Northern Lincolnshire and Goole NHS
NHS Foundation Trust

NLG(15)527

DATE OF MEETING	**22 December 2015**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Wendy Booth, Director of Performance Assurance & Trust Secretary**
CONTACT OFFICER	**Kathryn Helley, Deputy Director of Performance Assurance & Assistant Trust Secretary**
SUBJECT	**Quality Development Plan (QDP) & Key Performance Indicators (KPIs)**
BACKGROUND DOCUMENT (IF ANY)	**None**
REPORT PREVIOUSLY CONSIDERED BY & DATE(S)	**N/A**
EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)	**The report provides the Trust's full QDP and KPIs**
HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**N/A**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**N/A**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**NO**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**N/A**
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**NO**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**YES**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?	**YES**
THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S) AND COMPLIANCE WITH THE REGULATORY STANDARDS LISTED	**Ensures compliance with statutory requirements and the Monitor Enforcement Undertakings**
ACTION REQUIRED BY THE BOARD	**The Board is asked to note the report and consider any additional actions required**

Quality Development Plan (QDP) – Executive Summary

Background & Introduction

The Trust's QDP is intended to bring together in one place all of the Trust's quality actions and developments.

This report provides:

- an update on progress against the Trust's Quality Development Plan (QDP) – **Appendix A** refers;
- performance against the associated Key Performance Indicators (KPIs), which will demonstrate the impact of those actions over time (i.e. that actions have been embedded and have and are leading to the required improvements) – **Appendix B** refers.

Current Position including any slippage / risks to delivery and mitigating actions

Delivery of the QDP and in turn ensuring ongoing improvement to quality of care is the Trust's foremost priority.

As at the date of preparing this report, the majority of actions within the QDP have been completed and / or are on target for completion by the agreed deadlines.

Ongoing Monitoring & Assurance Arrangements

Progress against the action plan and performance against the associated KPIs continues to be reviewed weekly by the Executive Team, with the focus now being very much on ongoing effectiveness/embedding of the actions within the QDP through review of the KPIs.

Testing of the implementation and embedding of the actions within the QDP also continues via a further range of measures including Announced and Unannounced Director Visits, Chief Nurse and Medical Director Walkarounds and CQC Mock Visits.

The Board is also reminded of the role of the Board Sub-Committees, each of which has oversight of relevant sections of the QDP and associated KPIs. The Sub-Committees, in turn, are required to provide assurance to the Trust Board in respect of delivery of those elements of the plan and progress against the KPIs and/or to escalate any concerns or risks to delivery and the mitigating actions.

The CQC also reviewed the adequacy and effectiveness of the Trust's actions during their planned follow-up inspection visit which took place between 13 and 16 October 2015. The final report from this visit will be published in January 2016 at which point the QDP will re-freshed.

Sharing of Progress on the QDP

The Trust Board receives this monthly update report on progress against the Trust's QDP including evidence of impact. Assurance to the Trust Board will also be provided via the relevant Board sub-committees as outlined above.

The report submitted to the Trust Board will also be shared internally and with relevant external stakeholders.

Board Action Required

The Board is asked to:

- note progress with the achievement of actions within the QDP;
- note progress against the KPIs;
- agree any additional actions required at this stage;
- note plans to refresh the QDP on receipt of the report from the recent CQC re-inspection visit

QUALITY DEVELOPMENT PLAN v 30 11 15

Progress RAG Rating	RED	Action Not Achieved by Required Timescale or Risk to Achievement
	AMBER	Action on Target to Achieve within Required Timescale
	GREEN	Action Completed

ACTION PLAN NUMBER	SOURCE	RECOMMENDATION	ACTION	PROGRESS	EXECUTIVE LEAD	OPERATIONAL LEAD	TIMESCALE	IMPLEMENTATION OF ACTIONS PROGRESS RAG RATING	VERIFICATION OF ACHIEVEMENT/ EVIDENCE OF IMPACT	METHOD OF MEASUREMENT	BOARD SUB COMMIITTEE OVERSIGHT
SAFE											
Hydration and Feeding											
CQC1	CQC	Review access to soft diets outside of meal times.	Soft diets are available at ward level through a snack list.	Snack lists including soft diet options are available on all wards. Work has taken place to ensure that this has been communicated to raise awareness of this. In addition to this all patients have access to hot drinks and toast. Discussed at Matron's Forum in May 2015 to continue to raise awareness.	Karen Dunderdale, Chief Nurse	Hazel Moore, Quality Matron	Immediate	Completed	Patients are able to access soft diets outside of mealtimes.	CQC Mock Visit Process (Quarterly) Ward Review Update (Quarterly) Patient Experience Report (Quarterly)	QPEC
CQC2	CQC		Introduce hydration stations in each ward area to provide hot snacks 24 hours per day.	See above. The stations were made bespoke for the Trust and the design had to be amended. This was signed off in September and the order placed. The previous drinks trolleys remained in use until the new hydration stations arrived. Whilst there was some slippage on the original completion date, the risks were managed as above. The trolleys were received week commencing 9 January 2015, training provided to staff and the stations are now in use across the Trust.	Karen Dunderdale, Chief Nurse	Hazel Moore, Quality Matron	30 November 2014	Completed			QPEC
EVDR7.1	Enter and View Dignity and Respect Report	Variety of food not tailored to specific needs, eg, stews, soups, etc.	Review of patient menu to be undertaken.	A Dietitian is now dedicated to the review of the existing patient menu, and software purchased to allow a nutritional analysis. This is scheduled to complete in June 2015. The review has identified some nutritional gaps which will be addressed when we begin to create a seasonal menu over a two week rotation. The Food and Drink strategy has been reviewed by the Nutritional Strategy Group and a direction on how this will be implemented against the toolkit is under development.	Karen Dunderdale, Chief Nurse	Keith Fowler, Hotel Services General Manager	30 April 2015	Completed	New menu in place Menu Card Survey	Patient and Staff Experience Group Highlight Report (Quarterly)	QPEC
EVDR7.2	Enter and View Dignity and Respect Report		Review of the presentation/ serving of sandwiches.	Sandwiches are now served on plates.	Karen Dunderdale, Chief Nurse	Keith Fowler, Hotel Services General Manager	30 April 2015	Completed	Menu Card Survey findings	Patient and Staff Experience Group Highlight Report (Quarterly)	QPEC
EVDR7.3	Enter and View Dignity and Respect Report		Add details of personal dietary requirements to the Nutrition pathway.	Details added to the electronic template. Paper document has been amended.	Karen Dunderdale, Chief Nurse	Hazel Moore, Quality Matron	30 April 2015	Completed	Approved nutrition pathway approved and in use	Pathway	QPEC
Deteriorating Patient											

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CQC3	CQC	Ensure there are appropriate care planning and a paediatric early warning scoring system in the neonatal intensive care unit and that there is a routine nutritional and tissue viability screening and assessment on Disney ward.	The neonatal and paediatric areas use a collaborative document which details the management plan and care delivered to children/babies. This will be reviewed in light of the CQC feedback to ensure it meets service needs.	Feedback awaited from the CQC in relation to this area. As at 10 October 2014, feedback is still awaited from the CQC. Nutritional and tissue viability screening tools have been developed and are out for comment. A formal letter will be sent to the CQC informing them that, in the absence of any confirmation from themselves, this action is to be closed. Method of recording vital signs is well embedded in the Paediatric areas, with paper forms available in the A&E department and the recording of vital signs within the ward areas being done exclusively on the WEB V system. No issues within the paediatric ward areas regarding the recognition of the deteriorating child, all staff fully trained in the use of the PEWS system.	Karen Griffiths, Chief Operating Officer	Amanda Jackson, Head of Children's Nursing	30 September 2014	No further feedback received from CQC	Awaiting feedback from CQC	Awaiting feedback from CQC	QPEC
CQC4	CQC		In the absence of any national neonatal early warning score the neonatal unit is staffed with a nurse to baby ratio of 1:1. Each nurse is neonatal qualified. The Women's and Children's Group will continue to contribute to national conversations regarding any early warning score developments.	A Consultant Paediatrician is part of a national working group developing and trailing for new born babies (NEWTT). This is currently being trailed in some areas. Feedback awaited from the CQC in relation to this area. On-going work within the Neonatal Network to develop a regionally ratified NEWS Tool. Tool sourced for trial in the Neonatal units within NLaG but awaiting ratification at Clinical Governance.	Karen Griffiths, Chief Operating Officer	Amanda Jackson, Head of Children's Nursing	Immediate	Completed and Ongoing	Awaiting feedback from CQC	Awaiting feedback from CQC	QPEC
D1	Deanery Report	Patient Safety - Clinical Supervision	Trust must ensure that all staff are aware of the issue of FY1 trainees not taking GP calls within the Trust and Primary Care in relation to Surgery.	At SGH all calls go through the Single Point of Access and at DPOW the Surgical Assessment Unit takes the calls. The Trust feels that a critical element of a trainees teaching programme should be the taking of calls from GPs. This allows them to develop their communication skills and converse with other health care professionals. This does not mean that they will be admitting patients. It is proposed that this is issue could be raised at a Junior Doctor Forum to discuss what is appropriate and what is not appropriate. Evidence submitted to the Deanery has assured them to close this action.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	31 July 2014	Completed	Written confirmation that the new processes have been sustained in terms of FY1 doctors not taking GP referral calls.	Survey of Trainees (6 monthly) Director Visit Report (Quarterly) Operational Monthly Performance Minutes (Monthly)	QPEC
I13	Response to Incidents	Continue to monitor and ensure that appropriate action is taken in response to escalated NEWs scoring.	This requirements is monitored through the nursing dashboard and is reported in the monthly quality report.	A Trustwide audit of NEWs was undertaken in November 2014, the results of which are being collated. This led to the tool being reviewed and updated. A further audit has been undertaken and is due to be presented and discussed at NMAF 3rd July 2015	Karen Dunderdale, Chief Nurse	Quality Matrons	Immediate	Completed	Appropriate action taken as a result of the NEWs score.	Nursing Dashboard Report (Quarterly) Quality Report (Monthly)	QPEC
Falls											
CQC5	CQC	No issues/concerns raised.	The CQC identified no concerns in this area, however progress towards the Trust's Falls Action Plan and agreed quality objectives will continue to be monitored by the Quality and Patient Experience Committee and the Trust Board.	The Falls Action Plan in included in the work programme for the Quality and Patient Experience Committee and the Trust Board.	Karen Dunderdale, Chief Nurse	Mel Sharpe, Quality Matron	Immediate and Ongoing	Completed	The elimination of all repeat fallers.	Quality Report (Monthly) Falls Report (Quarterly)	QPEC
Pressure Ulcers											

