Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

QUALITY AND SAFETY IMPROVEMENT PLAN
(Version 2.0)

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 Implementation Group, fortnightly Quality and Safety Improvement 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.

QS01 - **Developing The Safety Culture**
SRO: Neill Hepburn
Project Leads: Karen Sleigh, Helen Nicholson, Sally Seeley

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS1.1	Staff across the organisation proactively learn and share lessons from incidents and complaints (System 2)	Mar-19	Evidence of newsletters, bulletins, changes in practice, discussions at sharing forums	QS1.1.1	There is regular communication as part of the trusts communication plan	Sep-18	
				QS1.1.2	There is an active feedback loop and discussion with staff following incidents/complaints being reported on Datix	Jan-19	
				QS1.1.3	There is a network in place where staff can share lessons and experience with each other in a safe environment	Dec-18	
				QS1.1.4	Learning and experience from NHCT is included in ongoing engagement/cascade mechanisms as part of the peer support work	Nov-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS1.1.5	There is an agreed mechanism to recognise staff who demonstrate good practice in learning and sharing lessons	Sep-18	
QS1.2	An in-house Quality Improvement (QI) Programme is developed and delivered	Dec-18	Full programme prepared for delivery	QS1.2.1	The In-house QI programme is delivered across ULHT sites.	Dec-18	Final sharing event to celebrate the projects / improvement initiatives to be delivered
QS1.3	Quality, Service Improvement and Redesign (QSIR) methodology is adopted by the organisation.	Apr-19	Achievemet of Practitioner status - accreditation with NHS Improvement	QS1.3.1	Staff identified and registered on the QSIR Programme at practitioner level.	Apr-18	NHSI has confirmed accredited practioner level for the named individuals
				QS1.3.2	Staff identified and registered on the QSIR Programme at faculty level.	Aug-18	
QS1.4	There is an exchange programme in place with NHCT to enable staff to gain knowledge, experince and best practice and to share that across the organisation	Mar-18	The individuals from the three cohorts are undertaking pieces of improvement work in their areas	QS1.4.1	The exchange programme is developed	Aug-18	
				QS1.4.2	The first exchange cohort have completed the programme	Sep-18	
				QS1.4.3	The first exchange cohort experience is evaluated and changes to the programme made as necessary	Oct-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS1.4.4	The second exchange cohort have completed the programme	Nov-18	
				QS1.4.5	The third exhange cohort have completed the programme	Feb-18	

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QS02 - Governance
SRO: Kevin Turner (Overarching) / Karen Brown (Corporate) / Neill Hepburn (Clinical)
Project Leads: Jayne Warner (Corporate) / Sally Seeley & Paul White (Clinical)

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS02a - Corporate Governance SRO: Karen Brown Project Lead: Jayne Warner							
QS2.1	The organisation has a Board Assurance Framework which is aligned to the organisations objectives and allows Board Committees to discharge their responsibilities	Nov-18	Board Assurance Framework report presented at Trust Board	QS2.1.1	The format of the Board Assurance Framework is fit for purpose and associated action plans are in place	Oct-18	Interim Head of Internal Audit Opinion stage 2 work gives positive assurance on Board Assurance Framework
				QS2.1.2	Robust governance, reporting, challenge and scrutiny processes are established surrounding the Board Assurance Framework	Oct-18	Interim Head of Internal Audit Opinion work stage 2 gives positive assurance on Board Assurance Framework

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.1.3	The Board Assurance Framework is aligned with the organisations corporate risk register and wider risk management arrangements.	Nov-18	Interim Head of Interim Audit Opinion work stage 2 gives positive assurance on Board Assurance Framework
				QS2.1.4	The Board has an agreed risk appetite which is described in the Risk Strategy.	Nov-18	Description of risk appetite in approved Trust risk strategy.
				QS2.1.5	Roles and responsibilities for the Board Assurance Framework and wider risk ownership are clearly described in the Board Assurance Framework and Escalation Policy document	Nov-18	Published Board Assurance Framework and Escalation Policy and Risk Strategy and Policy
QS2.2	Board Committees and Sub Committees have clearly defined roles and responsibilities which have eliminated overlap or omission.	Jan-19	Full set of revised TOR that have all been approved at Trust Board	QS2.2.1	Objectives are agreed and formally recorded for all Board Committees	Oct-18	Board Committees are operating to published objectives.
				QS2.2.2	Roles and responsibilities for each Board Committee based on objectives are defined and described in their ToR.	Sep-18	Revised ToR published and in use.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.2.3	Board Committee agenda and work plans have been structured to align with the Committee objectives and the Board Assurance Framework	Oct-18	Revised agenda and work plans in use at Board Committees.
				QS2.2.4	The Board and Committees have agreed the required sub committees/groups to support the assurance arrangements	Oct-18	Structure chart showing Board Committees and reporting committees/groups published on intranet.
				QS2.2.5	Board Committees have reviewed ToR relating to all of their reporting sub committees/groups	Nov-18	Minutes from Board Committees demonstrating sign off of ToR for reporting committees/groups
QS2.3	Corporate Governance Cornerstone documents and policies are all current, available to staff and in use.	Nov-18	Published, up-to-date documents available	QS2.3.1	Standing Orders, Standing Financial Instructions and Scheme of Delegation reviewed to align with interim management arrangements and best practice	Oct-18	Draft documents to present to Audit Committee
				QS2.3.2	Standing Orders, Standing Financial Instructions and Scheme of Delegation approved by Audit Committee	Oct-18	Audit Committee minutes from Oct 18 meeting
				QS2.3.3	Standing Orders, Standing Financial Instructions and Scheme of Delegation approved by Trust Board	Nov-18	Trust Board minutes
QS2.4	Agreed framework in place for Trust corporate and clinical policy management	Mar-19	Up-to-date policies are available	QS2.4.1	Stock take of existing corporate and clinical policies complete and cleansing exercise concluded	Feb-19	Refreshed list of all remaining policies

