and roll out		wards live with eCobs	
			with eCobs	wards	and confident							commenced			
				currently live	using the system										
		c : D II c	All line	 	LCT . · ·	1			Jul-17		Oct-17)	Jan-18		Mar-18
		Sepsis eBundle for		No	ICT training			Ongoing development		Sepsis eBundle package		Ward training of sepsis		All paediatric inpatient	
		Paediatric wards	wards to be live	-	Staff competent and confident			of sepsis eBundle		developed		eBundle and roll out		wards live with sepsis eBundle	
												commenced		eBundle	
			eBunale	currently live	using the system				Jul-17	,	Oct-17		Jan-18		Mar-18
		eCobs for	All maternity	No	ICT training	1		Ongoing development		eCobs package		Ward training of eCobs		All maternity inpatient	
		Maternity wards	wards to be live	maternity	Staff competent			of eCobs package		developed		and roll out		wards live with eCobs	
			with eCobs	wards	and confident							commenced			
				currently live	using the system						0				
		Carada a Describia face	A II	NI -	ICT to a local and	-		0	Jul-17		Oct-17	Mand tools on a factor	Jan-18	All and the street and	Mar-18
		Sepsis eBundle for			ICT training			Ongoing development of sepsis eBundle		Sepsis eBundle package developed		Ward training of sepsis eBundle and roll out		All maternity inpatient wards live with sepsis	
		Maternity wards		I	Staff competent and confident			or sepsis eburiale		developed		commenced		eBundle	
			· ·		using the system							Commenced		евиние	
			ebanaie	currently live	daing the system				Jul-17	,	Oct-17		Jan-18		Mar-18
		IR1 completed for	Review of IR1s	14 IR1s	All staff]		Sepsis Practitioner have		Sepsis Practitioners		Sepsis Practitioners		Continuation of	
				1	completing IR1s			completed IR1s for all		have communicated		have reviewed themes		lessons/ themes shared	
		compliance of	with non	in April 2017	when non			non compliance with		with ward sisters if non		and identified training		as identified from IR1s	
		sepsis screening	compliance data		adherence to			sepsis screening /		compliance with sepsis		needs for non			
		and treatment		still open	sepsis policy			treatment during audit		screening / treatment		compliance of sepsis			
				pending	Sepsis					as identified on		screening / treatment			
				investigation						eBundle to complete		and shared lessons			
					completing IR1s					IR1		with staff			
					when auditing										
					Ward sisters										
					reviewing all IR1										
					and acting on										
					them]	1		Jul-17		Oct-17		Jan-18		Mar-18

	Quality and														
	Safety	Outcome /			Dependencies	Francision		2 Manth Milestones		C Bd a while Bd Hanks was		9 Month Milestones		12 Manth Milestones	
No	Improvement	Outcome /	KPI Measure	Dasalina	Resource and	Executive	Duningting	3 Month Milestones	Doto	6 Month Milestones	Data		Doto	12 Month Milestones (Feb/Mar)	Date
No	Project	Key Milestone Completion of Harm Reviews for any patients with a NEWS 5 or above where sepsis screen/treatment not completed and patient outcome is an ICU admission or	Harm Reviews to be completed for patient who have been admitted to ICU or death when sepsis screening /treatment not completed		Support Sepsis Practitioners conflicting priorities	Lead	Project Lead	(May/Jun/Jul) Developed and agreed proforma for Harm Reviews Agreed Harm Review Process	Date	(Aug/Sep/Oct) Completed Harm Reviews for any NEWS 5 or above where sepsis screen/treatment not completed and patient outcome is an ICU admission or death	Date	(Nov/Dec/Jan) Sepsis Practitioners have reviewed themes and identified training needs for non compliance of sepsis screening / treatment and shared lessons with staff	Date	Continuation of lessons/ themes shared as identified from IR1s	
		death							Jul-17	,	Oct-17		Jan-18		Mar-18
		Front line staff are completing the sepsis eLearning module	mapped to complete sepsis	83% have completed their eLearning	Staff completing the eLearning			90% completed eLearning by July 2017		95% completed eLearning by October 2017		Sustaining 95% or greater		Sustaining 95% or greater	
		Sonsis Guardian /	Consis	130 silver	Clinical	_		Analysed training	Jul-17		Oct-17	Silver Cuardian on	Jan-18	Sustained Silver	Mar-18
		Champion role	Guardians on all clinical shifts	currently trained	Education Team & Sepsis Practitioner conflicting priorities to train extended skills Staffing levels may not allow for staff to attend training			Analysed training requirements and identified shortfalls of clinical skills on adult inpatient wards	Jul-17	Implemented appropriate training from TNA for adult inpatient wards	Oct-17	Silver Guardian on each shift on adult inpatient wards	Jan-18	guardian on each shift on adult inpatient wards	Mar-18
		PGD to be utilised on A&E / Admission Units	trained	96 currently trained in Gold	Clinical Education Team & Sepsis Practitioner conflicting priorities to train extended skills			Analysed training requirements and identified shortfalls of clinical skills in A&E / Admission Units	Jul-17	Implemented appropriate training from TNA for A&E / Admission Units	Oct-17	Gold Guardian on each shift on A&E / Admission Units		Sustained Gold Guardian on each shift on A&E / Admission Units	Mar-18