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CQC6	CQC	Ensuring there are appropriate care planning and a paediatric early warning scoring system in the neonatal intensive care unit and that there is a routine nutritional and tissue viability screening and assessment on Disney ward.	The paediatric wards on both sites undertake the same nutritional assessment on admission, which is re-evaluated during the child's stay and strict fluid balance is undertaken and documented.	Full implementation of Paediatric Nutritional screening tool on both paediatric ward areas. Close working with Dietetic colleagues in order to ensure training of staff completed prior to roll out. All children now have Nutritional Assessment carried out on admission and relevant interventions if need identified.	Karen Griffiths, Chief Operating Officer	Amanda Jackson, Head of Children's Nursing	Immediate	Completed and Ongoing	Children are assessed for nutrition and hydration.	Nursing Dashboard Report (Quarterly) Quality Report (Monthly) Patient Experience Report (Quarterly)	QPEC
CQC7	CQC		A tissue viability screening pathway is currently in development for complex needs children and those with mobility issues.	Full implementation of Tissue Viability screening tool in both paediatric ward areas. On-going work with Tissue Viability CNS's to develop child friendly information relating to reducing the risk of pressure injury.	Karen Dunderdale, Chief Nurse	Amanda Jackson, Head of Children's Nursing	30 September 2014	Completed	Pathway developed and completed in all cases of complex needs and those with mobility issues.	Copy of Pathway Clinical Audit Report (TBC - audit will take place once pathway implemented) Pressure Ulcer Group Minutes (Monthly) Quality Report (Monthly)	QPEC
CQC8	CQC		Progress towards the Trust's Pressure Ulcer Action Plan and agreed quality objectives will continue to be monitored by the Quality and Patient Experience Committee and the Trust Board. The escalation process has been revised with additional meetings with Chief Nurse for repeat avoidable harm.	The Pressure Ulcer Action Plan is included in the work programme for the Quality and Patient Experience Committee and the Trust Board.	Karen Dunderdale, Chief Nurse	Di Hughes, Quality Matron	Immediate and Ongoing	Completed	50% reduction in the number of avoidable grade 2, 3 and 4 pressure ulcers.	Quality Report (Monthly) CQUIN Report (Quarterly)	QPEC
Staffing Levels											
CQC9	CQC	Ensure there are sufficient qualified, skilled and experienced staff, particularly in A&E, medical and surgical wards. This is to include provision of staff out of hours, bank holidays and weekends.	The Trust continues to monitor and make changes to staffing levels where required and has plans in place to recruit to medical and nursing staff vacancies although recruitment remains a challenge in some areas and there will remain a reliance on locum and agency staff in some areas unit this issue is resolved. **Whilst the Trust continues to take all appropriate actions, this issue is also linked to the longer term Sustainable Services Review and the future configuration of services.** The Trust's clinicians are involved in developing options. Commissioner intentions to be published September 2014.	This work continues. Systems and processes in place include confirm and challenge meetings, Board papers on staffing and capacity and an escalation policy. The Operations Centre oversees the bed state and ensures that staff are redeployed as necessary to ensure that wards are staffed safely and appropriately in line with the acuity of the patients. A baseline assessment against the NICE guideline for adult in-patient wards and maternity wards has been undertaken and the draft guidance for A&E has also been reviewed. Partial compliance has been declared for the adult in-patient area and an action plan in place to address the gaps. A Task and Finish Group has been set up to oversee the implementation of this action plan - the deadline for which is the end of September 2015. An update on the gap analysis for maternity and A&E will be provided by the end of June 2015. To date, the gap analysis has shown that the Trust meets the requirements for staffing levels.	Karen Griffiths, Chief Operating Officer/ Lawrence Roberts, Interim Medical Director/ Karen Dunderdale, Chief Nurse/ Pam Clipson, Director of Strategy and Planning	Associate Medical Directors and Heads of Nursing for Medicine and Surgery	Immediate and Ongoing	Completed	Reduction in the nursing vacancy rate. Reduction in the medical vacancy rate. Reduction in the AHP vacancy rate. Reduction in the average monthly spend on nursing bank and agency staff. Reduction in the average monthly spend on locum/ agency medical staff. Reduction in sickness levels.	KPI28 (Monthly) KPI29 (Monthly) KPI30 (Monthly) KPI31 (Monthly) KPI32 (Monthly)	QPEC
IC1	Response to Incidents										

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CQC10	CQC		The Trust continues to explore innovative ways to support recruitment including overseas recruitment and collaboration with other local providers.	Work continues with overseas recruitment both for medical and nursing. Links have been made with the European Commission and work continues to identify recruitment packages to attract and retain staff. A number of career fairs have been held, one in London at the end of November 2014 and another in Hull at the beginning of December 2014. A recruitment agency from London with proven success is recruiting to substantive NHS vacancies has been commissioned by NLAG for an initial order to fill 30 high priority medical vacancies within the Trust. A further number of career fairs have been held at Hull University for newly qualified nurses and one is planed in June 2015 for Lincoln. Work continues to recruit to vacant posts and the Trust is working up proposals for innovative approaches to medical vacancies. We had a successful trip to Bulgaria and Poland at the end of February 2015 and to India in May 2015. The recruitment team continue to work with numerous agencies and use various methods to recruit registered nurses from the EU market.	Neil Pease, Director of OD & Workforce / All Executive Directors	Claire Smaller, Head of Employment Services	Ongoing	Completed and Ongoing		KPI33 (Monthly) Workforce Review Group Report (Quarterly) Workforce Review Group Minutes (Monthly) Resource Committee Report (Monthly) Sustainability Plan (Monthly) Safer Staffing Report (Monthly)	QPEC
CQC11	CQC		The above work to be completed in conjunction with the review of medical staff cover out of hours, bank holidays and weekends.	All groups have submitted relevant details to the Chief Operating Officer who is in the process of collating and checking this information. This data is allowing the Trust to undertake a scoping exercise in order to identify both current and future requirements. It is expected that this will report during Quarter 2.	Karen Griffiths, Chief Operating Officer	Karen Fanthorpe, Deputy Chief Operating Officer	30 September 2014	Completed			QPEC
CQC12	CQC		The Trust is also currently updating nursing roster templates to implement a standardised shift pattern and is investigating the option of updating templates with the competencies and skills of staff.	The standardised shift patterns have been fully rolled out where relevant. A 6 month review has been undertaken and will be shared by the end of May 2015 as an interim report. The levels of competency have been developed and mapped to a dummy roster. This is to be tested on the dummy roster prior to be piloted on a ward. The competencies include the shift leader requirements.	Karen Dunderdale, Chief Nurse	Tara Filby, Deputy Chief Nurse/ Derek Conlon, Erostering Lead	31 December 2014	Completed	New templates in place on e-rostering system.	Roster KPIs (to be included in QDP KPIs from next month) (Monthly) Workforce Review Group Report (Quarterly)	QPEC

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I9	Response to Incidents	Undertake a training needs analysis (of all wards/each ward involved in the review) to ensure that staff are competent and confident in respect of basic care delivery around fluid management and nutritional assessment, intervention, escalation and monitoring. This is linked to the work to update nursing roster templates to reflect the implementation of a standardised shift pattern and to include the competence and skills of staff.	A training need analysis is underway as part of the e-roster roll-out.	NMAF have agreed an essential nursing training bundle outlining the key elements that front line staff need to be able to evidence competency in. This includes key aspects such as pressure ulcers, MUST, dementia, etc. Phase 1 of the mapping to OLM has taken place and phase 2 is underway.	Karen Dunderdale, Chief Nurse	Derek Conlon	31 December 2014	Completed		Roster KPIs (to be included in QDP KPIs from next month) (Monthly) Nursing Dashboard Report (Quarterly) Director Visit Report (Quarterly) CQC Mock Visit Report (Quarterly)	QPEC
CQC13	CQC	Review the skills and experience of staff working with children in the A&E to meet national requirements.	Model of care agreed. Staff contractual changes currently being consulted on.	The review has been undertaken and is complete. In addition to this, a working party with representation from Children's Services and Medicine has been developed to look at how paediatric patients can be cared for by paediatric staff when they attend A&E. The opportunity to create staff rotation to Goole is being considered to support staff training. The implementation of the model at SGH is dependent upon the re-modelling of A&E premises. Resource allocation relating to this development needs to be considered in the light of 'Healthy Lives Healthy Futures'.	Karen Griffiths, Chief Operating Officer	Peter Bowker, General Manager/ Amanda Jackson, Head of Childrens Nursing	31 October 2014	Completed	Agreed model of care and revised model in place.	Staff Rosters Operational Minutes	QPEC
D10	Deanery Report	Patient Safety - Consent	Written confirmation from the Trust that trainees are not taking inappropriate consent and copies of the consent training logs. (Surgery Trustwide)	A consent passport has been produced which has been populated with the common procedures that junior doctors would take consent for. The document also provides the opportunity for adding additional procedures. This was implemented on 31 July 2014 and was issued at the junior doctors induction week commencing 4 August 2014. Directorates are maintaining their completion and return. Each Directorate is keeping a 'directory' for delegated consent which have been populated and will be maintained by the Risk and Governance Facilitators who escalate non returns to the clinical leads, Associate Medical Directors and the Directorate Governance meetings. Discussion on the consent passpost has taken place at the Surgery Quality and Safety Day. Trainees were informed that they must speak up when they do not feel that they have the correct competence to take consent and that they need to be proactive in completing the consent passport.	Wendy Booth, Director of Performance Assurance/ Lawrence Roberts Interim Medical Director	Lynn Young, Trust Medical Education Manager/ Jill Mill, Head of Risk Management/ All Clinical Leads	31 July 2014	Completed	Written confirmation from the Trust that trainees are not taking inappropriate consent and copies of the consent training logs.	Audit of Consent (May 2015) Survey of Trainees (6 monthly)	TGAC
D11	Deanery Report	Patient Safety - Consent	The concept of a consent passport to have been considered with evidence that this is starting to be implemented Trust-wide. (Trustwide)	See above.	Wendy Booth, Director of Performance Assurance/ Lawrence Roberts, Interim Medical Director	Lynn Young, Trust Medical Education Manager/ Jill Mill, Head of Risk Management/ All Clinical Leads	31 July 2014	Completed	The concept of a consent passport to have been considered with evidence that this is starting to be implemented Trust-wide.	Audit of Consent (May 2015) Survey of Trainees (6 monthly)	TGAC