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.4.2	Governance arrangements for the development, approval, review and dissemination of policies are in place.	Feb-19	Approved, published Policy on policies document.
				QS2.4.3	Document classification terms agreed and published	Feb-19	Approved, published Policy on policies document.
				QS2.4.4	Policy group re-established	Feb-19	Minutes of policy group meetings
				QS2.4.5	Agreed Trust approach for managing and maintaining policies and keeping them fit for purpose.	Mar-19	Policy owners and Exec Directors advised of responsibilities in respect of management of policies.
				QS2.4.6	Minimum quality standards for policy compliance and monitoring arrangements are in place.	Jan-19	Quality standards for policy compliance and monitoring documented in approved policy on policies document.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.4.7	Agreed process of escalation for non compliance documented	Jan-19	Quality standards for policy compliance and monitoring documented in approved policy on policies document.
QS02b - Clinical Governance SRO: Neill Hepburn Project Lead: Sally Seeley and Paul White							
QS2.5	Incident management systems and processes that are lean, practical, widely understood and consistently applied.	End of January 2019	Incident Management Policy with supporting guidance and documentation.	QS2.5.1	Clear guidance on incident reporting using Datix that is made available to all staff.	End of August 2018	Copy of guidance document; intranet screenshot showing publication.
				QS2.5.2	Revised policy and processes for incident reporting and investigation.	End of December 2018	Policy & guidance documents; minutes of meeting where approved.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.5.3	Integration of revised policy requirements for incident management within directorate and specialty governance arrangements.	End of January 2019	Directorate & specialty governance reports.
QS2.6	Serious Incident (SI) management systems and processes that are consistent with the national framework and support effective learning.	End of January 2019	Serious Incident section of Incident Management Policy; supporting documentation for SIs.	QS2.6.1	Backlog of overdue SI investigations is cleared.	End of June 2018	Data extract from Datix showing number of overdue SI investigations is below 20 (agreed with NHSI).
				QS2.6.2	Pilot revised SI management process at LCH.	End of July 2018	SI process flow chart.

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Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.6.3	SI management processes are reviewed against updated national frameworks for SIs & Never Events and requirements are incorporated within Trust policy.	End of December 2018	SI & Never Events sections of Incident Management Policy clearly reference national framework.
				QS2.6.4	Introduction of dedicated, centralised SI support team.	End of January 2019	SI support team established & recruited to within Clinical Governance.
QS2.7	Risk management systems and processes that are widely understood, supporting and informing good governance and decision making.	End of December 2018	Risk management reports to Trust Board & Committees; Internal audit review of risk management (Substantial level of assurance).	QS2.7.1	Up to date and approved risk management policy & strategy.	End of August 2018	Strategy & policy documents & minutes of Trust Board.
				QS2.7.2	Establishment of comprehensive corporate and operational risk registers aligned to core objectives and the Board Assurance Framework (BAF).	Nov-18	Corporate and operational risk registers; BAF.

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Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.7.3	Establishment of clear, regular reporting on risk through the Trust's governance arrangements to ensure the Board is appropriately informed as to the extent of its risk exposure and assured that risk management processes are effective.	End of November 2018	Copies of reports to Trust Board, assurance committees & executive-led groups.
				QS2.7.4	Provision of direct support and guidance to all clinical and corporate directorates to facilitate routine use of their new risk registers and risk reporting.	End of December 2018	Record of attendance at directorate governance / management meetings.

Key milestone				Milestone			
Number	**Description**	**Baseline finish date**	**Evidence key milestone has been achieved**	**Number**	**Description**	**Baseline finish date**	**Evidence milestone has been achieved**
QS2.8	A Datix system that supports revised policy and process requirements for incident, risk, complaints and claims management.	End of January 2019	Screenshots from Datix modules & 'recent changes' page of intranet.	QS2.8.1	Up to date Datix intranet page providing practical guidance, system development updates and contact details.	End of July 2018	Intranet screenshots & 'recent changes' section.
				QS2.8.2	Expansion of DatixWeb to include 'Dashboards', 'Claims' & 'Complaints' modules.	End of July 2018	Datix invoices, screenshots & 'recent changes' section.
				QS2.8.3	Implementation of management 'Dashboards' module for DatixWeb.	End of September 2018	Datix screenshots & 'recent changes' section.
				QS2.8.4	Datix system is consistent with approved changes to risk management policy & documents are linked.	End of September 2018	Datix screenshots & 'recent changes' intranet updates.
				QS2.8.5	Implementation of 'Claims' module for DatixWeb.	End of October 2018	Datix screenshots & 'recent changes' intranet updates.

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Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.8.6	Implementation of 'Complaints' module for DatixWeb.	End of November 2018	Datix screenshots & 'recent changes' intranet updates.
				QS2.8.7	Datix system is consistent with approved changes to incident management policy & documents are linked.	End of January 2019	Datix screenshots & 'recent changes' intranet updates.
QS2.9	Risk & incident management training that meets organisational and individual needs is routinely made available to all relevant staff.	End of March 2019	Training availability / advertisements, training needs analysis & attendance / completion records.	QS2.9.1	Introduce regular provision of introductory risk & incident management training for junior doctors Foundation Programme.	End of June 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.2	Delivery of 'Hearts & Minds' training in incident management & Duty of Candour.	End of July 2018	Training advertisement, attendance records & feedback forms.

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				QS2.9.3	Introduce regular provision of introductory risk & incident management training for the nursing Preceptorship Programme.	End of September 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.4	Delivery of a 2-day Serious Incident investigator training course.	End of October 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.5	Development & introduction of regular (quarterly) risk management training as part of Core Management Skills (M3 - Improving services).	End of November 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.6	Datix system and user training tailored to specific role profiles.	End of December 2018	Training attendance / completion records.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.9.7	Development & introduction of regular provision of incident management & SI investigation training.	End of March 2019	Training advertisement, attendance records & feedback forms.
QS2.10	Establishment of a dedicated Duty of Candour resource hub on the Trust intranet	End of September 2018	Screen shot of intranet page.	QS2.10.1	Review and update of current Duty of Candour intranet page content.	End of July 2018	Screen shot of intranet page.
				QS2.10.2	Develop a 'case studies' section of the intranet page to enable Trust good practice stories and advice to be shared.	End of September 2018	Screen shot of intranet page.

