CARING FOR YOU

NHS
United Lincolnshire Hospitals
NHS Trust

QUALITY AND SAFETY IMPROVEMENT PLAN (V2.0 28 June 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 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	2016: 30% (Average) Median for Acute Trusts 31%		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)	% staff reporting errors, near misses or incidents witnessed in the last month	2016: 91% (better than average) Median for Acute Trusts 90%		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	Fairness and effectiveness for reporting errors, near misses and incidents	2016: 3.62 (worst 20%) Median for Acute Trusts 3.72		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 confidence in reporting unsafe clinical	2016: 3.6				Staff Charter launched	Jul-17						

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		Freedom to Speak Out	practices	(worse than average) Median for Acute Trusts 3.65		Karen Brown	Helen Nicholson (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						
		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	Clinical Governance	**Trust Board Assurance:** Assurance Committee structure, processes and upward reporting in place				Kevin Turner	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				Kevin Turner	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

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		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	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	Kevin Turner	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						
		Clinical Governance Processes (including specialty governance, clinical audit, lessons learned, mortality reviews)				Neill Hepburn	Kevin Turner	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				Kevin Turner	Karen Sleigh	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	Michelle Rhodes	Resources identified to clear the backlog of SIs	May-17	SI backlog completed	Sep-17				

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		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	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
								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						
QS03	Sepsis	**Sepsis CQUIN** 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% screening for sepsis	99% (April 2017 for A&E and emergency admission	Staff initiating sepsis bundle when patients score NEWS of 5 or more Sepsis eBundle will enable all new NEWS 5 or more being audited which will show a deterioration of our current compliance	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 sepsis 6 within 1 hour	80% (April 2017 for A&E and emergency admission				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 1 hour	85% (April 2017 for A&E and emergency admission				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
			eCOBs to be live on all adult inpatient wards	All adult inpatient wards are using eCOBs	90% of wards are currently live	ICT training 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		All wards are live with eCOBs	Jul-17						
			Sepsis eBundle to be live on all adult inpatient wards	All adult inpatient wards are live with the sepsis eBundle	50% of wards are currently live	ICT training Sepsis Practitioner training 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		Sepsis eBundle rolled out to all inpatient wards	Jul-17	Sepsis eBundle compliance audit completed	Oct-17				

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		eCobs for Paediatric wards	All paediatric wards to be live with eCobs	No paediatric wards currently live	ICT training Staff competent and confident using the system			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
		Sepsis eBundle for Paediatric wards	All paediatric wards to be live with Sepsis eBundle	No paediatric wards currently live	ICT training Staff competent and confident using the system			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 for Maternity wards	All maternity wards to be live with eCobs	No maternity wards currently live	ICT training Staff competent and confident using the system			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
		Sepsis eBundle for Maternity wards	All maternity wards to be live with Sepsis eBundle	No maternity wards currently live	ICT training Staff competent and confident using the system			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
		IR1 completed for all non compliance of sepsis screening and treatment	Review of IR1s and compare with non compliance data	14 IR1s completed in April 2017 and 6 were still open pending investigation	All staff completing IR1s when non adherence to sepsis policy Sepsis Practitioners completing IR1s when auditing Ward sisters reviewing all IR1 and acting on them			Sepsis Practitioner have completed IR1s for all non compliance with sepsis screening / treatment during audit	Jul-17	Sepsis Practitioners have communicated with ward sisters if non compliance with sepsis screening / treatment as identified on eBundle to complete IR1	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
		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 death	Harm Reviews to be completed for patient who have been admitted to ICU or death when sepsis screening /treatment not completed within 1 hour	No base line data currently available	Sepsis Practitioners conflicting priorities			Developed and agreed proforma for Harm Reviews 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

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		Front line staff are completing the sepsis eLearning module	95% of staff mapped to complete sepsis eLearning module	83% have completed their eLearning	Staff completing the eLearning			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
		Sepsis Guardian / Champion role	Sepsis Champions / Guardians on all clinical shifts	130 silver currently trained	Clinical 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	Sustained Silver guardian on each shift on adult inpatient wards	Mar-18
		PGD to be utilised on A&E / Admission Units	One Gold PGD trained Guardian on each shift	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	Jan-18	Sustained Gold Guardian on each shift on A&E / Admission Units	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	Pharmacy bags being developed and ordered Meropenum stock levels			All adult inpatient wards to have one sepsis box	Jul-17						
		Development of sepsis Podcast	Staff to be viewing the podcast	Not currently developed so no baseline data	Staff to complete the podcast			Podcast developed and available on ULHT intranet	Jul-17						
		EMAS to screen and treat red flag sepsis	EMAS are 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	Neill Hepburn	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		
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	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	Mel Clements	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				