		Sepsis Boxes available on all adult inpatient wards	to be on each		Pharmacy bags being developed and ordered Meropenum stock levels			All adult inpatient wards to have one sepsis box	Jul-17						
		Development of sepsis Podcast	viewing the podcast	Not currently developed so no baseline data	Staff to complete the podcast			Podcast developed and available on ULHT intranet	Jul-17						

	Quality and Safety				Dependencies										
	Improvement	Outcome /			Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No		Key Milestone	KPI Measure	Baseline	Support	Lead	Project Lead		Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
No	rioject	EMAS to screen and treat red flag sepsis	EMAS are	Not currently underway so baseline data	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		Date
QS04	GI Bleed Service	Policy				Neill Hepburn	Mel Clements	Out of Hours GI Bleed audit commenced	May-17	Out of Hours GI Bleed audit commenced	Oct-17				
								audit findings reviewed Out of Hours Upper GI Haemorrhage Policy for Pilgrim Hospital approved by CESC and launched trust-wide	May-17	Audit findings reviewed	Nov-17				
		Out of Hours GI Bleed Rota (Pilgrim)				Neill Hepburn	Mel Clements	Review of current on call rotas and job plans completed Costed options for delivering an Out of Hours GI Bleed Rota, including "do nothing" developed		Option for Out of Hours GI Bleed Service model agreed Milestones for next stage agreed	Aug-17				
QS05	Airways Management (NIV Pathway)		Number of recorded SIs			Michelle Rhodes	Jenny Hinchliffe	Consultant lead for Pilgrim identified to chair the Project Group Project Group to review the internal system and process for airways management established Community wide Pathway review group established	Jun-17	Review of Community NIV pathway completed Implementation plan, based on the community wide	Aug-17			Community wide pathway compliance audit completed	Mar-18
								Baseline audit of pathway for patients admitted requiring NIV completed	Jun-17 Jul-17	nlace	Sep-17				

	Quality and Safety Improvement	Outcome /			Dependencies Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No	Project		KPI Measure	Baseline		Lead	Project Lead		Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
QS06	Mental Health and Learning Disabilities	Environmental risk assessments completed in all acute admission wards, ED and	Environmental risk assessments	Baseline	Support	Michelle Rhodes	Project Lead Jennie Negus	EDs have repeated initial risk assessments		Requirements of acute admission wards and paediatric audits have been addressed		EDs, acute admissions wards and paediatrics have repeated environmental risk assessments			Date
		Paediatrics						Deminerated FD as	Jun-17		Sep-17	'	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							
		Staff on acute admissions wards, EDs and Paediatrics are knowledgeable and know how to assess and manage the risk	Ward assurance metrics Number of SI and incident relating to patients self-			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				
		of self-harm Clinical staff	harming Number of staff		Core Learning	Michelle	Jennie	Training needs analysis	Jul-17		Oct-17		 		+
		understand the requirements of the administration and care of	who have completed Mental Health training (target 90% of relevant		requirements Training and Competencies (QS09)	Rhodes	Negus	completed identifying which staff require training Pre and post 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		
		patients detained under the Mental Health Act (Core Learning)			((303)			self-assessment proforma designed	Jun-17						
		Clinical staff understand how to respond and care for patients	Number of staff who have completed clinical holding		Links to Chemical Restraint Policy Training and	Michelle Rhodes	Jennie Negus	Clinical Holding and Restraint Policy developed and launched		50% of identified staff have completed clinical holding and restraint training		90% of identified staff have completed clinical holding and restraint training	Dec-17		
		who require clinical holding or restraint	or restraint training (target 90% of relevant staff)		Competencies (QS09)			Clinical holding and restraint training needs analysis completed				Existing policy reviewed and amended where necessary as a result of staff training			
								Clinical holding and restraint training developed	Jun-17 Jul-17				Dec-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				

	Quality and Safety				Dependencies										
	Improvement	Outcome /			Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No	Project	Key Milestone	KPI Measure	Baseline	Support	Lead	Project Lead	(May/Jun/Jul)	Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
								LD specialist nurses		Ward based training					
								commenced attending		completed on all wards					
								Matrons and Sisters							
								meetings	Jun-17	1	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			Speciality	Michelle	Jennie	Process developed and		Case reviews, including					