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Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS2.11	Up to date and published policy and guidance on Duty of Candour.	Oct-18	Policy and guidance documents published on trust intranet	QS2.11.1	Review and update the existing Duty of Candour / Being Open Policy. Ensure consistency with Regulation 20 & that responsibilities are made clear.	End of October 2018	Approved policy & guidance documents.
QS2.12	Up to date training on Duty of Candour available to all relevant staff.	Dec-18	Screenshots from intranet & copies of training materials (e-learning and classroom).	QS2.12.1	Develop bespoke Trust e-learning on Duty of Candour & include as either Core or Core Plus (tbc) mandatory training	End of October 2018	Screenshot of Core / Core Plus training on intranet. Copy of e-learning materials.
				QS02.12.2	Incorporate up to date Duty of Candour training in classroom-based incident management training courses.	Dec-18	Incident management training materials.
QS2.13	A Datix system that supports the Duty of Candour requirements.	Jan-19	Datix screenshots.	QS2.13.1	Review and update Datix system fields to correspond with Regulation 20 and NHS Standard Contract requirements.	End Aug 18	Datix screenshots.
				QS2.13.2	Link to up to date Trust policy and guidance on DoC through Datix.	Nov-18	Datix screenshots.
				QS2.13.3	Review processes for gaining staff access to Datix and introduce role-based access controls for all users.	Jan-18	Copy of protocol for role based access to Datix.

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Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS2.14	Effective performance management of Duty of Candour compliance is firmly established as part of directorate performance reviews.	End of January 2019	Compliance rates; performance improvement action plans for directorates.	QS2.14.1	Establish that the Trust is recording and reporting on the correct DoC compliance requirements through Datix.	End of July 2018	Copy of regular compliance data provided from Datix.
				QS2.14.2	Identify a Duty of Candour Champion for each Directorate (responsible for driving local compliance).	Aug-18	Details of named Champions for each directorate.
				QS2.14.3	Review effectiveness of DoC performance management.	Jan-18	Action plans and minutes from performance review meetings
QS2.15	There is an agreed governance team structure with leadership posts appointed	Dec-18	Agreed structure with named leaders / team members in post or appointed	QS2.15.1	The proposed structure is reviewed, revised and finalised by the newly appointed Associate Director of Clinical Governance (commenced in post 03/09/18)	Oct-18	Finalised version of structure for consultation
				QS2.15.2	Following the steps outlined within the Trusts Change Management Policy (2014), consult with staff about the proposed structure for Governance	Nov-18	New governance structure consulted upon and ready for implementation
				QS2.15.3	Following the steps outlined within the Trusts Change Management Policy (2014), implement the new structure for Governance	Dec-18	New governance structure implemented and posts filled

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.15.4	There is clarity on the functions / roles / responsibilities of the Clinical Governance Team which is understood across the organisation	Dec-18	Document showing functions
QS2.16	ULHT Governance, Assurance and Performance Framework is in place across the trust	Dec-18	Framework document	QS2.16.1	ULHT Governance, Assurance and Performance Framework is formally agreed	Sep-18	Framework document
				QS2.16.2	Existing meeting infrastructure is identified	Sep-18	
				QS2.16.3	New meeting structure agreed	Oct-18	
				QS2.16.4	The framework narrative and communications materials are prepared (including SOPs)	Nov-18	
				QS2.16.5	The ULHT Governance, Assurance and Performance Framework is launched across the organisation	Nov-18	
				QS2.16.6	The Quality and Safety Oversight Group (QSOG) is established and meeting regularly	Nov-18	1. QSOG Terms of Reference, agenda, minutes and action logs. 2. Assurance and Escalation reports to Quality Governance Committee and Clinical Management Board

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.16.7	Update and relaunch the Clinical Governance Toolkit (for specialities)	Oct-18	Clinical Governance Toolkit relaunched, evidence of distribution and promotion to relevant areas
				QS2.16.8	Assessment of current compliance with the Clinical Governance Toolkit (for specialities) undertaken	Oct-18	Report of performance / compliance at speciality level
				QS2.16.9	Improvement and sustainability plans are in place for all specialities deemed to be not compliant with the Clinical Governance Toolkit (for specialities)	Nov-18	Specialty specific Improvement and sustainability plans
				QS2.16.10	Specialty governance processes are established and functioning on a Trust wide basis	Mar-19	Minutes of meetings, escalation of concerns to appropriate level group / Committee
				QS2.16.11	Structures and processes for Divisional governance to be established and embedded across the organisation	Mar-19	Minutes of meetings, escalation of concerns to appropriate level group / Committee

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QS03 - Deteriorating Patient (including Sepsis)
SRO: Michelle Rhodes
Project Leads: Laura Strong, Jane Dulake, James Stutely-Brown

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.1	Medical engagement with sepsis is increased	Dec-18	Medical engagement with process	QS3.1.1	Medical lead for each workstream identified	Sep-18	Identified leads in place

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.2	An up-to-date sepsis policy that is embedded across the Trust	Nov-18	Sepis policy being updated	QS3.2.1	Updated adult section of the sepsis policy	Jul-18	Sepsis policy in place
				QS3.2.2	Updated children's section of the sepsis policy	Aug-18	Children's section within the sepsis policy is in place
				QS3.2.3	Updated neutropaenic section of the sepsis policy	Oct-18	Section in place within the sepsis policy
				QS3.2.4	Updated neonates section of the sepsis policy	Sep-18	Neonates section within the sepsis policy is in place
				QS3.2.5	Updated maternity section of the sepsis policy	Sep-18	Maternity section is in place within the sepsis policy

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.3	E-learning modules are up-to-date and available for all staff	Sep-18	Updated e-learning modules available on the intranet	QS3.3.1	Adult e-learning module updated	Jun-18	E-learning module is in place and accessible to staff
				QS3.3.2	Maternity e-learning module is available	Jul-18	E-learning module is in place and accessible to staff
				QS3.3.4	Patients on anti-cancer treatment e-learning module is available to all staff	Aug-18	E-learning module is in place and accessible to staff
				QS3.3.5	Evaluation and review of e-learning modules	Aug-18	Evaluation tool in place for review of e-learning modules
QS3.4	Accountability is reinforced	Nov-18	Staff receive regular updates on compliance with accountability	QS3.4.1	Sending of accountability letters for sepsis screens missed or completed outside of 60 minutes or 6 in 60 actions not completed appropriately has commenced.	Oct-18	Evidence of accountability available in patient records