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D14	Deanery Report	Support and Development	The Trust to provide a copy of their hours monitoring documentation and diaries.	The return rate for monitoring by using DRS online has increased. All the new starters were told at Induction that hours monitoring at this Trust is done on line and they were also shown where to find the guidelines on the intranet showing how to complete the diary cards. It is anticipated that this will be incorporated into a teaching session. Additional evidence being sought.	Lawrence Roberts, Interim Medical Director	Lynn Renardson-Oliver, E-rostering Implementation Lead	31 July 2014	Completed	A copy of the hours monitoring documentation and diaries.	Copy of forms (March 2015)	Resources Committee
D16	Deanery Report	Support and Development	The Trust to review how many times per day Phlebotomists visit wards.	The Trust feel that there should be a team approach on the ward to taking blood. Phlebotomists do visits wards and it is the role of midwives and Band 5 nurses to also take blood. It is, however, entirely appropriate for junior doctors to also take blood as this is an essential core skill. Work underway to ensure nurses can support this, alongside extra resource for more out of hours support. At present, a piece of work is being undertaken to agree the best way of identifying which staff members on the ward on any shift are the nominated individual for undertaking phlebotomy. The aim is that this person is clearly visible to all colleagues.	Karen Griffiths, Chief Operating Officer	Heads of Nursing/ Graham Sparling, Pathology Site Manager/ Richard Cartwright, Pathology Site Manager	31 July 2014	Completed	Staff available to undertake phlebotomy as appropriate.	Survey of Trainees (6 monthly)	QPEC
D19	Deanery Report	Patient Safety - Work Intensity	The Trust must consider options that will ensure that the Scunthorpe rota becomes compliant with a 1 in 11. It should be noted that HEYH do have plans to provide an extra StR in August. Staff for (2 more) new posts might be supplied by the Medical Training Initiative scheme.	The Trust has received from the Deanery confirmation that the 1:11 is a Rotyal College Recommendation. Work is now underway to identify a way of meeting this recommendation. The vacancy rate is exacerbated by the fact that the Trust does not receive its full complement of trainees from the Deanery. Evidence submitted to the Deanery has assured them to close this action. The evidence and background will be submitted to the Resources Committee for their assurance.	Karen Griffiths, Chief Operating Officer	Medicine SGH	31 July 2014	Completed	Written confirmation of the measures planned, and new rota arrangements demonstrating that rotas are safe.	Copies of rotas (March 2015)	Resources Committee
D21	Deanery Report	Patient Safety - Clinical Supervision	Review the rotas to ensure there is a more equitable spread across a 7 day week.	This has been actioned by the Associate Medical Director for Medicine and a response forwarded to the Deanery. In addition to this, the Trust is currently engaged in the Regional 7 day working project. The results of this work are due shortly following which an action plan will be developed to move this work forwards. Additional evidence being sought to be submitted.	Lawrence Roberts, Interim Medical Director	Oltunde Ashaolu, Associate Medical Director	31 July 2014	Completed	Copy of rota to be supplied demonstrating that rota is safe.	Copies of rota (March 2015)	QPEC
D22	Deanery Report	Delivery of Approved Curriculum Including Assessment	Trainees to incorporate into handover that the CMT trainees should go to clinic. (Medicine Trustwide)	Rotas have been modified to ensure that trainees are able to attend where necessary. Evidence to be submitted alongside surveys of trainees.	Lawrence Roberts, Interim Medical Director	Oltunde Ashaolu, Associate Medical Director	31 July 2014	Completed	Clinic lists and rotas to be supplied.	Survey of Trainees (6 monthly)	QPEC
D23	Deanery Report	Delivery of Approved Curriculum Including Assessment	Consider including more Registrars on the rota to allow flexibility in allowing CMT to attend clinics. (Medicine Trustwide)	See above.	Lawrence Roberts, Interim Medical Director	Oltunde Ashaolu, Associate Medical Director	31 July 2014	Completed	Clinic lists and rotas to be supplied.	Survey of Trainees (6 monthly)	QPEC
D26	Deanery Report	Patient Safety - Clinical Supervision	Trust to urgently review the patient safety aspects of the Gastroenterology service at DPOW Hospital. (Medicine DPOW)	The Deanery visit took place in September to review this. It demonstrated that good progress had been made. The Trust is to hold an evaluation meeting, supported by Karen Fanthorpe and Mike Tilston to for added assurance against the delivery of the action plan. Evidence submitted to the Deanery has assured them to close this action.	Karen Griffiths, Chief Operating Officer	Karen Wilson, General Manager	31 July 2014	Completed	A triggered visit from HEYH with an external College representative will take place in the summer to follow up on these concerns raised and review progress.	Visit Report (February 15)	QPEC
Medicines Management											

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I12	Response to Incidents	Review the mechanisms for the escalation, investigation and follow-up of incidents of delayed or omitted doses.	The Safer Medication Group will be asked to review the current mechanisms and make recommendations for change.	A pharmacy omitted medicines toolkit and audit tool has beendeveloped and was implemented in April 2015. Links to the nursing dashboards will be implemented when the first set of audit data is available in Q1. The Safer Medication Group will monitor the output from the audit data and recommend further development if necessary. KPIs have been agreed at QPEC to monitor this going forwards.	Karen Dunderdale, Chief Nurse / Wendy Booth, Director of Performance Assurance	Mike Urwin, Chief Pharmacist / Jill Mill, Head of Risk Management	31/03/2015 Development Complete 30 June 2015 Links to the dashboard to be fully completed	Completed	Reduction in incidents	Monthly Quality Report (Monthly)	TGAC
Mortality											
M1	Trust	Review the arrangements in place to support the mortality workstream due to the slowing down of improvement in the SHMI	The Trusts mortality position will continue to be monitored via the Mortality Performance and Assurance Committee, the Quality and Patient Experience Committee and the Trust Board.	The Mortality Action Plan is monitored by the Mortality Performance and Assurance Committee.	Lawrence Roberts, Interim Medical Director/ Karen Dunderdale, Chief Nurse/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors/ Heads of Nursing/ Clinical Leads	Immediate and Ongoing	On Target	Continued reduction in the SHMI	Mortality Report (Monthly) KPI (Monthly)	MPAC/ QPEC
M2	Trust	To review the medical model of service delivery across the Trust	Review of the Medical Model	Medical model agreed with all Physicians and in place. Paper taken to ET on 5 August 2015 which received approval for implementation.	Karen Griffiths, Chief Operating Officer	Tunde Ashaolu, Associate Medical Director	Immediate and Ongoing	Completed	TBA	TBA	TBA
Environment											
EVDR8.1	Enter and View Dignity and Respect Report	Older wards struggling with storage of equipment. Layout of bays needing a review. Layout of toilet and shower facilities on ward 22 not conducive to maintaining privacy and dignity.	Issues to be discussed at PLACE environment meeting and action to be taken as required.	Issues discussed as agreed. Quality Matron reviewing this issue as appropriate on the wards and raising with Ward Sisters where necessary. Clear the clutter dates have taken place and more are planned.	Karen Dunderdale, Chief Nurse	Angie Davies, Assistant Director of Nursing and Head of Quality	31 January 2015	Completed	Less clutter seen on the wards	PLACE Report	QPEC
EFFECTIVE											
Implementation and consistency of clinical strategies and pathways											