		is informed and			Governance	Rhodes	Negus	commenced for all		learning from incidents,					
		influenced by			Meetings			Mental Health related		available to share and					
		patient and staff						incidents to be		discuss at Specialty					
		feedback						reviewed by the Deputy		Governance Meetings					
	1				1			Chief Nurse,							
								Safeguarding Team and							
	1				1			Security Management							
	1				1				Jul-17	Wachaniem to tian	Aug-17				
								Commenced reporting		Montal Health and					
								of each review to the		Mental Health and					
								Mental Health and		Learning Disability					
								Strategy Group		patients within existing					
										feedback data					
										(complaints, PALs, FFT)					
									Jul-17	agreed	Aug-17				
								The mechanism to		Commonand					
								identify Mental Health		Commenced					
								and Learning Disability		discussions regarding					
								patients on Medway		Mental Health and					
								has been agreed		Learning Disability					
										patient feedback at the					
										Patient Experience					
									Jul-17	Committee	Sep-17				
	1				1										
	1				1					Mental Health and					
	1			1	1					Learning Disability staff					
	1				1					are notified in order to					
										attend patient in a					
										timely way	Sep-17		<u> </u>		
QS07	Safeguarding	There is a vision,	l			Michelle	Jenny	Safeguarding strategy				There is an updated	Ī		
ارمی	Jareguarumg				1	Rhodes	Hinchliffe					organisation Statement	.		
	1	strategy and		1	1	Kiloues	ппиние	developed				of Intent for	1		
		robust							Feb-17	.			Dec-17	7	
	1	governance			1				rep-1/			safeguarding	Dec-17	<u>'</u>	
	1	across adult and		1	1			There is a monthly							
	1	children's		1	1			Operational committee				A safeguarding audit			
	1	safeguarding		1	1										
	1	(Dec17)			1			for adult safeguarding		ĺ		plan is developed and		,	
	1				1			established	Mar-17	1		agreed	Dec-17	<u> </u>	
								The self assessment of							
								The self-assessment of							
	1			1	1			regulation 13 has been							
	1			1	1			completed and will be							
1								repeated every quarter	Mar-17	Ί					

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	Safety	Outroms /			Dependencies	Francision		2 Manth Milestones		C Bd a while Bd il a shaw a a		O Barrath Ballantanan		12 Mouth Milestones	
NI -	Improvement	Outcome /	I/DI 84	Decellor.	Resource and	Executive	Don't all and	3 Month Milestones	D-1-	6 Month Milestones	D-4-	9 Month Milestones		12 Month Milestones	D-1-
No	Project	Key Milestone	KPI Measure	Baseline	Support	Lead	Project Lead	(May/Jun/Jul) The safeguarding risk	Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
								register has been							
								reviewed and updated							
								as required	Mar-17						
								Safeguarding strategy	IVIGI 17						
								embedded within the							
								organisation							
								organisation	Jun-17						
		Safeguarding				Michelle	Jenny	Dignity in Care Policy		Dignity in Care Policy		Dignity in Care Policy		Dignity in Care Policy	
		policies have been				Rhodes	Hinchliffe	The dignity in care							
		reviewed,						policy has been							
		updated and						reviewed and updated							
		relaunched across						as required	Jan-17						
		the organisation						The revised dignity in							
1		(Jan18)					1	care policy has been							
1								relaunched and is embedded across the							
								organisation	Apr-17	MCA & DOLS Policy		MCA & DOLS Policy		MCA & DOLS Policy	
						-		MCA & DOLS Policy The MCA and DoLs		The revised MCA and		IVICA & DOLS POLICY		IVICA & DOLS POLICY	
								policy has been		DoLs policy has been					
								reviewed and updated		relaunched and is					
								<u> </u>		embedded across the					
								as required	Jun-17	organisation	Sep-17				
								Safeguarding Children		Safeguarding Children		Safeguarding Children		Safeguarding Children	
								and Young People		and Young People		and Young People		and Young People	
								Policy		Policy		Policy		Policy	
										The safeguarding		The revised			
										children and young		safeguarding children			
										people policy has been		and young people			
										reviewed and updated		policy has been			
										as required		relaunched and is			
												embedded across the			
											Sep-17	organisation Management of	Dec-17		
								Management of		Management of				Management of	
1								allegation against		allegation against		allegation against		allegation against	
								people who work with		people who work with		people who work with		people who work with	
1						4	1	Children Policy		Children Policy		Children Policy		Children Policy	
1							1			The management of		The revised			
1							1			allegations against		management of			
1							1			people who work with		allegations against			
1							1			children policy has		people who work with			
1							1			been reviewed and		children policy has			
