Worcestershire Acute Hospitals NHS Trust
CQC Chief Inspector of Hospitals Visit
Monitoring Report March 2016

Urgent Care and Patient Flow

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/06/16	Forecast 30/09/16
MUST DO								
M1	Improve the access and flow of patients in order to: •reduce delays from critical care for patients being admitted to wards; •reduce the unacceptable number of discharges at night; •reduce the risks of this situation not enabling patients to be admitted when they needed to be or discharged too early in their care; •reduce occupancy to recommended levels; and improve outcomes for patients.	COO	→ Weekly % discharges before 12 midday → Weekly % stranded patients (NEL LoS > 7 days) → Weekly bed days delayed (ICU step-down)	A	New Clinical Site Coordination Team to be implemented at WRH in March 2016. Revised SOP to be developed in March 2016 that prioritises ICU step down patients Daily Discharge targets to be implemented for complex and simple discharges at ward level from April 2016 Achieve 35% of discharges before 12 midday (current performance 18%) Stranded patient LOS daily reviews to be escalated within Divisions from March 2016 Implement Older Persons Assessment and Liaison service in March 2016 to avoid admissions	A	A	G
M2	Ensure there are the appropriate numbers of qualified paediatric staff in the ED to meet national guidelines.	CNO	→ Monthly % dual trained in post → Monthly % PILS/EPLS trained → Monthly % NLS trained	A	We do not meet the dual trained nursing quota but have mitigated with appropriate PILS/EPLS training. 97% ED paediatric training completed. University paediatric 5 day course completed by 4 RNs and 6 planned for later this year. Training commencing for all staff 1 day NLS training. Currently recruiting 3 band 5 paediatric nurses in March	A	A	G

Red	Delayed or currently unattainable	Amber	In progress and achievable	Green	Achieved and sustainable

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M3	Ensure that the risk matrix in Medical Assessment Unit is completed to the frequency required by the trust policy.	CNO	→ Results of assessment in March 2015	**G**	MAU complete a risk matrix every two hours which illustrates the level of activity and acuity. A scoring system provides the trigger for escalation. This risk matrix forms part of the MAU SOP. Fully in use. Assessment of use of risk matrix due in March 2016	**G**	**G**	**G**
M4	Ensure that there is sufficient levels of medical staff cover throughout the week to ensure patient reviews are carried out in a timely manner	CMO	→ Weekly % revised rota compliance → % emergency admissions patients reviewed by suitable Consultant/MDT members within 14 hours	**A**	Establish baseline in Medicine and Surgery Divisions. Establish appropriate levels of cover and monitor rota compliance. Medical workforce plan baseline established	**A**	**A**	**A**
M5	Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the service including the provision of daily ward rounds.	CNO	→ Weekly shift fill rates by Ward → Monthly BPWR compliance rate	**A**	Internal training sessions x 16 re Best Practice Wards Rounds/SAFER bundle Safer staffing levels remain positive Exemplar best practice wards rounds in place on 7 Wards and 11 Champions in place. Recognition this needs to be re energised for sustainability and roll out Planning a ward sister development programme on	**A**	**A**	**G**

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					ward leadership Medical workforce plan baseline established			
M6	Ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum	CMO	→ Weekly % compliance with RCEM recommend-ations	**R**	Business case being developed for additional ED Consultant – implementation to be staged	**R**	**R**	**R**
SHOULD DO								
S1	Ensure a county-wide consultant on call rota is achieved as part of the ED transformation programme. See also M6	CMO	→ Monthly average number of ED Consultants rostered to be on call each day	**A**	The Trust has in place an integrated rota that works countywide that means that the Consultants on call can cover either site in extremis. The Trust currently cannot aspire to a single countywide rota	**A**	**A**	**A**
S2	Ensure delays in ambulance handover times are reduced to meet the trust target of 80% of patients conveyed by ambulance have handovers carried out within 15 minutes of arrival (baseline 41.1% Jan 2015) and 95% of patients handed over within 30 minutes (82.2% Jan 2015).	COO	→ Monthly % ambulance handovers with 15mins → Monthly % ambulance handovers within 30 minutes	**A**	Performance in January 2016: 41.7% handovers within 15 mins; 86.0% handed over within 30 mins. Jointly signed letter to front line staff clarifying the SOP, roles and responsibilities for handover circulated in March 2016 Admin support on the ambulance desk in ED at WRH to support the clinical handover by entering the patient PIN number	**A**	**A**	**G**
S3	Ensure the changes to manage	COO	→ Weekly no of patients in the	**A**	Full capacity protocol in place. To be revised in March 2016 to include update on criteria for	**A**	**A**	**G**