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.5	All departments recognise and respond to missed/late sepsis screens or incomplete 6 in 60 actions	Nov-18	Ongoing audit of patient records and reported incidents	QS3.5.1	All areas have an allocation on web v	Oct-18	
				QS3.5.2	All areas returning their montly reviews every month has commenced	Aug-18	Compliance with submission of reviews is measured each month
QS3.6	Information is provided to patients, relatives and carers in line with NICE guidance	Nov-18	Access to most up to date information in compliance with nationally recognised guidance	QS3.6.1	Information is provided at discharge for people assessed for suspected sepsis, but not diagnosed with sepsis	Oct-18	Patients have information provided to them before discharge
				QS3.6.2	Information is provided at discharge for people at increased risk of sepsis	Oct-18	Patients have information provided to them before discharge

Key milestone				Milestone			
Number	**Description**	**Baseline finish date**	**Evidence key milestone has been achieved**	**Number**	**Description**	**Baseline finish date**	**Evidence milestone has been achieved**
				QS3.6.3	Information is provided at discharge for people who have had sepsis	Nov-18	Patients have information provided to them before discharge
				QS3.6.4	Patients with sepsis and their families and carers are given details of national charities and support groups who provide information about sepsis and the causes of sepsis.	Dec-18	Patients, familiers and carers have information provided to them before discharge
QS3.7	90% Sepsis Screening achieved	Dec-18	Ongoing audit of patient records	QS3.7.1	90% Sepsis Screening for adult inpatients achieved	Nov-18	Audit of patient records

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.7.2	90% Sepsis Screening for adult A&E patients achieved	Nov-18	Audit of patient records

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.7.3	90% Sepsis Screening for Paediatrics achieved	Nov-18	Audit of patient records
				QS3.7.4	90% Sepsis Screening for maternity achieved	Nov-18	Audit of patient records

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.8	90% administration of IV antibiotics on diagnosis of sepsis achieved	Dec-18	On-going audit of patient records	QS3.8.1	90% administration of IV antibiotics on diagnosis of sepsis for adult inpatients achieved	Nov-18	Audit of patient records
				QS3.8.2	90% administration of IV antibiotics on diagnosis of sepsis for adult A&E patients achieved	Nov-18	Audit of patient records

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.8.3	90% administration of IV antibiotics on diagnosis of sepsis for Paediatrics achieved	Nov-18	Audit of patient records
				QS3.8.4	90% administration of IV antibiotics on diagnosis of sepsis for maternity achieved	Nov-18	Audit of patient records
QS3.9	Neonates to be incorporated into sepsis work	Jan-19	Work undertaken to include neonates screening	QS3.9.1	Neonatal screening tool developed	Dec-18	Screening tool in place
				QS3.9.2	Audit sepsis screening within neonates	Dec-18	Audit of patient records
				QS3.9.3	Audit antibiotic administration within neonates	Dec-18	Audit of patient records
QS3.10	There is a clear rescreening protocol for sepsis	Jan-19	Work undertaken for rescreening protocol	QS3.10.1	Adult rescreening protocol embedded within practice	Dec-18	Audit of patient records
				QS3.10.2	Paediatric sepsis rescreening protocol produced	Dec-18	Rescreening protocol in place
				QS3.10.3	Maternity sepsis rescreening protocol produced	Dec-18	Rescreening protocol in place

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.10.4	Neonates sepsis rescreening protocol produced	Dec-18	Rescreening protocol in place
QS3.11	Quick and efficient screening process available for staff	Jan-19	Work undertaken for screening process to be in place	QS3.11.1	Ipods are in use to enable staff to complete the first two questions of all the sepsis screens	Dec-18	Screening process in place
				QS3.11.2	Adult Sepsis trust bundle implemented	Dec-18	Audit of patient records
QS3.12	Deteriorating patient/Sepsis link nurses on identified areas	Dec-18	Nominated staff in key areas	QS3.12.1	There is an identified link nurse for relevant areas and link nurses for deteriorating patients incl.sepsis	Nov-18	Link nurses identified in all relevant areas
				QS3.12.2	Link nurses role profile is developed	Aug-18	Link nurses role agreed and in place
				QS3.12.3	Competencies and expectations identified in the role profile	Aug-18	Review of link nurse role agreed
QS3.13	Deteriorating patient incl. AKI/Fluid balance, NEWS2, SBAR, Failure to escalate	Dec-18	Staff and patients aware of fluid balance and AKI	QS3.13.1	Fluid balance inpatients policy developed and launched across the organisation	Nov-18	Policy agreed and followed

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.13.2	e-learning package available for fluid balance charts and AKI including AKI Bomb with signposting in place	Sep-18	Staff able to access e-learning package for their development
				QS3.13.3	There is a poster providing guidance to patients to record all fluid intake daily in place across the organisation	Nov-18	Posters in place in patient areas for their information
				QS3.13.4	Housekeepers record fluid intake from cups and jugs before removing from patient area	Nov-18	Documentation audit reflects evidence of patient fluid intake
				QS3.13.5	There is an e-learning package for HCSW and Housekeepings to adequately record fluid intake	Oct-18	E-learning package available for staff to access
				QS3.13.6	There is an AKI/FBC micro-teaching session developed	Nov-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.13.7	30 minute micro-teaching sessions are delivered four days a week at AKI/FBC at LCH every 3 weeks.	Aug-18	Staff have accessed a micro-teaching session on all sites for their development
				QS3.13.8	30 minute micro-teaching sessions are delivered four days a week at AKI/FBC at PHB every 3 weeks.	Sep-18	Staff have accessed a micro-teaching session on all sites for their development
				QS3.13.9	30 minute micro-teaching sessions are delivered two days a week AKI/FBC at GDH every 3 weeks.	Sep-18	Staff have accessed a micro-teaching session on all sites for their development
				QS3.13.10	NEWS2 is used to record observations and escalation in a timely manner	Nov-18	Compliance with NEWS2 evidenced through audit of patient records
				QS3.13.11	SBAR - communication tool is in use across the trust	Dec-18	Evidence of tool through audit of patient records
				QS3.13.12	Notable reduction in failure to escalate deteriorating patients	Dec-18	Increased evidence noted in escalation rates