							1			updated as required		been relaunched and is			
												embedded across the			
							1				Sep-17	organisation	Dec-17		
						1		Self-Harm in Children		Self-Harm in Children		Self-Harm in Children		Self-Harm in Children	
							1	Policy		Policy		Policy		Policy	
						7				The self harm in					
1										children policy has		The revised self harm			
1										been reviewed and		in children policy has			
										updated as required		been relaunched and is			
							1					embedded across the			
						_	I		<u> </u>		Sep-17	organisation	Dec-17		<u> </u>

March Mission Missio		Quality and														
Project Ry Milestone Ry Milest		Safety				Dependencies										
Compared Child Coath Policy Co		Improvement	Outcome /			Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
Death Policy Death Policy Death Policy The unsequented fillid death policy has been reviewed and any one process for children with OPD Appointments Applicationents DNA Process for Children with OPD Applicationents There is a robust process for thickness or this process for children with OPD Applicationents There is a robust process for this process for t	No	Project	Key Milestone	KPI Measure	Baseline	Support	Lead	Project Lead		Date		Date				Date
There is a robust process for children with Ord											-		=			
DHA Process for DHA Proces									Death Policy		Death Policy				Death Policy	
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DNA Process for Children with OPD Appointments There is a robust performance performance performance performance performance chocked on the comprehensive chocked on the comprehensive chocked on the comprehensive chocked on all states of the comprehensive chocked on the comprehensive chocked on all states of the comprehensive chocked on the compre																
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DNA Process for Children with OPD Appointments Process for Children with OPD Process for Chi													i			
DNA Process for Children with OPD Appointments Appointmen													relaunched and is			
DNA Process for Children with OPD Appointments													embedded across the			
Children with OPD Appointments Appointments																
Appointments Appointments Appointments Appointments Appointments Appointments Appointments The DNA process for children with outpatient appointments has been reviewed and amended as required August 21 There is a robust process for monitoring and reporting safeguarding performance There is a completed monitoring and reporting safeguarding performance There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and development offer There is a comprehensive education, training and the training after a comprehensive education and the training and the training after a comprehensive education and training after a comprehensi																
The DNA process for children with outpatient appointments has been reviewed and amended and sembedded across the method and is embedded across the method and sembedded across the method across the method and sembedded across the method ac									Children with OPD		Children with OPD		Children with OPD		Children with OPD	
there is a robust process for monitoring and reporting safeguarding performance with an appointment has been developed and succeed and suc									Appointments						Appointments	
Outpatient appointments has been reviewed and amended as required as rebust process for monitoring and reporting safeguarding safeguarding safeguarding performance monitoring and comprehensive education, training and development offer There is a comprehensive education, training and development offer Training dates are arranged and published for 2017/18 Training dates are arranged and publi											•					
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reporting safeguarding performance			process for				Rhodes	Hinchliffe								
Safeguarding performance The use of sedation and rapid tranquilisation is monitored and reported monthly There is a comprehensive education, training and development offer Training dates are arranged and published for 2017/18 Training dates are arranged and published for in practice Training dates are arranged and published for 2017/18 Training dates are arra			monitoring and						1							
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development offer Mar-17 Sep-17 in practice Dec-17									for 2017/18		1					
offer Mar-17 Sep-17 in practice Dec-17											been completed					
Training dates are arranged and published Mar-17 Clinical supervision sessions are provided on all sites Mar-17 The training offer is reviewed and revised as required May-17 Tailored training is developed for staff on the silver and gold on-			-							Mar-17	,	San-17		Dec-17		
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Clinical supervision sessions are provided on all sites Mar-17 The training offer is reviewed and revised as required May-17 Tailored training is developed for staff on the silver and gold on-										Mar-17	,					