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Urgent Care and Patient Flow								
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	overcrowding and patient safety in ED are sustainable.		ED corridor → Weekly % discharges before 12 midday → Weekly % stranded patients (NEL LoS > 7 days)		boarding patients. Crowding largely relates to 'exit block' from the ED to the main hospital			
S4	Ensure patients receive an initial assessment within 15 minutes of arrival (baseline 77.3%, Jan 2015).	COO	→ % of ED attenders assessed within 15 minutes compared with with target and with Peer Trusts	**A**	DDOps for Medicine to focus on triage at AGH and KTC to improve the average	**A**	**A**	**A**
S5	Continue to engage with local organisations to improve patient flow to ensure that patient waiting for hospital beds in ED can be transferred in a timely manner to prevent breaches	COO	→ Monthly no of DTOCs →Monthly % of stranded patients	**A**	Baseline 79 DTOCs Jan 2015.. DTOCs reduced to 26 in Jan 2016, System Resilience Group and Best Practice Urgent Care Board action plan in train, supported by ECIP to reduce % stranded patients	**A**	**A**	**G**
S6	Evaluate the effectiveness of the Patient Flow service to ensure it meets patient needs and improves access and flow of services	COO	→ Monthly no of DTOCs → Monthly no of stranded patients (NEL LoS > 7 days)	**A**	Review undertaken, implementation of actions underway, including in-reach, revised governance, multi-disciplinary multi-agency approach to discharge coordination to be confirmed at March 2016 SRG	**A**	**A**	**G**

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Urgent Care and Patient Flow

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/06/16	Forecast 30/09/16
S7	Ensure unplanned re-attendance to ED within seven days meets the target of 5%.	COO	→ Monthly % ED re - attendance	**A**	Performance is 5.8%. Analysis of cases underway in March and action plan on repeat attendances to be developed in April	**A**	**A**	**G**

Reducing Avoidable Mortality

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/06/16	Forecast 30/09/16
MUST DO								
M7	Evaluate and improve practice in response to the results from the hip fracture audit for 2014	CMO	Monthly % to theatre within 36 hours compared with target and Peer Trusts	**A**	Countywide actions In place:- Prioritisation of #NOF cases to be done first on the PM Trauma Theatre Sessions; this is driven by the Trauma Nurse Practitioners & Clinical Teams and is supported by the Hip Fracture Escalation policy. Trauma Nurse Practitioners submit a Daily Report to monitor #NOF performance countywide to COO & Surgical Division. Monthly #NOF performance reviewed and discussed at the Countywide Directorate Meetings attended by the Clinical Teams. Business case for weekend Trauma sessions submitted to allow for dedicated sessions. Regular Orthogeriatric input required.	A	A	A

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SHOULD DO								
S8	Record Mortality and Morbidity reviews in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust	CMO	Monthly % eligible primary and secondary reviews presented at the weekly Operational Governance Meeting	**A**	The primary review process is well established with compliance increasing. In **March 2016** those primary reviews resulting in the need for a secondary review will be discussed at the M&M section of the weekly OGM – 100% compliance by end of March From **April 2016** secondary reviews will be presented at Week 2 of the OGM cycle From **May 2016** the outcome of all secondary reviews will be presented to Week 2 of the OGM cycle. Where action plans are developed as a result of the secondary reviews, progress will be tracked Week 2 of the OGM cycle. By the September OGM meeting the process of ensuring actions are completed and that the impact is assessed will be part of business as usual for the meeting.	**A**	**A**	**G**
S9	Ensure the morbidity and mortality meeting minutes clearly document discussions	CMO	As S1	**A**	The mortality section of the weekly OGM will continue to be clearly minuted. Systems in development to ensure that individual directorates and divisions clearly minute all M&M meeting discussions	**A**	**G**	**G**