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.14	ReSPECT is in place across the organisation	Jan-19	Promotion of appropriate management and use of relevant forms in patient records	QS3.14.1	DNACPR forms are accurately completed	Nov-18	Increased evidence demonstrated in audit of patient records
				QS3.14.2	The plan for every review is documented accurately	Nov-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.15	Learning from DKA serious incidents is implemented within ULHT.	Mar-19		QS3.15.1	Near patient testing for hyperglycaemia.	Dec-18	

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(Version 2.0)

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QS04 - Emergency Department at Pilgrim
SRO: Mark Brassington
Project Lead: Clare Culpin

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved

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(Version 2.0)

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QS05 Children and Young People Services
SRO: Michelle Rhodes
Project Leads: Jo Wilson

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS5.1	Expert children's improvement support in place	Sep-18		QS5.1.1	A defined review of Children and Young People Services is undertaken	Sep-18	
				QS5.1.2	Draft Children and Young People plan reviewed and developed	Sep-18	
QS5.2	Children requiring care in 'non-children specific' services are identified across the trust	Nov-18	Comprehensive list which identifies aeas in which services are deliver to children	QS5.2.1	Emergency and urgent care pathways which C&YP may access are identified	Sep-18	
				QS5.2.2	Elective care pathways which C&YP may access are identified	Oct-18	
				QS5.2.3	Outpatient pathways which C&YP may access are identified	Nov-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS5.3	C&YP receive patient centered care and treatment	Feb-19	Metrics of experiences of care of C&YP implements regularly and evaluated	QS5.3.1	Process and metrics are in place to evaluate the experience of care of children, young people and their families in non children specific environments	Feb-19	
QS5.4	There is a defined governance structure in place to assure the board of the quality and delivery of care to children	Sep-18	Trustwide meetings in place providing oversight and governance for children and young people pathways	QS5.4.1	Multidisciplinary C&YP committee in place and meetings occur and report to Trust Board	Jul-18	Minutes of meetings
				QS5.4.2	There is an effective process for clinically prioritising C&YP (patients) for admission	Sep-18	
				QS5.4.3	Multidisciplinary C&YP surgical committee in place and meetings occur and report to Trust Board	Sep-18	Minutes of meetings
				QS5.4.4	Evidence based care and treatment tools are consistently used across C&YP pathways.	TBC	
				QS5.4.5	There is a formalised mechanism for instigating paediatric morbidity and mortality reviews	TBC	
				QS5.4.6	There is a robust audit plan which is carried out to ensure evidence-based care is applied	TBC	
QS5.5	Environments in which C&YP are cared for are appropriate to their needs	TBC					

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QS06 - Safe Care
SRO: Michelle Rhodes
Project Lead: Victoria Bagshaw

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS6.1	Positive Patient ID is used consistently across the trust	Dec-18	All ULHT sites utilising consistent approach to patient identification	QS6.1.1	Positive Patient ID policy reviewed and amended as required	Sep-18	Complete policy
			No incidents reported concerning incorrect patient identification	QS6.1.2	methodology, interventions and timeline for rollout identified	Aug-18	Project plan
			Patient ID policy approved	QS6.1.3	Implementation sites agreed	Aug-18	Ward managers / matron agreement to take part

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.1.4	Implementation commenced across All 3 sites at the same time	Aug-18	Implementation progress, feedback from staff, datix.
				QS6.1.4	Regular reporting on compliance commenced	Dec-18	Audit / report results, ward accreditation, ward assurance
QS6.2	Intentional Rounding used consistently across the trust	Dec-18	All adult inpatient areas trust wide effectively using intentional rounding	QS6.2.1	Implementation methodology agreed	Aug-18	Implementation Plan
			Reduction in hospital acquired pressure damage, falls	QS6.2.2	Initial implementation sites agreed	Aug-18	Identifiction of 3 sites
			Increased quality of care & documentation to evidence this				

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.2.3	Intentional Rounding launched across the trust	Nov-18	Implementation progress, feedback from staff, datix.
				QS6.2.4	Regular reporting on compliance commenced	Dec-18	Audit / report results, ward accreditation, ward assurance
QS6.3	Safety Huddles are used consistently across the trust	Mar-19	All adult inpatient areas effectively integrated the safety huddle process	QS6.3.1	Implementation PDSA methodology agreed	Aug-18	Implementation Plan
			Patients at risk and daily factors which could impact on patient safety are identified and managed appropriately	QS6.3.2	Initial implementation sites agreed	Aug-18	Identifiction of 3 sites
			Potential lapses in care or documentation are identified early				
				QS6.3.3	Implementation commenced (All 3 sites at the same time)	Oct-18	Implementation progress, feedback from staff, datix.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.3.4	Regular reporting on compliance commenced	Feb-19	Audit / report results, ward accreditation, ward assurance
QS6.4	There is a consistent accountibility handover process across the trust	Mar-19	Handover is consistent across all sites.	QS6.4.1	Initial implementation PDSA methodology agreed	Aug-18	Project plan
			Consistently effective communication between incoming and outgoing teams, highlighting areas of importance for the upcoming shift. Improved documentation / individualised care planning.	QS6.4.2	Initial implementation sites agreed	Aug-18	Ward managers / matron agreement to take part
				QS6.4.3	Initial implementation commenced all sites	Dec-18	Evidence of data
				QS6.4.4	Accountibility handover launched across the trust	Mar-19	Ward compliance with accountability handover
				QS6.4.5	Regular reporting on compliance commenced	Mar-19	Audit / report results, ward accreditation, ward assurance
QS6.5	NG tubes are inserted and managed safely and effectively across the trust	Mar-19	All patients with NG tube have decision discussion prior to inserting the tube and this is documented	QS6.5.1	NG tube policy reviewed and amended as required	Aug-18	Ward managers / matron agreement to take part