sessions are provided on all sites Mar-17 The training offer is reviewed and revised as required May-17 Tailored training is developed for staff on the silver and gold on-									Clinical supervision					<u> </u>		1
on all sites Mar-17 The training offer is reviewed and revised as required May-17 Tailored training is developed for staff on the silver and gold on-									<u> </u>							
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required May-17 Tailored training is developed for staff on the silver and gold on-																
Tailored training is developed for staff on the silver and gold on-									reviewed and revised as							
Tailored training is developed for staff on the silver and gold on-									required	May-17	<u>'</u>					
the silver and gold on-									Tailored training is							
									•							
call rota May-17									the silver and gold on-							
									call rota	May-17	<u> </u>					

	Quality and Safety Improvement	Outcome /			Dependencies Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No Q508	Project Medicines Management (previously Medication Safety CQUIN)	Key Milestone	KPI Measure	Baseline	Support	Neill Hepburn	TBC	(May/Jun/Jul) Conference Call with Richard Seal, Neill Hepburn and Claire Pacey taken place Fri 02-06-17 Missed critical medicines implementation plan agreed	Jun-17		Date Aug-17	(Nov/Dec/Jan) Missed critical medicines implementation plan completed Missed critical medicines audit completed		Missed critical medicines re-audit completed	Date Mar-18
												Further actions, based on findings of the audit, agreed	Jan-17		
QS09	Training and Competencies	Core Learning Plus	90% of staff who are up-to-date with core learning requirements (Excludes vacant posts and maternity leave)		Links to values QS01	Martin Rayson Martin Rayson	Helen Nicholson Helen Nicholson	Review of core learning completed (stakeholder views used to confirm or amend existing requirements and current core learning defined) Refreshed core learning package launched and promoted to staff	Jun-17		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) Mechanism for recording completion of core learning plus training in place including escalation process for noncompliance	Mar-18
QS10	Appraisal and Supervision	Appraisal Rate	Non-medical: Number of staff with at least 12			Martin Rayson	Helen Nicholson	80% recorded appraisal for all available staff	May-17					85% recorded appraisal for all available staff	Mar-18
			months service with the Trust who have had an appraisal in last 13 months (one month					Executive letter sent to all managers outlining responsibilities in line with the Appraisal Policy	Jun-17						

	Quality and Safety				Dependencies										
		Outcome /			Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No			VDI Moasuro	Racolina					Data						Date
No		Performance Management	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	Baseline	Support	Martin Rayson	Project Lead Helen Nicholson	(May/Jun/Jul)	Date	(Aug/Sep/Oct) Approach to Individual Performance Management reviewed		(Nov/Dec/Jan) Performance Management Policy approved		(Feb/Mar) Revised Individual Performance Management Approach (incorporating appraisal) launched	Date
			Survey								Oct-17		Dec-17		Apr-18
			_			1	I						1		, , ===
QS11		Health Records		Case note	Health Records		Buddhika	Health Record function		Trustwide SOPs for					
		Health records	availability 98%	•	Business Case	Brassington	Samarsinghe	processes reviewed and		Health Record function					
		service is		92%	approval			SOPs developed		launched					
		compliant,	Number of case						Jun-17		Sep-17				
		responsive and	notes merged /		Ability to Recruit			Subject Access	l 17						
		performance /		circa	approved			Trajectory in place Case note merge and	Jun-17				+		
		quality issues have been	Number of	notes	numbers / skill mix to Health			repair trajectory in							
		reduced		require	Records			place	Jun-17						
		reduced		merge and	Records			Health Records business							
			40 days	repair				case refreshed							
			40 days	Герин					Jun-17						
				384 Subject				Health Records business							
				Access				case approved	11.47						
				Requests				Monthly case note	Jul-17						
				over 40 days				availability audit							
				(Jan17)				commenced	Jul-17						
								Health Records					1		
								implementation plan							
								(including recruitment							
								and capital							
								requirements)							
								developed with							
		For time to the	Down of OCC		Comital form !!	N 4 m d :	Charia	milestones	Aug-17				 		
		Environment	Part of QS17		Capital funding	Mark	Chris	OPD capital		Business case for OPD					
		All Out-Patient facilities are fit for			Part of QS17	Brassington	Farrah	requirements identified and prioritised		priorities approved					
		purpose						and prioritised	Jun-17		Sep-17				
		purpose						Business case for OPD		Implementation plan	-1		1		
								priorities developed		for OPD priorities					
]	<u> </u>		Aug-17	commenced	Oct-17		<u> </u>		

	Quality and														
	Safety				Dependencies .										