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OD Plan/GGI recommendations Action Plan								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 31/09/16**
MUST DO								
M8	Ensure that suitably qualified staff in accordance with the agreed numbers set by the trust and taking into account national policy are employed to cover each shift	DoHR/ OD/ CNO/ CMO	→ Monthly shift fill rates by Ward → Monthly Qualified and Unqualified Nurse turnover → % nursing agency expenditure by Division → % medical agency expenditure by Division	**A**	Appointment process at Band 5 Nurse and HCA assessments reviewed. Recruitment events held both on the Alexandra Hospital and Worcester hospital site. Senior Nurse Team attended recruitment event with UW students. Agreed with UW to increase number of student nurse placements. Business case for overseas recruitment completed. Implemented new exit interview process and analysing reasons for leaving. New roles group developed and implementation of new roles commenced. Ward Administrator role developed and post being advertised in March 2016. Band 4 Assistant Practitioner role developed, job description agreed and matched. Band 4 Assistant Practitioner programme commissioned with UW. Medical workforce plan baseline established	**A**	**A**	**A**

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OD Plan/GGI recommendations Action Plan								
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M9	Ensure all staff meet the trust wide mandatory training target of 95% compliance *Mandatory training target revised to 90% and agreed by Workforce Assurance Group in line with other trusts compliance targets across West Midlands to 90%*	DoHR/ OD	→ Monthly aggregate mandatory training rates and rates by topic	**A**	Review undertaken of all departments identifying staff that have not completed their mandatory training requirements. Topic Leads made contact with all staff with out of date mandatory training. Compliance reports produced weekly and provided to each Head of Department. Poor performing Departments escalated to relevant Divisional Director of Operations. 5 of the 10 mandatory training topics now achieving over 90% remaining 5 topics all on target to achieve 90% target by end of June 2016.	**A**	**G**	**G**
M10	Ensure that staff providing care or treatment to patients receive appropriate support, and training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform	DoHR/ OD	→ Monthly % staff appraisal rates, medical, clinical and non-clinical	**A**	Appraisal data analysed and all managers whose compliant percentage is below 85% received notification of which staff have not received an annual appraisal. All staff who have not received an appraisal in the last 12 months received letter informing them of course of action to take to ensure appraisal undertaken. Departmental training plans requested from all heads of departments to be received by 30.3.16 so enable collation of all departments training requirements. Weekly training update to all staff produced to be implemented week commencing 14.3.16. Trust Training Directory updated weekly.	**A**	**G**	**G**

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OD Plan / GGI recommendations Action Plan								
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SHOULD DO								
S10	Ensure staff are aware of the trust's strategy and vision for the future	DoHR/ OD	→ Monthly staff engagement results from Trust 'Pulse' surveys and → Quarterly staff engagement results from 'Chat Back' surveys	**A**	2015 National Staff Survey revealed low levels of satisfaction through staff engagement at WAHT Trust has engaged with Optimise to develop Listening into Action (LiA) from April 2016 Trust's own Big Conversation being rolled – out alongside improved internal communications strategy. Trust developing its own monthly staff 'Pulse' survey (from April 2016) and quarterly 'Chat Back' Survey	**A**	**A**	**A**

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CIH Governance and Safety Improvement Plan								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 31/09/16**
MUST DO								
M11	Review the existing incident reporting process to ensure that incidents are reported, investigated, patient harm graded in line with national guidance, actions correlate to the concerns identified, lessons learnt are disseminated trust wide, and reports are closed appropriately	CNO	→ Monthly number of serious incidents open > 60 days – trust wide and specific to Women and Children's → % new incidents with 72hr update received (Women and Children's)	**A**	Improvements in all areas of the incident management process, particularly Women's and Childrens Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT)	**A**	**G**	**G**
M12	Ensure that risk registers are reviewed regularly in a timely fashion	CNO	→ Monthly % risks overdue for review → Monthly % risks with overdue actions	**A**	Improvement trust wide in 15/16. Sustained improvement planned in 16/17 Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT)	**A**	**G**	**G**
M13	Take steps to ensure that all staff are included in lessons learnt from incidents and near misses, including lessons learned from mortality reviews, with effective ward based risk registers and safety dashboards being in place and understood	CNO		**A**	Ward based quality dashboard phase 1 and 2 in place and due to report March 16 – phase 3 for roll out in May 16 Directorate based risk registers in place which identify ward based risks and mitigation Weekly lessons learnt from incidents and SIs disseminated throughout the organisation and a	**A**	**G**	**G**