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CQC14	CQC	Review the consistency of care and level of consultant input, particularly out of hours and at weekends in the High Dependency Unit at DPOW.	Review of ITU and adherence to best practice already underway including formal assessment against the Intensive Care Society (ICS Standards)*. Above review to consider whether, longer term, HDU needs to transfer under the critical care umbrella. A cross site board has been set up to have oversight of the review and to discuss models of care looking at best practice and involving both Anaesthetic and Medicine Clinicians. In the interim, consultant lead for HDU confirmed and communicated to staff. ***Note:** these standards have only been published within the previous 16 months. As yet, it remains unclear whether small DGHs may derogate from some of the requirements. Still awaiting an update from the network as to how these guidelines are developing and the level to which we can derogate.	Following an internal review the Critical Care Strategy was presented to ETeam on 20/10/14. The paper detailed various options of service delivery and improvement with financial costings ranging from £410k to £2.5 m. In respect of the significant investments potentially required, it was requested that further work be considered on short and long term delivery options. This further work was presented on the 10/11/14.It was agreed that a plan be progressed to support short term actions (6 months) and a funding total of £410.555k was allocated at this point. The short term recommendations approved consisted of: a Cross site Clinical Leadership proposal for anaesthetics and critical care (2 posts); Medical Staffing investment to Consultant Intensivist to support patient review within 12 hr of admission with additional junior medical cover on weekdays; Nursing Staffing- rotation and shared training between ITU and HDU, investment of HDU ward manager (DPOW) and additional band 5 support; Administrative staff increase; Location options for DPoW supported only – ICU and HDU remain in current locations. These actions are complete.The management of HDU/ITU is now within one management group (S&CC) Discussions re long term strategies to better support HDU at SGH sit within the locality sustainability work HLHF.	Karen Griffiths, Chief Operating Officer	Kate Wood, Associate Medical Director	31 August 2014 (Review Complete) 1 September 2014 to 31 March 2015 (Implementation Phase)	Completed (Review) / On Target (Implementation)	Rota reviewed and in place.	Medical Rota	QPEC
		Review care and treatment to ensure that it is keeping pace with National Institute of Clinical Excellence guidance and best practice recommendations, particularly within the Critical Care Unit (ITU) and High Dependency		There is various guidance for critical care including intensive care standards. Nursing care has been assessed as good in all critical care areas. A dedicated page on the Trust intranet has been devised on which polcies and procedures are available. There is a rolling programme of review, governance approval and document control.		Kate Wood, Associate Medical Director		Completed Revised target of 30 June 2015 agreed	90% adherence to NICE guidance by 31 March 2014. Data contained within the Critical Care Report.	KPI03 (Monthly) Critical Care Report	
		Ensure that the ITU uses nationally-recognised best practice guidance in terms of consultant ward rounds and reviewing admissions to the unit.		We confirm that National Guidelines are being adhered to and are available to steer best practice. Clinicians are up to date with CPD/Appraisal. One of our anaethetists is the Critical Care Regional Network Lead and therefore our link to national and regional work is more timely and linked.		Kate Wood, Associate Medical Director		Completed Revised target of 30 June 2015 agreed	Evidence that twice daily ward rounds are taking place.	Clinical Audit Report via ITU Audit Staff	
		Review delayed discharges from the ITU in terms of the negative impact this can have on patients.		The review of any delayed discharge takes place triggered by the unit managers, with managers presenting to the Critical Care Group and the Terms of Reference are being revised to reflect this. Reporting mechanisms are set up with ward managers and data analysts to ensure that delayed discharges are being captured and analysed. A handover document for ITU patients to ward doctors has been developed and been ratified by the S&CC Govenance Group to ensure that movement of patients from ICU are medically led with robust handover for appropriate ongoing care.		Kate Wood, Associate Medical Director		Completed	Evidence of the log of delays and the review of these.	Evidence Log (Monthly) Minutes of the Critical Care Delivery Group Meeting (Monthly) Minutes of Discharge and Transfer Group (Monthly)	

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		Ensure that the designation of the specialty of some medical wards reflect the actual type of patients treated.		As above.		Oltunde Ashaolu, Associate Medical Director		Completed	Reduction in the number of patient moves due to capacity.	KPI59 (Monthly) Minutes of Discharge and Transfer Group (Monthly)	
I3	Response to Incidents	Minimise the movement of patients from critical care areas to general wards during the night.	The Discharge & Transfer Group are taking forward this work.	KPI agreed and monitored via the QDP at QPEC. The Discharge and Transfer Group are also providing regular updates to QPEC.	Karen Griffiths, Chief Operating Officer	Karen Fanthorpe, Deputy Chief Operating Officer	31 March 2015	Completed	Reduction in patient moves	KPI59 (Monthly) Minutes of Discharge and Transfer Group (Monthly)	QPEC
I4	Response to Incidents	Establish a formal mechanism for handing over ITU patients to junior doctors when patients return to the wards.	Being picked up as part of review of ITU.	Dr Jerry Thomas is the Trust Lead for this action and it linked into the Critical Care Group. Dr Thomas has produced a cross trust document which is being discussed at the Critical Care Group on 27 February 2015. The handover document has been agreed and ratified through S&CC governance and is being implemented through both Intensive Care Units.	Karen Griffiths, Chief Operating Officer	Kate Wood, Associate Medical Director	31 August 2014 (Review Complete) 1 September 2014 to 31 March 2015 (Implementation Phase)	Completed	As above	As above	QPEC
I5	Response to Incidents	Review the HDU facilities for patients who step down from ITU in order to ensure that these are appropriate and responsive.	Being picked up as part of review of ITU.	In DPOW the intensivist cover to MHDU was increased from 1 April 2015 to facilitate twice daily ward rounds during the week. The same has been implemented in SGH critical care from 1 May. With regard to SGH HDU facilities, an option appraisal document has been developed with the medical and surgical teams. This work will support the Healthy Lives, Healthy Futures programme.	Karen Griffiths, Chief Operating Officer	Kate Wood, Associate Medical Director	31 August 2014 (Review Complete) 1 September 2014 to 31 March 2015 (Implementation Phase)	Completed	As above	As above	QPEC
CQC15	CQC	Ensure the availability of emergency theatre lists is improved at SGH. (These lists are already in place at DPOW).	There is currently capacity for all day CEPOD lists 2/3 times per week. Plans are in place to ensure there is capacity and provision 7 days per week, by changing current theatre timetables and job planning.	Additional resource has been provided as part of the Resiliance monies to enable additional lists to be put on. Theatre timetables were adjusted to allow implementation on 24 November for Medical Staff. Recruitment to substantive theatre staff posts needs to take place to ensure that this remains robust. All day emergency lists are now available.	Karen Griffiths, Chief Operating Officer	Claire Phillips, General Manager/ Kate Wood, Associate Medical Director	31 August 2014 (Review Complete) 1 September 2014 to 31 March 2015 (Implementation Phase)	Completed	Availability of emergency theatre lists.	Theatre lists Resiliance KPIs (To be inlcuded in KPI list from February 2015)	QPEC
CQC16	CQC	Review the environment/ layout of the accident and emergency department at SGH so that it can meet the needs of children and patients with mental health needs.	There is a short term plan in place for reconfiguration of the environment in A&E at SGH to convert office space to additional clinical space and the project brief has been agreed. The longer term plan is to expand the footprint and further reconfigure the department and this is included in the overall SGH reconfiguration plans. A&E performance action plan is also in place and ongoing.	The initial works are complete which have provided additional majors rooms and a segregated paediatric waiting area. Phase 2 commences in the near future to create an ambulance handover bay. Design works for a complete new Emergency Centre have commenced with a planned build date for 2017. New plans take into consideration paediatrics and mental health patients with staff and patient engagement planned. Conversations have taken place with Healthwatch to enlist their support with understanding the failings of the current environment and patient views to enable this intelligence to be built into the plans. This work is currently on hold due to the work taking place with regard to HLHF.	Karen Griffiths, Chief Operating Officer	Peter Bowker, General Manager/ Amanda Jackson, Head of Childrens Nursing	31 March 2015	Completed	Environment/ layout appropriate.	Work signed off as complete	QPEC

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CQC17	CQC	Review the location and facilities with the birthing room at Goole District Hospital and ensure that these are risk assessed.	The risk assessment in respect of the birthing room at Goole has been re-visited to ensure that the area is safe. Longer term actions in respect of re-configuration and relocation to be confirmed.	Risk assessment completed. All actions have been addressed except for one relating to the birthing pool. The pool is currently out of action until this has been resolved. The patient information leaflet and guidelines associated with the unit have been reviewed and extensive discussions take place with mothers to ensure that they are aware that the facility is a home birth unit. The Women and Children's Team are working with the Estates Team to agree a quote to extend the room to alleviate the risks identified.	Karen Griffiths, Chief Operating Officer	Julie Dixon, Head of Midwifery	01 October 2014	Completed	Risk assessment undertaken. Audit demonstrates that risk assessment of women has taken place.	Copy of Risk Assessment (March 2014) Clinical Audit (March 2014)	TGAC
D2	Deanery Report	Patient Safety - Clinical Supervision	The Trust should ensure that the single point of access team is aware of relevant admission protocols, specifically to ensure that children under 5 are not admitted under surgery.	The single point of access has been taking surgical referrals since mid-March. The process is now well established. If a GP wants surgical advice, the call is transferred to the duty middle grade of the appropriate specialty. Protocols for the under 5's are in place. The Trust is also engaged in the regional work currently taking place reviewing paediatric surgery. The Trust is involved in the work being undertaken by the Regional Team to agree guidance in paediatric surgery which may required further changes in the future. Following discussions with the Deanery, this action has been removed from their system.	Karen Griffiths, Chief Operating Officer	Claire Phillips, General Manager/ Kate Wood, Associate Medical Director/ Amanda Jackson, Head of Children's Nursing	31 July 2014	Completed	Evidence that children under 5 are not being admitted inappropriately	Survey of Trainees (6 monthly)	QPEC
D7	Deanery Report	Patient Safety - Induction	The Trust must ensure that all protocols/ guidelines, including induction information, are consolidated in one place on the intranet and are publicised to Trainees.	The Trust has a well established document control process and all documents are on the Trust intranet. To support the trainees in navigating around the system, a leaflet has been produced which is provided to them at induction. The Trust has also purchased IGNAZ which is an app that trainees can access via their mobile phones and should provide essential information that trainees would find useful. To populate IGNAZ Lynn Young has written to Clinical Leads asking them for their top 3 guidelines/protocols to be made available via the APP.	Wendy Booth, Director of Performance Assurance/ Lawrence Roberts, Interim Medical Director	Lynn Young, Trust Medical Education Manager/ Jeremy Daws, Head of Quality Assurance	31 July 2014	Completed	Details of where on the intranet the protocols/ guidelines are stored and how this is publicised to Trainees.	Survey of Trainees (6 monthly)	QPEC
D24	Deanery Report	Support and Development of Trainees, Trainers and Local Faculty	Identify good practice from one site and implement this Trust-wide, for example, handover at Scunthorpe medicine, timetabled theatre time for FY2 Trainees at DPOW hospital.	Since the introduction of the new clinical leadership structure, there are a number of examples where good practice has been shared. Associate Medical Directors and Clinical leads to be asked to provide evidence of where good practice has been shared and incorporated. No examples to date collated. To discuss with PR & Comms team for help in identifying from recent news releases.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Clinical Leads	31 July 2014	Completed	Documented evidence that joint processes are being instigated, for example, handover procedures. 90% of compliance with NICE guidance.	KPI03 (Monthly)	QPEC
CARING											
Eliminating Mixed Sex Accommodation											
CQC18	CQC	No issues. Patients were observed being treated with compassion, dignity and respect.	There is ongoing monitoring and testing of the arrangements in place to ensure compliance with EMSA requirements.	Ongoing monitoring of this continues. The Trust continues to maintain single sex accommodation standards. Occurrences are subject to an RCA investigation. The Enter and View visit for Dignity & Respect at SGH did not identify any MSA issues.	Karen Dunderdale, Chief Nurse	Tara Filby, Deputy Chief Nurse	Immediate and Ongoing	Completed	Zero cases of mixed sex accommodation breaches	KPI29 (Monthly) MSA Report (Quarterly)	QPEC
Dementia											