	Improvement	Outcome /			Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No	Project	Key Milestone		Baseline	Support	Lead	Project Lead	<u>, </u>	Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
		Access, Booking	Centralised ABC			Mark	Lee	ABC business case		Phase 2		Phase 3		Centralisation of ABC	
		and Choice	Service		Case approval	Brassington	Parkin	approved		Implementation plan		Implementation plan		function completed	
		Centralised ABC								for centralised ABC		for centralised ABC			Mar-18
		function with a fit								function developed		function developed			IVIAI-10
		for purpose								with milestones		with milestones			
		structure and							Jun-17		Sep-17		Dec-17		
		workforce						Phase 1 Implementation			3cp 17		Bec 17		
								plan for centralised ABC							
								function developed							
								with milestones							
									Jul-17	,					
		Innovation	Patient calling		Completion of	Mark	Buddhika	Roll out plan for patient		Business case for		All trust wide roll out		E-room booking plan	
		Progressed the			Medway	Brassington	Samarsinghe	calling at Pilgrim		patient calling at		plans for patient		implemented	
		implementation	e-outcomes		Upgrade (Oct17)			completed		Grantham approved		systems fully			
		of digital solutions	;						Jul-17	,	Aug-17	implemented	Jan-18		Mar-18
		within OPD	Net call		Business Case			Business case for		Roll out plan for					
					approval			patient calling at		patient calling at					
			clinic room					Grantham submitted		Grantham completed					
			e-booking		Centralisation of					(subject to business					
					ABC service			- "	Jul-17	case approval)	Sep-17				
								Roll out plan for net call		E-room booking					
					IT support /			completed	1 1.7	functionality plan	Sep-17				
		Constitutional	Delivery of		ABC Business	Mark	Neil	Constitutional	Jui-17	developed	3ep-17				
		Performance	constitutional			Brassington	Ellis	standards recovery							
		Standards	standards		implementation	Di assirigion	Lilis	plans and trajectories in							
		Standards	recovery		Implementation			place							
			trajectories		Clinical capacity			•	May-17						
			trajectories		Cirrical capacity			Harm review process in	Jun-17	,					
								place Demand management	Juli-17						
								plans with CCG support							
								agreed	Jun-17	4					
0012	Infantion Control	IBC Link Numers	Number of IPC			Michelle	l _{lam} a			IPC Link Nurse					
QS12	Infection Control	There is a cadre of				Rhodes	Jane Finch	Capacity and capability of IPC Link Nurses				Focused monthly			
			Link Nurses			Rilodes	FINCH			implementation plan, based on review, in		awareness raising by			
		competent IPC Link Nurses	% of trained IPC					reviewed (including training needs analysis)		place		IPC Link Nurses			
		LITIK NUTSES	Link Nurses					training needs analysis)	Jul-17	place	Aug-17	commenced	Nov-17		
			LIIIK INUISES							Various communication		IPC Link Nurse			
										channels with IPC Link		innovation scheme			
										Nurses established (eg		established			
										closed Facebook group					
											Aug-17		Dec-17		
										Quarterly IPC					
										development days					
										aligned to key priorities					
										commenced	Sep-17				
I	I	1	I I		I	I	I	<u> </u>	ļ	commenced	Jeb-17				

	Quality and														
	Safety	Outcome /			Dependencies	Francision		2 Manth Milestones		C Manth Milatona		O Basach Ballastanas		12 Month Milestones	
No	Improvement Project	Outcome / Key Milestone	KPI Measure	Baseline	Resource and Support	Executive Lead	Project Load	3 Month Milestones (May/Jun/Jul)	Date	6 Month Milestones (Aug/Sep/Oct)	Date	9 Month Milestones (Nov/Dec/Jan)	Date		Date
INO	Froject	Key Milestone	KFT Wieasure	Daseille	Зиррогс	Leau	FTOJECT LEAU	(IVIAY/JUII/JUI)	Date	IPC Link Nurse folders	Date	(NOV/ Dec/Jan)	Date	(FED/IVIAI)	Date
										in all clinical areas					
											Sep-17	<u>'</u>			
										Role of IPC Link Nurses					
										in IPC Outbreak					
										management agreed					
										and commenced	Oct-17	,			
		Gram Negative	Number of			Michelle	Jane	Project Group		Milestone Plan, based					
		Bacteraemia and Contaminated	Bacteraemia			Rhodes	Finch	established		on audit findings, developed					
		Blood Cultures	reported							developed					
		The Trust aims to	reported												
		reduce Gram	Number of												
		Negative	Contaminated						l 4-	,	A 47				
		Bacteraemia by	Blood Cultures					Baseline audit	Jun-17	E-coli rates displayed	Aug-17				
		10% (YR1) and						completed		on Ward Quality					
		Contaminated						Completed	Jun-17	Boards	Aug-17	,			
		Blood Cultures						Communication plan in							
		rates by 5% (YR1)						place							
									Jul-17	,					
		Cleanliness audit	Average score in	Mar17 audit				NHS I IPC site visits		Business Case for phase	2				