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
			Insertion fully documented in all cases	QS6.5.2	Safety improvement methodology agreed	Aug-18	Education plan
			Patients aren't delayed with feeding	QS6.5.3	Improvement implementation sites agreed	Aug-18	Ward managers / matron agreement to take part
			Patient aren't exposed to unnecessary x-rays				
			Staff aware of policy revision and their responsibilities.				
			Training and competencies in place and staff uptake >75% in key areas				
				QS6.5.6	Policy evaluated and changes to policy agreed	Sep-18	No incidents, SI's or never events associated with NG tubes.
				QS6.5.7	Revised NG Tube policy launched across the trust	Sep-18	All staff are fully aware of NG policy, competencies, documentation and processes
				QS6.5.8	Compliance monitoring method agreed and commenced	Sep-18	Ongoing evaluation continues, audit, SQD, Datix
				QS6.5.9	Regular reporting on compliance commenced	Oct-18	Ongoing evaluation continues, audit, SQD, Datix
				QS6.5.10	Staff competencies have been reviewed across the trust	Oct-18	Policy agreed by stakeholders

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.5.11	There is an engagement programme in place across the trust	Nov-18	Intranet, writen evidence of comms
							Launch new policy
				QS6.5.12	There is an agreed NG Tube audit and timetable across the trust	Sep-18	NT Tube audit timetable
				QS6.5.13	There is an agreed Never Event Template for NG Tubes in place across the trust	Oct-18	Template
QS6.6	Registered nurses are being recognised for theircompassion through the Daisy Awards scheme	Nov-18	Number of RNs recommended for Daisy award	QS6.6.1	Aggreements is in place with the DAISY Foundation to be a recognised member	Aug-18	MOU in place
					Daisy Awards launched Trust wide	Sep-18	launch event
					RN receiving Daisy awards	Nov-18	names of RN's recognised for compassion in care through the Daisy award scheme

QUALITY AND SAFETY IMPROVEMENT PLAN

(Version 2.0)

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QS07 - Safeguarding
SRO: Michelle Rhodes
Project Lead: Elaine Todd, Lisa Newboult

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS7.1	Conscious sedation is used appropriately and safely when required.	Dec-18	Conscious sedation policy & local guidance in place. Compliance and effectiveness audited.	QS7.1.1	Conscious Sedation Policy developed by Task & Finish Group.	Oct-18	Conscious sedation policy approved by CESC and published.
				QS7.1.2	Speciality guidelines reviewed/ developed for departments where conscious sedation used.	Oct-18	Speciality guidelines in place.
				QS7.1.3	Specialities to audit practice against Trust policy and guidelines to ensure effective monitoring after sedation & intervention.	Dec-18	Audit results shared at speciality governance meetings and SGC.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS7.2	Adherence to Use of Appropriate Chemical Restraint in the Management of Agitated Patients on General Adult Wards & in A&E Policy and Clinical Holding & Restraint Policy.	Mar-19	Capacity assessed and evidence least restrictive options considered in 100% of cases audited where restraint or chemical sedation used.	QS7.2.1	Clinical Holding and restraint training completed for all identified staff.	Dec-18	Training compliance.
				QS7.2.2	Audit of chemical sedation logs and pharmacy data show compliance with policy.	Mar-19	Audit results.
QS7.3	All adults are offered a chaperone for all intimate examinations and children and young people are provided with chaperones.	Jan-19	Audit of compliance with chaperone policy.	QS7.3.1	Chaperone policy updated by task & finish group.	Sep-18	Updated Chaperone policy approved and published.
				QS7.3.2	Risks of full compliance in all clinical areas assessed to inform ongoing priorities and training needs.	Nov-18	Updated risk assessment.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS7.3.3.	Audit of compliance with Chaperone Policy undertaken by clinical leads.	Dec-18	Audit results.
QS7.4	Trust is fully compliance with Savile and Bradbury report recommendations.	Dec-18	Evidence reviewed by SGC.	QS7.4.1	Management of Allegations Policy updated and ratified.	Dec-18	Policy approved and published.
				QS7.4.2	Managerial lead to ensure that the chaperone policy is embedded on each site.	Dec-18	See QS7.3
				QS7.4.3	DBS checks (including, where applicable, enhanced DBS and barring list checks) are undertaken on all staff and volunteers	Oct-18	Risk assessment in place and decision reached re DBS checks.
				QS7.4.4	The Trust has a social media policy which is widely communicated to staff. It is used to ensure all members of staff understand their rights and responsibilities in relation to the correct use of social media.	Dec-18	Updated Social Media Policy published.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS7.4.5	Arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are in place	Dec-18	Policy in place to support requirements.
				QS7.4.6	A review to ensure that the support, advice and care provided to victims of sexual assault and statutory rape are consistent with current best practice has been undertaken	Dec-18	Audit results demonstrate compliance.
				QS7.4.7	All Trust policies have been extended in their scope to the broader community, including volunteers, non-executive directors and, where appropriate, contractors; and in time, to governors	Dec-18	Policy in place to support requirements.
				QS7.4.8	Assurance that charitable funds are channelled appropriately are gathered on a systematic and ongoing basis and reported to both the Charitable Trustees and the Trust Board Audit Committee to ensure that the mechanisms in place to do this continue to be effective.	Sep-18	Reports to Committee showing evidence of complaince.
QS7.5	Pathway is seamless for young adults with LD who transition between children and adult services.	Mar-19	Pathway in place. Compliance audited.	QS7.5.1	LD pathway developed.	Oct-18	Pathway approved and published.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS7.5.1	Compliance audited against pathway.	Dec-18	Audit results shared at speciality governance meetings and SGC.
QS7.6	Trust is compliant with CP-IS	Mar-19	CP-IS in place.	QS7.6.1	Care portal approved to support CP-IS.	Sep-18	Notification received.
				QS7.6.2	Requirements mapped and understood.	Sep-18	Process map developed and training planned.
				QS7.6.3	Test site to test CP-IS system and training scheduled	Sep-18	Test completed.
				QS7.6.4	Rollout of CP-IS.	Mar-19	CP-IS in use in all relevant areas.