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CQC19	CQC	Review access to and attendance at Dementia Awareness training for staff working with people who live with Dementia.	This training is already mandatory and a significant number of staff have already been trained. Different methods of providing this training (eg, at the bedside are currently being implemented. Attendance will be monitored as part of the wider monitoring of mandatory and essential training.	Three tiers of dementia training are being delivered across the organisation. Tier 1 dementia awareness training is currently being mapped to OLM to form part of a bundle of Essential Training for all front line clinical staff. The mapping of the competencies to relevant staff continues to enable the Trust to be able to report on the percentage of staff trained. Different ways of achieving Tier 1 training is currently being explored. The HEE Lifelong Learning Lead announced that the Trust has been set a target of reaching 80% of relevant staff having Tier 1 training by 31 March 2018. To ensure that the Ttrust delivers this, a stepped target for the training is currently has been agreed as follows:- 45% by December 2015 60% by December 2016 80% by December 2017. At the end of March, the tier 1 dementia awareness training figure had risen to 37% from 19%. As at the end of April 2015 compliance with training had reached 46% As of the end of May 2015 this had risen to 49% of staff trained in tier 1 dementia awareness.	Karen Dunderdale, Chief Nurse	Rachel Greenbeck, Quality Matron	31 March 2018	Completed	80% of relevant staff to have received Tier 1 dementia training by December 2017.	KPICB17 (Monthly) Dementia Report (Quarterly) NMAF Minutes (Monthly)	QPEC
Friends and Family Test											
CQC20	CQC	Review the use of the Family and Friends Test, to improve uptake and completion across departments.	The FFT action group is reviewing ward level response rate data to target specific wards.	Ward level data on FFT response rates is provided to all wards on a regular basis. This information is also included in the monthly Quality Report. Significant effort has gone into improving response rates in A&E and additional promotion with posters and bespoke FFT stands being implemented. Specific areas with a low response rate are being targetted to identify actions to be put in place. Additional large posters are being put up in both A&Es which include a QR code which will allow smart phone users to utilise it as another methodology. Quality comments are now being sent out to all groups to share and action. There are improvements noted in some of the areas of concern and support continues to be offered. The individual results for each ward area and sent to the Ward Manager who displays this on the Quality Wall Board. A review of the methodology for collecting the FFT data is underway and is expected to conclude end of September 2015.	Karen Dunderdale, Chief Nurse	Jo Loughborough, Quality Patient Experience Practitioner	Immediate and Ongoing	Completed	Achieve response rate of the following for each of the areas:- 40% for in-patents; 20% for accident and emergency.	KPI1(2a) KPI1(2b) (Monthly) Quality Report (Monthly)	QPEC
CQC21	CQC		Move to in-house analysis to give timely update to wards/ departments.	The Trust is no longer out-sourcing this work to an external provider. A meeting is planned to confirm the financial proposal for resources needed to provide in house FFT management. A Business Case is being developed to identify the resources required to sustain the analysis of FFT. Analysis continues to be undertaken in-house with support from a HCA on the bank.	Karen Dunderdale, Chief Nurse	Jo Loughborough, Quality Patient Experience Practitioner	31 December 2014	Completed			QPEC

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CQC22	CQC		Collection methods increased and technology to be used to support.	Netcall was implemented in October 2014 and this has impacted on the response rates in A&E. Additional technologies are being explored to provide other collection points. An additional web platform is being explored which could be used on tablets and toughbooks across the Trust. The cost for the new platform has been confirmed and now be considered. The issues identified for this action will be included in the review for CQC20.	Karen Dunderdale, Chief Nurse	Jo Loughborough, Quality Patient Experience Practitioner	Immediate and Ongoing	Completed			QPEC
Patient Understanding											
EVDR1.1	Enter and View Dignity and Respect Report	Patients not always being introduced to staff caring for them, specifically medical staff.	Ensure yellow name badges fully rolled out to front-line staff where not yet worn.	Discussed at the QDP update meeting and the Chief Operating Officer has advised all General Managers to collate orders via procurement to ensure that all front line staff have a name badge in situ. In future this will be picked up as part of the recruitment process. It is anticipated that the additional badges will be distributed by the end of May. Dress Policy to be updated. A decision has been made by Executive Team that all staff, not just those who are patient facing should now have yellow name badges. The issue in relation to supplies of the badges being delayed has now been resolved. Control mechanisms for ensuring that name badges are recalled once staff leave the Trust are being reviewed.	Karen Griffiths, Chief Operating Officer	General Managers	31/03/2015 Revised timescale of 31 May 2015	Completed process in place - monitoring continues.	All appropriate staff wearing yellow name badges.	CQC Mock Visit	QPEC
EVDR1.2	Enter and View Dignity and Respect Report		Refresh and re-launch Hello My Name Is campaign.	The refresh and re-launch has taken place and was timed to co-incide with national re-launch.	Karen Dunderdale, Chief Nurse	Operational Matrons/ Communications Team	28 February 2015	Completed	Reduction in complaints where this is a theme.	Complaints Report	QPEC
EVDR1.3	Enter and View Dignity and Respect Report		Names nurse/clinician board to be installed above every bed space.	Named nurse boards in place and in use on many areas. Orders placed for additional boards where required. These were received and have been installed in the majority of areas. Monitoring whether these are being used appropriately is now taking place.	Karen Dunderdale, Chief Nurse	Operational Matrons	31 January 2015	Completed	Feedback via the Matron's Forum	Minutes of the Matron's Forum	QPEC
EVDR2.1	Enter and View Dignity and Respect Report	Lack of privacy for sensitive conversations.	Remind staff that when a patient is fit to take to an alternative area for such discussions, eg, a private room, then this should be undertaken.	This issue has been reinforced via the General Managers meeting. As refurbishments take place, space for relative's rooms will be considered. Additional relatives room created on C Floor at DPOW and Ward 2 SGH. The Deputy Chief Operating Officer will also re-inforce this message via the Experience Group.	Karen Griffiths, Chief Operating Officer/ Karen Dunderdale, Chief Nurse	Operational Matrons	28 February 2015	Completed	Reduction in complaints where this is a theme.	Complaints Report Matron's Dashboard	QPEC
EVDR2.2	Enter and View Dignity and Respect Report		Reinforce communication issues during the handover process between shifts.	This issue has been reinforced via the General Managers meeting and also during handover.	Karen Griffiths, Chief Operating Officer	Heads of Nursing	28 February 2015	Completed	Reduction in complaints where this is a theme.	Complaints Report Matron's Dashboard	QPEC
EVDR2.3	Enter and View Dignity and Respect Report		Review opportunities to create additional private spaces.	An additional relatives room has been created on C Floor at DPOW and Ward 2 at SGH. A review of GDH has identified no issues. SGH site has a space available near each area, some of which require refurbishment. Requests have been made to progress with this. DPOW has 3 relative rooms on the C Floor, B Floor is pending review. In the interim, the relatives rooms on C floor are available for use.	Karen Dunderdale, Chief Nurse/ Pam Clipson, Director of Strategy and Planning	Angie Davies, Assistant Director of Nursing and Head of Quality/ Kerry Carroll, Planning Manager	Ongoing	Completed	All appropriate areas to have access to a private room for sensitive conversations with patients and families.	PLACE Report	QPEC