		results are	MiC4C	data				completed		2 of the Housekeeping					
		improved across	Cleanliness audit							investment developed					
		all indicators	results per site						Jul-17	7	Aug-17	,			
									Jul-17	Milestone plan	Aug-17				
										developed based on					
										the findings of the IPC					
										visit	Aug-17	'			
										Plan developed for					
										trust-wide deep					
										cleaning	Aug-17	,			
		Bare Below the	Compliance					Dress Code Policy		Revised Dress Code				Compliance audit of	
		Elbows	audit of bare					revised		Policy launched				bare below the elbows	
			below the elbows and											and dress code policy	
			dress code						May-17	7	Aug-17	,		completed	Mar-18
			policy					Bare Below the elbows		Audit of bare below the	2				
			,					relaunched		elbows and dress code					
										policy compliance					
									Jun-17	completed	Oct-17	,			
								Consultation on Dress	70.11 17		000 17				
								Code Policy completed							
									11.4-	,					
	_		<u> </u>	ļ	ļ		ļ	<u> </u>	Jul-17	<u>'</u>		ļ			ļ

No	Quality and Safety Improvement Project	Outcome / Key Milestone	KPI Measure	Baseline	Dependencies Resource and Support	Executive Lead	Project Load	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
QS13	Reducing	Diabetes - DKA	Compliance with	Daseinie	Зирроге	Neill	Leicester	Medical Director		DKA compliance audit		DKA compliance audit		DKA compliance audit	
	Variation in Clinical Practice	Pathway	the DKA pathway			Hepburn	contact	contacted Leicester Terms of Reference	May-17	completed	Oct-17	completed	Jan-18	completed	Mar-18
	Cillical Flactice		patriway					agreed	Jun-17	,					
								DKA pathway review							
								commenced Further milestones	Jul-17	1	1				
								agreed once scope and							
								TOR in place with							
		D				A1 :11	0 1	Review Team	Jul-17	<u>'</u>					
		Deteriorating Patient (Out of			P2 - Productive Hospital	Neill Hepburn	Carol Staples	Review of current							
		Hours)			riospitai	Первин	Stapies	Hospital at Night service		Review of Hospital at					
		·						against Trust Board		Night service					
								paper commenced	Jun-17	completed	Aug-17	<u>'</u>			
										Further milestones ,					
										KPIs and Project Lead					
										agreed based on recommendations from					
										the review		,			
QS14a	Clinical Staffing -	Workforce Plan				Michelle	Debrah			Initial draft for Nursing					
Q314a	Nursing	Workforce Flair				Rhodes	Bates			and Midwifery					
										workforce plan	Sep-17				
										completed and circulated for					
										consultation	Sep-17	workforce plan			
											1				
										Revised draft for Nursing and Midwifery					
										workforce plan					
										circulated for comment	Oct-17	,			
		Recruitment	Nursing Vacancy			Michelle	Debrah	Canaria iah dasarintians							
		Process	Rate			Rhodes	Bates	Generic job descriptions for band 2 and band 5							
								approved	Jul-17						
								Cohort recruitment plan in place for 2017-18	Jul-17						
								Standardised	Jui-17		1				
								recruitment process in							
								place for Nursing and	1						
		Care Certificate	Number of HCA				1	Midwifery Plan for all current HCAs	Jul-17	All new starters from		First Care Certificate	1		
		All new HCAs will						to complete Care		01-09-17 are		presentation event			
		complete the Care	Certificate (new					Certificate developed		apprentices and will		taken place			
			and existing							complete the Care					
		schedule in place								Certificate					
		for all existing HCAs	separately)												
	1								Aug-17	1	Sep-17	1	Dec-17	1	

	Quality and Safety Improvement	Outcome /			Dependencies Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No	Project	ACP and Workforce in	KPI Measure	Baseline		Michelle Rhodes	Project Lead TBC	(May/Jun/Jul) Workforce plan developed with NHSI	Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
06141		conjunction with	lad 1: 137		Tri to the suits	D	ls:	<u> </u>	Aug-17						
QS14b	Clinical Staffing - Medical	Medical Rotas	Medical Vacancy rate (Trust target 12%)		Links with NHS Employers and NHSI	Mark Brassington	Steve McGowan	Business case for Allocate system approved	Jun-17	Implementation plan and schedule for improved medical rotas commenced	Aug-17			Implementation plan for improved medical rotas completed	Mar-18
								All medical rotas reviewed and efficiencies identified Allocate software	Jul-17						
		Job Planning monitoring	Average number of PAs		Allocate business case approval		Steve Anglin	system implemented Existing long term	Jul-17			95% of job plans are agreed and uploaded			
		monitoring	OT AS		case approval			agency doctor job plans have been submitted for compliance checks	Jun-17			to Allocate	Nov-17	,	