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QS05	Airways Management (NIV Pathway)	There is a NIV pathway in use across Lincolnshire	Number of recorded datix and Sis. % 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	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				
		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						

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		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	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, relauncehd and available on the intranet.	Existing policies in place.		Michelle Rhodes	Jenny Hinchliffe	**Dignity in Care Policy**		**Dignity in Care Policy**		**Dignity in Care Policy**		**Dignity in Care Policy**	
								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						
								MCA & DOLS Policy		**MCA & DOLS Policy**		**MCA & DOLS Policy**		**MCA & DOLS Policy**	
								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				

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								Safeguarding Children and Young People Policy		**Safeguarding Children and Young People Policy**		**Safeguarding Children and Young People Policy**		**Safeguarding Children and Young People Policy**	
										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		
								Management of allegation against people who work with Children Policy		**Management of allegation against people who work with Children Policy**		**Management of allegation against people who work with Children Policy**		**Management of allegation against people who work with Children Policy**	
										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		
								Self-Harm in Children Policy		**Self-Harm in Children Policy**		**Self-Harm in Children Policy**		**Self-Harm in Children Policy**	
										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		
								Unexpected Child Death Policy		**Unexpected Child Death Policy**		**Unexpected Child Death Policy**		**Unexpected Child Death Policy**	
												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		
								DNA Process for Children with OPD Appointments		**DNA Process for Children with OPD Appointments**		**DNA Process for Children with OPD Appointments**		**DNA Process for Children with OPD Appointments**	
										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

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		There is a robust process for monitoring and reporting safeguarding performance	Safeguarding dashboard used and reports circulated.	Data collected and inculded 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				
								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						

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QS08	Medicines Management (previously Medication Safety CQUIN)					Neill Hepburn	Charles Barstead	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

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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 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	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						
		Performance Management				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	Buddhika Samarasinghe	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						

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		Environment All Out-Patient facilities are fit for purpose	Part of QS17		Capital funding Part of QS17	Mark Brassington	Chris Farrah	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						
		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	Buddhika Samarasinghe	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						

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QS12	Infection Control	**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	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		
										Various communication channels with IPC Link Nurses established (eg closed Facebook group)	Aug-17	IPC Link Practitioner innovation scheme established	Dec-17		
										Quarterly IPC development days aligned to key priorities commenced	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				
		Gram Negative Bacteraemia and Contaminated Blood Cultures The Trust aims to reduce Gram Negative Bacteraemia by 10% (YR1) and Contaminated Blood Cultures rates by 5% (YR1)	Number of Gram Negative Bacteraemia reported Number of Contaminated Blood Cultures			Michelle Rhodes	Jane Finch	Project Group established	Jun-17	Milestone Plan, based on audit findings, developed	Aug-17				
								Baseline audit completed	Jun-17	E-coli rates displayed on Ward Quality Boards	Aug-17				
								Communication plan in place	Jul-17						
		Cleanliness audit results are improved across all indicators	Average score in MiC4C Cleanliness audit results per site	Mar17 audit data				NHS I IPC site visits completed	Jul-17	Business Case for phase 2 of the Housekeeping investment developed	Aug-17				
										Milestone plan developed based on the findings of the IPC visit	Aug-17				
										Plan developed for trust-wide deep cleaning	Aug-17				

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		Bare Below the Elbows	Compliance audit of bare below the elbows and dress code policy					Dress Code Policy revised	May-17	Revised Dress Code Policy launched	Aug-17			Compliance audit of bare below the elbows and dress code policy completed	Mar-18
								Bare Below the elbows relaunched	Jun-17	Audit of bare below the elbows and dress code policy compliance completed	Oct-17				
								Consultation on Dress Code Policy completed	Jul-17						
QS13	Reducing Variation in Clinical Practice	Diabetes - DKA Pathway	Compliance with the DKA pathway			Neill Hepburn	Leicester contact - Dr Rob Gregory	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						
								Further milestones agreed once scope and TOR in place with Review Team	Jul-17						
		Deteriorating Patient (Out of Hours)			P2 - Productive Hospital	Neill Hepburn	Carol Staples	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						

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		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				
		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						

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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						
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						

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		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				
		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" Clincal 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