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EVDR3.1	Enter and View Dignity and Respect Report	Terms of endearment used.	Reinforce the message that staff need to ask patients how they would prefer to be addressed.	This issue has been reinforced via the General Managers meeting. The Deputy Chief Operating Officer will also re-inforce this message via the Experience Group.	Karen Griffiths, Chief Operating Officer	Heads of Nursing	28 February 2015	Completed	Reduction in complaints where this is a theme.	Complaints Report	QPEC
EVDR5.1	Enter and View Dignity and Respect Report	Responsiveness to call bells and patient needs.	Audit the use of care rounds and take further actions as necessary.	Data collection undertaken for audit. Results discussed at Matrons Forum in January 2015 and recommendations taken to NMAF in February. Amendments have been made to the care round form and this has been uploaded and implemented. The results were positive and no major concerns in relation to responsiveness to call bells were identified.	Karen Dunderdale, Chief Nurse	Quality Matrons	28 February 2015	Completed	Decrease in number of issues raised by patients/relatives of call bells not being answered	Care Round Audit	QPEC
RESPONSIVE											
Improved Patient Flow											
CQC23	CQC	Ensure that there is an improvement in the number of Fractured Neck of Femur patients who had surgery within 48 hours.	This is primarily an SGH issue and is linked to the improved use of trauma lists and will be resolved as part of ongoing fracture neck of femur pathway work.	Best practice tarrif has reduced this target from 48 hours to 36 hours. The monies agreed with commissioners as part of the resiliance funds will enable additional theatre sessions to further support this action. A review of effectiveness of the use of all unplanned lists is a feature of service improvement team theatre review.	Karen Griffiths, Chief Operating Officer	Kate Wood, Associate Medical Director	31 October 2014	Completed	75% of patients to be operated on within 36 hours.	KPI53 (Monthly)	QPEC
CQC24	CQC	Review the effectiveness of handovers, particularly in the medical services.	Observational audits in place and ongoing. Testing also occurs as part of the Director Visits and the CQC Mock Visits.	Observational audits, Director visits and mock CQC visits continue to take place. Ad hoc reviews by the Groups continue. The recent Deanery visit showed improvements had been made in this area but it remains an area which the Trust wishes to further develop.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors	31 August 2014	Completed	Audit demonstrates that handover is taking place appropriately.	Observational Audit by Groups Director Visit Report (Quarterly) CQC Mock Visit Report (Quarterly)	QPEC
IC6	Response to Incidents										
CQC25	CQC		Effectiveness and embedding of handover (as evidenced by documentation of handover) to be added to the clinical audit programme.	This is on the programme and the Quality and Audit Manager is currently working with the General Managers to determine the most effective way to support the groups in this area. AMDs also attend handovers to observe and ensure this happens.	Wendy Booth, Director of Performance Assurance/ Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors	30 September 2014	Completed	Audit demonstrates that handover is taking place appropriately.	Clinical Audit (Q1 2015/16) Director Visit Report (Quarterly) CQC Mock Visit Report (Quarterly)	QPEC
D3	Deanery Report	Patient Safety - Handover	The Trust to continue to implement the e-handover system to ensure consistent handover practices across the Trust. (Trustwide)	The project scoping work has now been completed and work has commenced to develop the system. Once fully developed this will be reviewed and signed off by senior doctors and be rolled out by 31 December 2014. Sufficient time for handovers now in place, awaiting on development of E Handover.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Karen Wilson, General Manager/ Ian McNeil, Clinical Lead for Anaesthetics	31 July 2014	Completed (implementation phase commenced)	Evidence from rotas that handovers and ward rounds are not overlapping and causing confusion for Trainees. E-handover in place.	Observational Audit by Groups Survey of Trainees (6 monthly)	QPEC

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D4	Deanery Report	Patient Safety - Handover	The Trust to review the number of handovers in Medicine at Scunthorpe and how ward rounds are managed in conjunction with these. (Medicine SGH)	This relates to a specific incident. If the Deanery are able to provide us with further information we will investigate accordingly. No additional information has been received from the Deanery and this cannot be found on their Quality Management Action Plan follwoing the visit. To be discussed further with the Deanery with a view to closing this action. 11-Feb-15: Deanery agreed to close this action as no further steps can be taken.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Karen Wilson, General Manager/ Ian McNeil, Clinical Lead for Anaesthetics	31 July 2014	Completed	Confirmation that inappropriate comments are not being made in Handover meetings relating to Trainees who are not present.	Observational Audit by Groups Survey of Trainees (6 monthly)	QPEC
D5	Deanery Report	Patient Safety - Induction	The Trust to review the Trust induction for Trainees who have an intermediate start date and for Foundation Trainees whose first placement is in a community setting. (Trustwide)	A process has now been agreed and put into place to identify trainees who have an intermediate start date to ensure that they receive a comprehensive induction to the Trust and their Department. For those whose first placement is in a community setting they will attend the Trust Induction at the onset of their post and this will be followed by a departmental induction when they commence their hospital posts. Additional testing needed through further trainee surveys.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer/ Neil Pease, Director of OD and Workforce	Ian McNeil, Director of Medical Education/ Harriet Stephens, Head of Education, Training and Development/ Lynn Young, Trust Medical Education Manager	31 July 2014	Completed	A copy of the reviewed induction processes for Trainees starting at intermediate points or whose placement is in the community.	Survey of Trainees (6 monthly)	TGAC
D15	Deanery Report	Support and Development	The Trust to ensure that time for handover is built into rotas. (Trustwide)	The Trust can confirm that although not specified specifically, time is allowed in the rota for handover to take place.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Karen Wilson, General Manager/ Ian McNeil, Clinical Lead for Anaesthetics	31 July 2014	Completed	A copy of the monitoring/ documentation reporting process and copies of the information submitted by trainees.	Observational Audit by Groups Survey of Trainees (6 monthly)	QPEC
CQC26	CQC	Review 'did not attend' and waiting times in outpatients' clinics and put in steps to address issues identified.	In respect of DNA rates, the Trust has a work programme in place to implement an SMS reminder system.	The SMS reminder system was rolled out to 16 specialities across medicine and surgery on the 29th of June 2015. The service is providing a reminder 7 days and 2 days prior to a clinic appointment. At present there is no definitive data on the impact as a larger sample size across the new specialities is required to measure against the baseline data already available. We are initially expecting a limited impact as it has been identified that the number of patient records with accurate mobile phone numbers is poor across the trust, therefore we are only targeting 15-20% of patients in each speciality. Work is ongoing to ensure we have up to date records for each patient that attends to increase the numbers of patients that we can reach.	Pam Clipson, Director of Strategy and Planning/ Karen Griffiths, Chief Operating Officer	Karen Wilson, General Manager	30 September 2014	Completed	DNA rate in out-patients (target to be agreed. Waiting time whilst in out patient department. Patient feedback	KPI64 (Monthly) Mock visit process (Quarterly) Out patient Friends and Family Test Results Quality Report (Monthly)	QPEC
CQC27	CQC		Plans remain in place including weekly meetings between the central Data Quality Teams and the Group Business teams to ensure that there are robust arrangements in place for the management and monitoring of the waiting lists / Patient Tracker Lists (PTLs) and waiting times in all specialties.	A new and robust structure has now been implemented across the groups which ensures business groups, performance and the Executive Team are fully engaged with the 18 week performance process. Business Groups now have weekly internal specialty based performance meetings, and DQ support these meetings if and when required. The Head of Performance meets with AGMs / Group Managers every week to go through performance / waiting lists / DQ issues etc. A weekly report is sent to ET. Following an 18 week mapping session, it has been agreed that the Head of Performance will meet with ACOOs on a fortnightly basis to ensure actions are being progressed.	Karen Griffiths, Chief Operating Office/ Pam Clipson, Director of Strategy and Planning	Sarah Coombs, Service Development Manager	Immediate and Ongoing	Completed			QPEC

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CQC28	CQC		An external review is also being arranged to review the adequacy of the Trust's arrangements for the management and monitoring of the waiting lists / PTLs across all specialties and to provide the necessary assurances internally and externally.	The Trust has not been able to source independent review however has acted upon both audits undertaken by - Developing a pilot for centralised referrals received into the Trust , the pilot has undertaken some initial reflection after operating since Oct 14 and feel the target of appointments received to going onto a system with 24hrs for medicine and surgery has achieved its aim and therefore will continue - 4 eyes consulting has also work with the Trust to understand how clinical admin functions can be improved and wrap around the patient. A business case has been approved at ET 10/2/15 and the work will progress to resdesign admin functions with benefits and outcomes developed as part of the implementation plans monitored via the Trust sustainability programme - - DQ teams continue to validate PTL meeting with operational group reps weekly. The 45 day consultation with regard to the new clinical administrative process commenced on 5 May 2015.	Pam Clipson, Director of Strategy and Planning/ Karen Griffiths, Chief Operating Officer	Not Applicable	31/12/2014 The above deadline has been revised due to work taking place as part of the Sustainability Plan - revised date to go live is 1 November 2015. **It should be stressed that actions have been taken to strengthen the management and monitoring of waiting lists/ PTLs. This further work relates to the wider review of clinical administration which will further strengthen these arrangements.**	Completed and Ongoing			QPEC
				Update as at 30/11/15 - Weekly meetings have taken place following the clinical admin consultation to support the transition from the end of the consultation until implementation. Go live went ahead on 23 November 2015 and the transition into new work which will evolve and include SATs being responsible for PTL management. Following the CQC visit, the COO has chaired bi-weekly meetings that have focussed on processes and patient admin models in order that review has been considered in line with the clinical admin transformation. A detailed action plan of the work schedule and progress is taken weekly to ET.							
				The Central Referral Gateway (CRG) has been implemented. This establishes a single point of entry for Trust referrals ensuring all referrals are logged onto the system within 24 hours. Informal feedback received is that the new processes are working well, however, this will be formally evaluated. Update as at 30/11/15 - The work of the CRG will transition in a phased approach to the new SATs. There will still be a single point of contact for GPs in order to offer a referral to.	Pam Clipson, Director of Strategy and Planning/ Karen Griffiths, Chief Operating Officer	Sarah Coombs, Service Development Manager	31 October 2014	Completed			QPEC
CQC29	CQC		Where appropriate, discussions are underway with Commissioners.	Pressures, across both planned and unplanned specialties are being escalated and action agreed through NEL and NL Operational Resilience Structures. Discussions with commissioners continue to take place at service development/review level, eg, SUDIC. A Planned SRG Group with NEL has been developed to review specialties which are exceeding wiating times and to identify reasons for this including demand. In North Lincs work is underway to develop a new model of diabetes care which will result in some patients being returned back to the care of Primary Care. This could be a model for other specialties.	Pam Clipson, Director of Strategy and Planning/ Karen Griffiths, Chief Operating Officer	General Manager an identified clinical representatives for the specialties	Ongoing	Completed and Ongoing			QPEC