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(Version 2.0)

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QS08 - Medicines Management
SRO: Michelle Rhodes
Project Leads: Colin Costello, Nabil Fahimi & Dana Sheanon

KEY MILESTONES				MILESTONES			
Number	**Description**	**Baseline finish date**	**Evidence key milestone has been achieved**	**Number**	**Description**	**Baseline finish date**	**Evidence milestone has been achieved**
QS8.1	Reducing harm through the culture of safety and learning from medication related adverse events.	Mar-19	Increase reporting rate of medication related incidents and near misses.	QS8.1.1	There is a baseline of external benchmarking and audit to enable monitoring of	Sep-18	Monthly data report
				QS8.1.2	Datix reporting system for medication incidents is approved.	Mar-19	
				QS8.1.3	Ensuring learning from medication incidents and near	Dec-18	Trends and themes collated, learning shared and training needs
				QS8.1.4	There is a local ward accreditation medication action plan with measurable outcomes for all areas.	Jul-18	Ward accreditation action plans to reflect learning from visits, incidents and near misses.
				QS8.1.5	Guidance for reducing risk of omitted and delay doses reviewed.	Oct-18	
				QS8.1.6	Safer medication administration process reviewed.	Mar-19	Reduction/zero medication related Datix incidents.

KEY MILESTONES				MILESTONES			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS8.1.7	Ward handover process reviewed.	Sep-18	Critical information communicated and chart reviewed as part of handover process.
				QS8.1.8	The management of patients with allergies and adverse reactions to medications is improved.	Sep-18	Reduced number of incidents related to allergies and adverse reactions.
				QS8.1.9	Use of the Summary Care Record (SCR) for medicines reconciliation.	Oct-18	
				QS8.1.10	Reduce risk of errors with use of multiple prescription charts.	Mar-19	Prescription charts and processes reviewed. SOP/Policy in place.
				QS8.1.11	The opportunity for near patient dispensing explored.	Sep-18	
				QS8.1.12	Self administration of medicines practice reviewed and use increased as	Mar-19	Policy and procedures updated and published on intranet.
QS8.2	Pharmacy are integrated into clinical areas MDT and Specialty Governance Meetings.	Mar-19	Minutes of Specialty Governance Meetings.	QS8.2.1	Clinical pharmacy ward cover is improved.	Mar-19	
				QS8.2.2	Pharmacist rota based on risk assessments.	Mar-19	
				QS8.2.3	Urgent care/Emergency Department Pharmacist in	Dec-18	
				QS8.2.4	Full time pharmacy cover for Acute Admissions Units.	Sep-18	
				QS8.2.5	Clinical Pharmacy Technician role integrated into nursing team.	Mar-19	
				QS8.2.6	Pharmacy open hours are extended.	Mar-19	
				QS8.2.7	Pharmacy Team leaders are integrated into Divisional Governance Meetings.	Mar-19	
				QS8.2.8	Ensuring a safe process is in place to support supply of	Mar-19	

KEY MILESTONES				MILESTONES			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
					discharge medication.		
				QS8.2.9	Chief Pharmacist and Medication Safety Officer has	Mar-19	
QS8.3	An education and training process for pharmacy, medical staff and nurses on medicines optimisation is robust and effective.	Mar-19	Training compliance numbers.	QS8.3.1	Core learning reviewed and updated as required.	Dec-18	Core learning and competency assessments in place.
				QS8.3.2	Policies reviewed to ensure they support the Nursing	Dec-18	Policies updated and published on intranet.
				QS8.3.3	Prescribing Skills Induction for junior doctors in place.	Mar-19	
				QS8.3.4	Distribution of Pharmacy newsletter commenced.	Sep-18	
				QS8.3.5	Pharmacy intranet pages are developed as resource for MDT.	Mar-19	
QS8.4	Improve Medicines security, storage and safe handling.	Mar-19		QS8.4.1	Medicines stored according to policy.	Dec-18	Audits demonstrate medicines and controlled drugs stored safely and
				QS8.4.2	Medicines are transferred safely with the patient when	Dec-18	Audit demonstrated medicines are transferred with patient and
				QS8.4.3	Introduction of green bins to ensure medicines no longer in use are safely returned to Pharmacy.	Dec-18	Audit demonstrates compliance

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QS09 - Mortality Outliers
SRO: Neill Hepburn
Project Leads: Bernadine Gallen

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS9.1	Clinicans are fully engaged with mortality	Mar-19	All clinicans are fully appraised of their mortality and sharing lessons	QS9.1.1	All consultants have attended a clinical coding masterclass to improve their knowledge and understanding	Mar-19	% increase in clerking proforma completion for Main Condition Treated, Comorbidities and significant History

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.1.2	Information and clinical coding training is in place for middle grade and junior doctors to improve knowledge and understanding	Mar-19	To be in line with national average for elective and non-elective depth of coding. Elective:National Average is 3.9. Non elective: National Average is 4.4
				QS9.1.3	Each speciality reviews their mortality and discusses mortality briefings at their monthly specialty governance meetings	Mar-19	100% compliance with reviews
QS9.2	Medical Examiner Role is in place	Mar-19	Implementation of the Medcial Examiner at Lincoln and Pilgrim	QS9.2.1	The Medical Examiner is appointed	Mar-19	100% screening completed by Medical Examiner. Reducation in the number of cases escalated for further review. Reducation in the number of complaints related to mortality

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.2.2	MCCD are completed accurately	Mar-19	All MCCD are disucssed with the Medical Examiner prior to being completed
				QS9.2.3	There is a process in place for the Medical Examiner to engage with bereaved families	Mar-19	All bereaved families to be contacted by the Medical Examiner
				QS9.2.4	Initial screening of deaths is undertaken within 7 days.	Mar-19	All deaths have an initial screen by the Medical Examiner wihtin 7 days of a patients death
				QS9.2.5	All reviews that have been graded 1 or above are escalated for a Speciality review	Mar-19	All reviews who have been graded 1 or above have been escalated for a Speciality review
QS9.3	Perinatal - Alerting diagnosis with 14 deaths over the risk adjusted expected. Trust alert for 4 months.		Perinatal not to be alerting and consistently within the normal parameters	QS9.3.1	Review coding of perinatal deaths	Mar-19	To be within expected limits (HSMR 100)
				QS9.3.2	Detailed plan developed	Sep-18	
QS9.4	Coding and documentation are accurately recorded	Mar-19	Achieve the national rate of spells coded for age 65+ 2.08% Achieve national rate of 43.45% for deaths coded	QS9.4.1	Medical clerking proforma's are completed accurately	Mar-19	To be in line with national average for elective and non-elective depth of coding. Elective:National Average is 3.9. Non elective: National Average is 4.4