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	by all staff.				lesson of the month in place Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT)			
M14	Risk assessments must be completed and used effectively to prevent avoidable harm such as the development of pressure ulcers	CNO	→ Monthly no of avoidable pressure ulcers by ward	**G**	Matrons audits and ward based dashboards indicate adherence to pressure ulcer prevention plans	**G**	**G**	**G**
M15	Ensure patients nutrition and hydration status is fully assessed recorded and acted upon in a timely manner.	CNO	→ Monthly audit results by ward	**G**	Matrons audits and ward based dashboards indicate adherence to nutrition and hydration care plans	**G**	**G**	**G**
M16	Ensure complaints investigated in a timely manner with appropriate audit trail and that learning is shared. Respond to complaints within agreed timeframes and summary data and meeting minutes should be explicit as to which location the complaint relates to and where performance times need to be improved	CNO	→ Monthly % complaints responded to with 25 days by Division → Monthly no of complaints re-opened by Division	**A**	New processes implemented. Location now available. Triangulation of learning from patient experience event undertaken in Feb 16 – key learning actions being agreed Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT)	**A**	**G**	**G**
M17	Ensure patients receive appropriate training and information about self-medication such as self-administration of heparin prior to discharge home.	CNO	→ Monthly number of reported incidents relating to patient self - administration	**A**	A framework is in place to facilitate self-administration of medicines by patients The Trust Medicines Policy outlines the criteria and policy by which patients may self-administer their medicines. The procedure by which self- administration by patients should be undertaken is outlined in	**A**	**A**	**G**

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			of medicines.		MedsPolSOP13 of the Medicines Policy An improvement programme together with the necessary audit/assurance will be discussed and planned at the meeting on 3rd March. This will be undertaken in conjunction with appropriate patient engagement to ensure that any changes/developments to these policies and procedures reflect the needs of our local population.			
M18	Ensure all medicines are prescribed and stored in accordance with trust procedures.	CNO	→ Audit results from Deep Dive in March and August	**A**	Audit programme in place. Deep dive of results to occur in March and link to operational governance meeting. Aiming for full assurance August 16	**A**	**A**	**G**
SHOULD DO								
S11	Ensure that adherence to the Duty of Candour regulation is recorded in incident reports in line with requirements.	CNO	→ % incident reports with DoC adherence recorded	**A**	Weekly operational governance meeting ensures and records duty of candour compliance. Further training planned to embed processes Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT)	**A**	**G**	**G**
S12	Resolve the issues relating to the faulty refrigeration storage units and inadequate water system in the mortuary	CNO	→ Monthly number of exceptions to refrigerator temperature tolerances	**G**	The shower has been replaced and repairs were carried out to the water system which has stopped the problems experienced with the temperature of the water. The temperature of the fridges is monitored on an on-going basis. At WRH a bid to replace the fridges is currently agreed by the PFI team. At AGH the	**G**	**G**	**G**

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CIH Governance and Safety Improvement Plan								
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					fridges have been confirmed as requiring replacement in 2016 and a capital bid request for replacement has been submitted.			
S13	Ensure investigations of incidents have clear learning points and actions to prevent similar incident occurring, particularly in relation to staff assault.	CNO	→ Monthly no of incidents relating to staff assault	**G**	Weekly operational governance meeting ensures measurable actions and disseminates learning	**G**	**G**	**G**
S14	Ensure all medicines storage areas have systems for measuring and recording temperatures	CNO	→ Monthly number of exceptions to temperature tolerances	**A**	Sample audit of systems occurring first week March	**A**	**A**	**A**
S15	Ensure all risks are risk assessed and are on the risk register with mitigated actions taken (part 1)	CNO	→ Summary results of risk survey	**A**	Further trust wide risk survey currently being undertaken to confirm all risks captured Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT)	**A**	**G**	**G**
S16	Ensure sufficient security measures are in place on the Kidderminster site to protect staff, patients and visitors. (part 2)	CNO	→ Monthly number of security incidents reported at KTC	**A**	All security actions completed on action plan. Portering service undergoing management of change process to enhance role re security	**A**	**G**	**G**