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D12	Deanery Report	Patient Safety	The Trust must ensure there is a robust process in place for identifying where medical outliers are within the hospital and that it is communicated to all relevant parties. (Trustwide)	Patients can be identified by Consultant on the WebV screen. SGH general medical handover is used to discuss outliers and who is taking responsibility. Outliers including consultant and location displayed within Ops Centre at DPoW and email sent to Consultants. Consistency in processes being addressed through Discharge and Transfer of Care Group. Evidence submitted to the Deanery has assured them to close this action.	Karen Griffiths, Chief Operating Officer	Graham Jaques, Operations Centre Manager/ Simon Buckley, Operations Centre Manager	31 July 2014	Completed	Confirmation of the process in place for identifying the location of medical outliers at DPOW Hospital. (Handover which includes identification and management of outliers are scanned and saved by the medicine group).	Copy of Process (March 15) Discharge and Transfer Group Minutes (February 15)	QPEC
D13	Deanery Report	Patient Safety	The Trust to determine who manages the medical outliers and that this is explicit. (Trustwide)	At DPoW the Medical responsibility remains with the Consultant who the patient is currently under, when patients are transferred as outliers to Surgery then they are hosted in one ward. At SGH a 'buddy' system is used dependent upon which surgical area patients are outlied to. Consistency in processes being addressed through Discharge and Transfer of Care Group. Evidence submitted to the Deanery has assured them to close this action.	Karen Griffiths, Chief Operating Officer	Graham Jaques, Operations Centre Manager/ Simon Buckley, Operations Centre Manager/ Associate Medical Directors	31 July 2014	Completed	Decision on who manages the medical outliers.	Copy of Process (March 15) Survey of Trainees (6 monthly)	QPEC
Senior medical involvement out of hours											
CQC30	CQC	Review the on-call medical rota covering patients admitted with gastrointestinal bleeding (GI bleed).	Plans are in place to ensure the provision of this service on both sites. Consultation underway.	A review of the on call rota has allowed us to identify whether there is a physician or surgeon already available on one of the main sites who would be able to undertake a therapeutic scope. Where there is an evening or weekend slot which is not already covered by one of these clinicians, specific arrangements are then made to put the necessary cover in place by agreeing an additional on call with one of these consultants. An on call rota for nursing support has also been put in place – because the majority of physicians/surgeons covering the rota are doing so at DPOW, the majority of the nursing cover is also drawn from the DPOW based team. Information about who is covering the on call has been shared with both Ops Centres so that they are available in the event that they need to be activated. A draft policy written by the AMD for Medicine for the Management of Upper GI Bleeds has been circulated to all clinicians involved in scoping Upper GI Bleed patients. This will be offered as a final document to medicine, surgery and clinical support services governance groups asap and then uploaded onto the intranet as a controlled document. The longer term solution is going to strategy and planning on 29 June. The Re Shaping Endoscopy paper has been completed and will be presented at Strategy and Planning.	Karen Griffiths, Chief Operating Officer / Lawrence Roberts, Interim Medical Director	Tracey Broom, General Manager	30 September 2014	Completed	Rota reviewed and in place.	Copy of rota	QPEC
CQC31	CQC	In some areas, in particular the medical wards, the CQC commented that the Trust was not able to offer a seven-day service and there were times when patients had to wait over a weekend or bank holiday to access some tests and scans. Additionally, medically input on wards was poor over bank holidays periods with some	Access to diagnostics is available 7 days a week including bank holidays. All in-patients are prioritised over the weekend and on a bank holiday in order to support diagnosis and timely discharge. The Trust will review the specific areas / services where this may not be currently available e.g. medical physics and action will be taken accordingly.	The review has been undertaken and has demonstrated that endoscopy is an issue. Further to this a capacity and establishment review is being undertaken to support the gap analysis. Staffing levels have been assessed against demand and recommended JAG staffing levels. A Re Shaping Endoscopy paper is due to be presented at the Strategy and Planning meeting.	Karen Griffiths, Chief Operating Officer	Tracey Broom, General Manager	30 September 2014	Completed	KPIs will be identified once the report of the gap analysis from the regional project has been received.	Copy of gap analysis included within 7 day report	QPEC

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IC2	Response to Incidents	patients not being seen by a doctor until after the holiday.									
CQC32	CQC		Review the levels of medical cover to all wards including out of hours, bank holidays and weekends.	All groups have submitted relevant details to the Chief Operating Officer who is in the process of collating and checking this information. The Trust has taken part in the regional 7 day working project led by ATOS which includes a gap analysis against the 10 national standards. The outcomes from the gap analysis and recommendations for further work were submitted to the Chief Executive in November 2014. The Transfer and Discharge Group have picked up the 8 high impact actions issued by NHSE in April which suggest that Trusts should achieve 80% of their weekday discharges at a weekend.	Karen Griffiths, Chief Operating Officer	Karen Fanthorpe, Deputy Chief Operating Officer	30 September 2014	Completed	Review to be undertaken.	Copy of review	QPEC
D27	Deanery Report	Patient Safety	Review protocols around reporting of CT Scans out of hours in a set timeframe and implement changes to ensure that all patients who require thrombolysis receive the treatment.	All of our out of hours CT scans are reported by 4ways. They have reassured us that they can turn round the stroke head reports quickly and we get a quality audit report from them which enables us to monitor their turn around times. Q1 report shows turnaround times as 80% within 30 minutes and 100% with 1 hour. Based on the Stroke Unit accreditation the Deanery have indicated that they are satisfied that this action has been dealt with.	Karen Griffiths, Chief Operating Officer	Tracey Broom, General Manager	31 July 2014	Completed	Documented evidence that Radiologists report on CT Scans out of hours to a set timeframe.	Audit (May 2015)	TGAC
WELL LED											
Improved Clinical Leadership											
CQC33	CQC	The new clinical leadership structure needs embedding and need for behavioural change in respect of some medical staff in some areas (as highlighted in verbal feedback from the CQC) needs to be addressed. ("In some areas there was a lack of medical leadership and direction, particularly end of life and critical care services".)	Review of leadership opportunities for Consultants to be undertaken.	The Medical Director is currently identifying trust and regional projects which Consultants can take part in as development opportunities to support with succession planning. Some consultants are also attending the Leadership Programme at Sheffield Hallam to prepare them for a future leadership role. A succession planning exercise is currently being undertaken through the workforce planning function relating to forecasting retirements and future hotspots in recruitment. This also links to the Leadership Development Programme being undertaken in conjunction with Sheffield Hallam University.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer/ Neil Pease, Director of Organisational Development and Workforce	Associate Medical Directors/ General Managers	31 December 2014	Completed	Review to be undertaken.	Copy of review	QPEC
I11a	Response to Incidents										
CQC34	CQC		Specific concerns to be addressed with individual clinicians, as appropriate.	Issues will be dealt with appropriately as and when they arise.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors/ General Managers	Immediate and Ongoing	Completed and Ongoing	50% reduction in incidents by 31 March 2015 relating to areas of Zero Tolerance if applicable.	KPI 10 (Monthly)	QPEC
CQC35	CQC		'Zero Tolerance' Framework to be strengthened and enforced and appropriate actions taken.	The Zero Tolerance Framework has been re-enforced at Trust Management Board. A review has been undertaken which and some amendments were identified. Discussions are taking place to ensure that this is operationalised. Issues are raised during consultant discussions and through Governance Meetings and Trust Governance and Assurance Committee.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer/ Wendy Booth, Director of Performance Assurance	Associate Medical Directors and General Managers	31 September 2104	Completed	50% reduction in incidents by 31 March 2015 relating to areas of Zero Tolerance if applicable.	KPI 10 (Monthly)	QPEC
I8	Response to Incidents										