								Medical agency staff reduced to a maximum of 10 PAs (excluding on-				Milestone plan agreed to assess needs of the service against existing			
		Internal Bank system	Agency to Bank conversion % of medical		Allocate business case approval		Chloe Scruton	call) Internal bank rates agreed and standardised	Jul-17	Recruitment campaign and process for medical bank to include AHPs and surgical first		job plans	Nov-17		
			staffing spend attributable to bank and agency						Jul-17	Automatic registration for new starters in	Aug-17				
										Process for compliance checks in place	Aug-17 Aug-17				
		Skill Mix					ТВС	Scoping exercise completed Skill mix plan in place	Jun-17 Jul-17						
QS15	Medical Engagement	National Medical Staff Survey results			Engagement	Neill Hepburn	E2P	Preliminary discussion taken place with E2P	May 17	Medical Engagement Survey closed, data analysed and report	A.v. 17				
					Survey			Data requirements completed		received Survey results reviewed and action plan developed	Aug-17 Sep-17				
								Medical and Senior Management staff briefed prior to launch	Jun-17						
								Medical Engagement Survey launched	Jul-17						

	Quality and														
	Safety				Dependencies										
	Improvement	Outcome /			Resource and	Executive		3 Month Milestones		6 Month Milestones		9 Month Milestones		12 Month Milestones	
No	Project	Key Milestone	KPI Measure	Baseline	Support	Lead	Project Lead	(May/Jun/Jul)	Date	(Aug/Sep/Oct)	Date	(Nov/Dec/Jan)	Date	(Feb/Mar)	Date
QS16		Ward				Michelle	Penny	Ward Accreditation		Pilot evaluated process				Implementation	
	Support for	Accreditation				Rhodes	Snowden	Project Group		and tool revised as				schedule delivered for	
	Pilgrim Hospital	recreatation				modes	Showach	established		necessary		Agreed posts from		Pilgrim and Grantham	
	Filgrilli Hospital							established	May-17	Tiecessal y	Aug-17	Business Case filled	Dec-17		Mar-17
								Visit to partner	,		710.6 =7	Duomess Gase mica		Implementation	
								organisations (Salford /		Ward Accreditation				schedule delivered a	
								Pennine, Northampton)		implementation				Lincoln and Louth	
										schedule developed				Lincolli and Louth	
								taken place		and agreed for Pilgrim					
									May-17	and Grantham	Aug-17				твс
								Business Case for on-	IVIGY 17	Mechanism agreed and					TBC
										commenced to revisit					
								going implementation							
								and sustainability of		wards					
								Ward Accreditation							
								completed							
									May-17		Sep-17				
								Salford tool mapped to		Implementation					
								fundamental standards		schedule agreed for					
								of care, CQC KLOES and		Lincoln and Louth					
								nursing standards							
									May-17		Oct-17				
								Communication							
								Strategy for Ward							
								Accreditation							
								developed and agreed							
									Jun-17	•					
								Placement visit							
								schedule in place	Jun-17	•					
								Business Case agreed	Jul-17						
								Ward Accreditation							
								pilot commenced at							
								Pilgrim (2 Wards) and							
								Grantham (1 Ward)	Jul-17	,					
								Nursing Quality	70 27						
								Assurance Framework							
								in place to develop and							
								monitor	Jul-17	,					
		To provide a	 		1	Mark	Michael	implementation plans	Jul-17	Cardio-respiratory			1		
		quality, safe	[Woods			clinical strategy					
						מווופנטוו	WOOUS								
		service for cardio-	[1						developed and agreed					
		respiratory	[1						Clinical Model/SOPS					
		patients with	[1						Workforce Model					
		appropriately	[1						Estates Plan					
		trained	[1							A 17	Dusiness sees sees	Nov. 17		
		competent	[1							Aug-1/	Business case approved	NOV-1/		
		nursing staff	[1						Business case					
			[1						developed including					
			[1											
										KPIs and dashboard	C = : 4-				
	1	1	I	1	1	1	I			(Including Gap analysis)	Sep-17		<u> </u>		

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)		9 Month Milestones (Nov/Dec/Jan)	Date	12 Month Milestones (Feb/Mar)	Date
										Implementation plan with milestones developed and agreed	Sep-17				
										milestones for implementation agreed	Sep-17				
										Staff are engaged and consulted with regarding new service (including HR process)	Oct-17				
QS17	Estates Environment					Paul Boocock	Claire Hall	Analysis of E&F requirements							
								completed Mechanism and process	Jun-17						<u> </u>
								in place to bring together and prioritise all E&F work							
								programmes E&F priorities rationalise, costed and	Jun-17						
								agreed	Jun-17						-
								E&F work plan agreed and milestones in place	Jul-17						