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.4.2	Main condition treated is accurately coded	Mar-19	
				QS9.4.3	Co-morbidity and significant history is accurately coded	Aug-18	To be in line with national average for elective and non-elective depth of coding. Elective:National Average is 3.9. Non elective: National Average is 4.4
				QS9.4.4	Palliative care patients seen are coded and are present in Dr Foster data	Mar-19	Achieve the national benchmark of 1.19% for palliative care coding of spells Achieve the national rate of 43.45% for palliative care coding for deaths
QS9.5	The Trust is an outlier for sepsis mortality	Mar-19	Sepsis HSMR to not be alerting on Dr Foster and to have a sepsis HSMR of 100 or less	QS9.5.1	Review sepsis coding	Oct-18	Report to be completed on a sepsis notes review

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(Version 2.0)

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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 Implementation Group, fortnightly Quality and Safety Improvement 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.

QS10 Data Quality
SRO: Kevin Turner
Project Leads: Identified a/w checks

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS10.1	Core data quality improvement	Mar-19		QS10.1.1	Information requirements of Trust are agreed	Dec-18	signed off List
				QS10.1.2	Current Information flows are assessed and confirmed	Dec-18	Documented record of existing flows of data to Board and governance structures
				QS10.1.3	KPI data specs, and Information SOPs are agreed	Dec-18	Library of agreed KPI data specs, Information SOPs; data owners and Information owners

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS10.2	Single repository for Information (Inphase)	Mar-19	Inphase becomes the single source for Board and Governance information	QS10.2.1	Inphase build capacity to commence build of SSOT established	Mar-19	contract agreed
				QS10.2.2	Inphase capability built	Mar-19	
				QS10.2.3	Inphase used to feed IPR and Governance reporting	Mar-19	
QS10.3	Data Quality (Kite Marking) approach is implemented	Dec-18	All Board data on IPR quality assessed in January 19 Board reports)	QS10.3.1	Best practice in NHS is reviewed	Dec-18	Evidence of examples for other NHS Trusts

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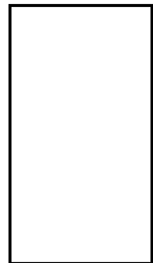
QS11 Hospital @ Night
SRO: Mark Brassington
Project Leads: Simon Evans / Victoria Bagshaw

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS11.1	There is a oversight and management of the curent H@N service and any issues	Sep-18	Names of ED and Trustwide service lead	QS11.1.1	An Executive Director has ovesight and leadership responsibility for the H@N framework.	Sep-18	Named ED with reponsibility
				QS11.1.2	A trust wide lead position for the service is identified and in place who will work within a well described H@N framework.	Sep-18	Named Trustwide lead with responsibility
QS11.2	Clear defined corporate and clinical governance arrangements for the current H@N service and the care and safety of patients is in place.	Nov-18	Updated H@N service framework in place	QS11.2.1	A system is in place to ensure the H@N workforce model is in place and monitored	Nov-18	Clear workforce model incorporated into the H@N service Framework

Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS11.1	There is a oversight and management of the curent H@N service and any issues	Sep-18	Names of ED and Trustwide service lead	QS11.1.1	An Executive Director has oversight and leadership responsibility for the H@N framework.	Sep-18	Named ED with reponsibility
				QS.11.2.2	A suite of management reports are in place which provide oversight of patient safety, compliance and operational performance.	Nov-19	A system is in place to ensure incidents, issues and feedback related to the H@N model are monitored, and actions taken and escalated in line with operating model
				QS.11.2.3	A system is in place to ensure all SOPs associated to the H@N opereating model are in place and monitored	Nov-18	A refreshed SOPs incorporated into H@N service Framework



Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS11.1	There is a oversight and management of the curent H@N service and any issues	Sep-18	Names of ED and Trustwide service lead	QS11.1.1	An Executive Director has ovesight and leadership responsibility for the H@N framework.	Sep-18	Named ED with reponisbility
				QS.11.2.4	Sharing Learning from incidents and practice from internal improvements occurs widely across the trust	Dec-18	Process in place
QS11.3	There is a revised H@N model in place	Apr-19	Revised H@N model	QS11.3.1	Best practice in NHS is reviewed	Jan-19	Examples of national bestpractice identified
				QS11.3.2	A single service delivered across multiple sites with clear lines of communication, leadership and management	Apr-19	Revised model rolled out
				QS11.3.3	Sharing Learning and best practice from internal improvements, external organisations and national recommendations widely across the trust	May-19	

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QS12 Medicine Devices
SRO: TBC at QSIB on 04/10/18
Project Leads: As above

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS12.1	Medical devices policy in place and used effectively	Mar-19	Policy in place	QS12.1.1	Policy agreed and uploaded to Trust intranet	Jan-19	policy in place
				QS12.1.2	There is an upto date inventory of all medical devices	Nov-19	inventory in place
				QS12.1.3	SOPs are agreed	Jan-19	SOPs availabe
				QS12.1.4	Audits against policy are developed, implementd and monitored	Mar-19	Audit Calender
QS12.2	Trustwide medical devices group has been reconstituted and is delivering against the Terms of Reference	Feb-19	ToR available	QS12.2.1	ToR for medical devices group ratified	Jan-19	ToR available
				QS12.2.2	First meeting of medical Devices group has taken place	Feb-19	Minutes from first meeting

QS12.3	Wards , A&E's and outpatient departments have process in place to demonstrate addherance to trust policy and Health and Safety legislation	Apr-19	Ward accreditation demonstrates compliance	QS12.3.1	Wards , A&E's and outpatient departments have a process and documentation in place to check all medical equipment is checked and tested in line with requirements	Jan-19	Sample of documentation
				QS12.3.2	Wards have a process in place to ensure all staff have intitial and update training on all medical devices in use in their area	Oct-19	Training log
				QS12.3.3	Ward accreditation captures medical device equipment compliance	Jan-19	Ward Accreditation Documetation