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Women and Children Improvement Plan								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 30/09/16**
MUST DO								
M19	Ensure that patient records are safe from removal or the sight of unauthorised people. (part 1)	CNO	→ Results from spot checks	**A**	Trust wide communications in place and quality champions spot checks commenced Riverbank now has lockable cabinet.	**A**	**G**	**G**
M20	Develop a robust system to ensure children and young people who present with mental health needs are suitably risk assessed when admitted to the department to ensure care and support provided meets their needs.	CNO	→ Monthly no of incidents related to lack of appropriate care and support	**G**	An agreed county wide protocol is in place that outlines CAMHs support. No related incidents in last five months Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs)	**G**	**G**	**G**
M21	Ensure that midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic.	CNO	Monthly % midwives completing Mandatory Midwifery Training	**G**	An ODP or recovery nurse is provided for 30 minutes post spinal or GA in recovery 24/7, handing over to the midwife once appropriate to do so/ prior to transfer to postnatal ward. Obstetric anaesthetists are assigned to maternity for all shifts and provide support and advice as required/ indicated. Enhanced care topic is now included on 3 day mandatory midwifery training Checklist in place for orientation of AGH midwives to WRH theatre processes. Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs)	**G**	**G**	**G**
M22	Ensure the facilities in the Early Pregnancy Unit are fit for purpose.	CNO		**G**	Works took place in Aug 15 to expand the facility into 2 rooms. Risk assessment for EPAU completed for AGH site shows low risk.. Walk round has taken place at The AGH to consider relocation of EPAU	**G**	**G**	**G**

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Women and Children Improvement Plan								
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					and other ambulatory Gynaecology services in the future as part of Trust ASR capital development programme 2016/17 – 2018/19 Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs)			
SHOULD DO								
S17	Respond to complaints within agreed timeframes and summary data should be explicit as to which location the complaint relates to. Meeting minutes should clarify which area of Women's and Children's complaints relate to and where performance times need to be improved.	CNO	→ Monthly % complaints responded to with 25 days by Division → Monthly no of complaints re-opened by Division	**G**	Processes in place within division with improved performance against low numbers of complaints Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs)	**G**	**G**	**G**
S18	**Evesham:** Review arrangements for utilising the full theatre capacity to ensure patients are treated sooner	CNO	→ Monthly utilisation – Evesham Theatres	**G**	Weekly process in place to maximise all theatre capacity including Evesham.	**G**	**G**	**G**

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Outpatient and Diagnostics Improvement Plan								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 30/09/16**
MUST DO								
M23	Review the environment within outpatients to ensure that the seating is fit for purpose	COO	→ Results from spot checks	**G**	9 High chairs with arm rests were purchased and installed in the fracture clinic waiting area for elderly patients and were in place by October 2015. Quality Champions to undertake spot checks in all outpatient areas	**G**	**G**	**G**
M24	Review the existing arrangements with regards to the management of referrals in to the organisation in order that the backlog of patients on an 18 week pathway are seen in accordance with national standards	COO	→ Monthly % RTT pathways completed within 18 weeks of referral.	**A**	Delivered the aggregate 'Incomplete' RTT standard in Dec 2015 and Jan 2016. RTT performance is likely to deteriorate from 92% within 18 weeks to approximately 90% in a planned way from February 2016 onwards due to capacity constraints. Our focus is on prioritising urgent and cancer patients and communication with longer waiting patients and harm reviews/action for patients to take if there is any deterioration in their condition	**A**	**A**	**A**
M25	Ensure that equipment within the radiology department is fit for purpose	COO	→ Monthly % patients seen outside of national diagnostic waiting time standard	**G**	All radiology equipment has been maintained to a standard and frequency of checks by approved contractors according to a strictly adhered to schedule. The Regional Radiation Physics Protection Service conducts regular QA reviews for assurance. The DDOps in CSS/TACO will present a summary report to TMC in May 2016.	**G**	**G**	**G**

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Outpatient and Diagnostics Improvement Plan

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/06/16	Forecast 30/09/16
SHOULD DO								
S19	Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology (IR) service.	COO	→ Number of reported incidents relating to lack of 24/7 cover	**A**	The CMO has organised a meeting with University Hospitals Coventry and Warwickshire NHS Trust IR team to build on our current radiotherapy links to scope a networked IR arrangement for 24/7 cover. An informal arrangement is currently in place.	**A**	**A**	A

Emergency Surgery (Including Hospital at Night)

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/06/16	Forecast 30/09/16
MUST DO								
M26	Ensure there is a sustainable system in place to ensure all surgical patients receive safe and timely care.	CMO	→ Increase in number of direct emergency surgery admissions to WRH from AGH catchment	**A**	Implementation plan developed following risk assessment and agreement from QSS committee to proceed with centralisation at WRH. Revised Consultant rota being developed whilst additional capacity is secured at WRH to realise the full transfer	**A**	**A**	**G**
SHOULD DO								

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Emergency Surgery (Including Hospital at Night)								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 30/09/16**
S20	Review and risk-assess the provision of the critical care outreach team service which was not being provided for 24 hours a day.	CMO	→ Monthly % of cardiac arrests and unexpected deaths at night.	**A**	Self-Assessment Gap Analysis undertaken by the Critical Care Unit, against the draft D16 Service Specification for Adult Critical Care Outreach Risk assessment has commenced and will include a review of the Trusts 'Recognising And Responding To Early Signs Of Deterioration In Hospital Patients' Procedure (WAHT-CRI-016) and the National Outreach Forum Operational Standards and Competencies for Critical Care Outreach Services. A variety of factors are being considered in the risk assessment including level of experience of responders, ability to attend patient promptly, and availability of support staff and services 24/7. The risk assessment will include analysis of Resuscitation Audit data, Mortality reviews, and the Hospital Standardised Mortality Ratio (HSMR).	**A**	**A**	**G**
S21	Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology service.	CMO	→ % compliance with the audit standards	**A**	Updated status to be confirmed. As of Nov 2015: • 6 standards met • 3 standards partially met • 2 standards not met	**A**	**A**	**G**

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High Dependency Unit Review								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 30/09/16**
MUST DO								
M27	Review the High Dependency Units to bring their data collection and provision of care and treatment up to all Faculty of Intensive Care Medicine Core Standards.	CMO	→ Monthly proportion of current HDU patients identified as requiring level 2 care → Monthly proportion of level 2 patients receiving level 2 care in an appropriate environment	**A**	Established Task and Finish Group Agreed Terms of Reference Agreed project workstreams Benchmarked current service against Intensive Care Medicine Core Standards	**A**	**A**	**A**
M28	Ensure there is a timely and appropriate response from the medical teams to the Critical Care Unit requests for support, follow-up and patient discharge.	COO	→ Monthly number of ICU patients discharged directly to place of residence	**A**	The Trust is developing with Consultant Medical Staff a set of key professional clinical standards in line with the national aspiration to sustainably and consistently provide 7 day emergency services, and this requirement will be made explicit therein.	**A**	**A**	**G**

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Sign up to Safety								
Ref	**Item**	**Lead**	**Improvement Measures**	**Current Status RAG**	**Comment**	**Forecast 31/03/16**	**Forecast 30/06/16**	**Forecast 30/09/16**
MUST DO								
M29	Ensure that patient records are accurate, complete and fit for purpose (Part 2)	CMO	→ % compliance with record keeping audit standards	**A**	The record keeping audit will be modified in **March 2016** to include all areas of concern. From **April 2016** the audit will be completed fortnightly (10 records each ward) and reported to each ward area manager/clinical lead The outcomes will be reported using SPC methodology (proportion of records with 100% compliance) for each division. Methodology developed in April 2016 – reporting in divisional performance packs from **May 2016** (to include March/April figures). Overall aim is 95% of records with 100% compliance with standards and no record with less than 90% compliance by September 2016	**A**	**A**	**G**

Red	Delayed or currently unattainable	Amber	In progress and achievable	Green	Achieved and sustainable

Infection Prevention Control Peer Review

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/06/16	Forecast 30/09/16
SHOULD DO								
S22	Ensure staff are aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people and the actions required if a patient presents with associated symptoms.	CNO	→ Results of spot checks	G	Trust wide communications and IP awareness raising in emergency portals undertaken. Quality Champions to undertake spot checks	G	G	G

HEWM visit to Medicine Action Plan

Ref	Item	Lead	Improvement Measures	Current Status RAG	Comment	Forecast 31/03/16	Forecast 30/04/16	Forecast 31/05/16
MUST DO								
M30	Ensure there are effective systems in place for the ongoing management of outlying patients.	COO	→ Weekly number of medical patients outlying in other ward areas	A	Policy drafted and presented to TMC in February 2016, to be signed off in March 2016 via Divisional boards and published in April, which sets out clear standards for care and the SOP for outlying patients.	A	G	G

Red	Delayed or currently unattainable	Amber	In progress and achievable	Green	Achieved and sustainable