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CQC36	CQC		Multi-disciplinary Clinical Leadership Development Programme agreed and in place for AMDs / Clinical Leads.	Programme for the AMDs and Clinical Leads is in place and commenced on 1 October 2014. The course leaders met all the participants and undertook pre course diagnostics. The course has been completed and is currently being evaluated through post course diagnostics, a report will be available later in the year. Planning for a further course is being explored.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors and General Managers	Immediate and Ongoing	Completed and Ongoing	All appropriate AMDs and Clinical Leads to have attended development programme.	KPI90 (Monthly)	QPEC
I11b	Response to Incidents										
CQC37	CQC		External validation of implementation and effectiveness of new clinical leadership structure commissioned from KPMG – underway.	The review is complete and the recommendations arising from the plan have been incorporated into the Trust Quality Development Plan.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Not Applicable	31 August 2014	Completed	Review to be undertaken.	Copy of review	QPEC
CQC38	CQC		Clinical leadership KPIs drafted: as a sub-set of the wider Trust quality KPIs and KPIs in order to assess the impact of change over time.	These are included as part of the wider KPI reporting.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors	31 July 2014	Completed	Inclusion of the Clinical Leadership KPIs in the Trust Quality Indicators	See Trust Quality Indicators (Monthly)	QPEC
CQC39	CQC		Trust to act on feedback from Junior Doctors including development of Junior Doctors Forum.	The informal Junior Doctor Forum continues to meet and work is taking place at the moment to pull together some of the issues which have been dealt with via this forum to demonstrate that doctors views are listened to and actioned where appropriate.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Ian McNeil, Director of Medical Education	30 September 2014	Completed	Forum in place.	Minutes of Forum	QPEC
D25	Deanery Report		Review the effectiveness of Junior Doctor Forums. (Trustwide)	The informal Junior Doctor Forum continues to meet and work is taking place at the moment to pull together some of the issues which have been dealt with via this forum to demonstrate that doctors views are listened to and actioned where appropriate. Evidence submitted to the Deanery has assured them to close this action.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Ian McNeil, Director of Medical Education	31/07/2014 CQC Target Date 30 September 2014	Completed	Feedback from Junior Doctor Forums is listened to and acted upon if appropriate.	Survey of Trainees (6 monthly) Minutes of Forum (February 15)	QPEC
CQC40	CQC		Associate Medical Directors and Clinical Leads to continue to support pathway re-design as part of Sustainable Services Review.	Associate Medical Directors and Clinical Leads continue to support and attend meetings as necessary. Work is underway in cardiology and haematology in terms of service re-design for the future. The Associate Medical Director and Clinical Leads are involved in this work. One of the Deputy Medical Directors is leading the Clinical Group for maternity, the next one is scheduled for March 2015.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors	Immediate and Ongoing	Completed and Ongoing	75% of SSR meetings to have doctor attendance	KPI82 (Monthly)	QPEC
D17	Deanery Report	Patient Safety - Clinical Supervision	The Trust must ensure that FY2 trainees are not discharging patients without prior senior review, or at a minimum a discussion with a more senior surgeon if a physical review is difficult, for instance by the registrar being in theatre. (All Groups Trustwide)	This relates to a specific incident. If the Deanery are able to provide us with further information we will investigate accordingly. From the evidence submitted to the Deanery, this action has been closed.	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors	31 July 2014	Completed	Written confirmation from the Trust that this practice has ceased.	Survey of Trainees (6 monthly) Discharge and Transfer Group Minutes (February 15)	QPEC
EVDR4.1	Enter and View Dignity and Respect Report	Concerns around discharge planning and information	Issues to be reviewed by the Discharge and Transfer group for further action.	The Discharge and Transfer Group has been reviewed and membership and focus have been refreshed. The issues identified by the Enter and View visit will be included in their work programme.	Karen Griffiths, Chief Operating Officer	Karen Fanthorpe, Deputy Chief Operating Officer	31 March 2015	Completed		Discharge and Transfer Group Minutes	QPEC

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EVDR4.2	Enter and View Dignity and Respect Report		Develop a discharge information booklet.	Discharge information booklet drafted and circulated for comments. This is entitled 'Planning Your Dischage From Hospital'. It has been approved at the Group Governance Groups and is going to the Information for Patients Group for approval on 8 May following which, the leaflet will be implemented. Following this meeting it was circulated for futher comments. None were received and it it is to be taken to the July meeting for ratification.	Karen Griffiths, Chief Operating Officer	Karen Fanthorpe, Deputy Chief Operating Officer	31 March 2015	Completed		Discharge and Transfer Group Minutes	QPEC
D18	Deanery Report	Patient Safety - Clinical Supervision	The Trust to investigate the report that trainees are being pressurised into seeing patients. (Medicine DPOW)	The Trust has asked the Deanery for more specific information with regard to this issue. If necessary the Medical Director will write to all doctors outlining the Trust approach in this instance. The Trust have submitted some evidence to the Deanery with respect to this action. They have accepted the evidence and downgraded the action from red to amber but they wish it to remain open to ensure ongoing monitoring. As this is a national problem, due to pressures, this is going to be discussed with the Deanery on the 27 January 2015. 11-Feb-15: Deanery view is that their feedback has been that care of poorly inpatients has the potential to suffer from pressure to see patients in A&E. To ask the question of trainees in March 2015 at next QM visit and to determine "is it any worse at NLAG than other Trusts/National picture?"	Lawrence Roberts, Interim Medical Director/ Karen Griffiths, Chief Operating Officer	Oltunde Ashaolu, Associate Medical Director	31 July 2014	Completed	Investigation findings and action plan.	Survey of Trainees (6 monthly)	Resources Committee
CL1	KPMG Clinical Leadership Report	Capability to drive the quality agenda.	The Trust should ensure that the 'Dragons Den ' forum encourages staff from all clinical and non clinical groups to propose innovative ideas to support the pace and scale of quality improvement in the Trust.	One 'Dragons Den 'event was held in August 2014 with more now planned. The event has received a great deal of publicity which can only help in the promotion of future events. The initial 'Dragons Den' received a mix of clinical and non-clinical applicants with a full lecture theatre audience in attendance. Each project is well underway from concept to full implementation. The second Dragons Den was held in November 2014 with the same successes from the first event. The schemes put forward in phase 1 continue to make progress. Dragons Den phase 3 is being scheduled for March 2015.	Neil Pease, Director of OD & Workforce	Simon Dunn, Assistant Director of OD and Workforce	31 December 2014	Completed	Staff submitting ideas for Dragon's Den come from a wide variety of clinical groups.	Review of Dragons Den Vision and Values Report (Quarterly)	QPEC
CL2	KPMG Clinical Leadership Report	Triggers to drive change	The Medical Director (MD) should ensure that the recently implemented clinical leadership arrangements encourage role development and autonomy at all levels and allow this structure further time to embed into the organisation.	Existing arrangements to support the current leadership structure will be augmented by a new MD structure to include medical leadership and managerial support to the MD (proposals were ratified by the Executive Team on 15 September 2014). This will embed leadership accountability, distributed leadership support for autonomous decision making and project management resource. The leadership development programme commenced in September: 2014. This has a clear focus on successful leadership behaviours and quality improvement and builds on a successful leadership programme delivered to senior non-medical staff.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	31 December 2014	Completed	New MD Structure in place. All appropriate AMDs and Clinical Leads to have attended development programme.	All posts appointed to KPI90 (Monthly)	QPEC

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CL3	KPMG Clinical Leadership Report	Triggers to drive change	The Medical Director and Board should review the current arrangements in place, and consider future requirements for Associate Medical Director (AMD) support to Therapeutics and Diagnostics Group. These arrangements will require formalising.	The proposal above includes a recommendation for augmenting the support for the Medicine AMD and leadership for diagnostics and therapeutics on top of the current clinical lead arrangements. The role of one of the newly appointed Deputy MDs will support this action. A Deputy Medical Director for Diagnositcs has been appointed.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	31 December 2014	Completed	Arrangements in place for Diagnostics and Therapeutics	All posts appointed to	QPEC
CL4	KPMG Clinical Leadership Report	Triggers to drive change	The Trust should ensure that the leadership and management structure in place for allied health professionals is formalised and complementary of the new nursing and medical structures. Fostering a leadership culture of clear accountability and inclusivity in the clinical groups will strengthen the Trust's progression of the Quality Development Plan.	The role of one of the newly appointed Deputy MDs will support this action. Clinical Leads in allied health professions have been established.	Karen Jackson, Chief Executive	Relevant Associate Medical Directors	31 December 2014	Completed	Arrangements in place for allied health professionals.	All posts appointed to	QPEC
CL5	KPMG Clinical Leadership Report	Triggers to drive change	The Trust should consider reviewing the extent to which cross site working occurs within services. Visibility of the new clinical leadership structure on all sites is important to ensure inclusive engagement of the clinical body and will also strengthen the embedment of clinical leads within the organisation.	The entire leadership structure is cross site. Team job planning will further seek to embed opportunities for cross site working into permanent staff job plans. Further work is underway to ensure clinical lead job plans contain sufficient time for travel and that their objectives to ensure quality delivery is equal between sites. The technical work required to delivery this has been completed and this is now being operationalised. Medicine are currently experiencing a worsening position with regard to clinical leadership as some consultants have resigned from this role.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	30 September 2014	Completed	Doctor attendance at relevant meetings. All clinical lead posts appointed to.	KPI82 (Monthly)	QPEC
CL6	KPMG Clinical Leadership Report	Triggers to drive change	All new clinical strategies should include consideration of a 'patient pathway walkthrough' during the development phase. This would encourage consideration of a all departments impacted by the clinical change, allow appropriate consultation to be made and avoid delays to implementation.	Clinical leads will have objectives in respect of pathway design and a clear need to work across into primary care/CCGs. Pathway redesign will also seek advantages of cross site provision. Areas where this has been used include diabetes (NL), dermatology (NL & NEL) and extensivist model (NEL). The Patient Experience Practitioner has recruited representatives of the public and patients to form a Patient Panel. One of the aims of the panel is to match the individuals to groups which require a patient rep for a patient viewpoint, eg, service developments, patient leaflet, etc. The Panel is currently writing its Terms of Reference, however, in the meantime this is covered in the Patient Experience Policy. A Frail Elderly Assessment Support Team practitioners event is due to take place on 21 May 2015 to undertake a patient walkthrough.	Lawrence Roberts, Interim Medical Director/ Karen Dunderdale, Chief Nurse/ Karen Griffiths, Chief Operating Officer	Associate Medical Directors	31 December 2014	Completed	All new strategies can demonstrate that a walkthrough has taken place.	Minutes of Meetings	QPEC
CL7	KPMG Clinical Leadership Report	Use of relevant data to support change	The Trust should consider regular Board representation at Group governance meetings to affirm the role of the triumvirates in the new leadership structure and oversee data robustness from 'Ward to Board'.	Regular meetings between the Chief Executive and Group triumverates are held. Any further required actions will be agreed following the review of quality governance at Group level. AMD and GM attends Group Governance meetings to ensure accurate communication. Arrangements to be discussed and finalised as part of the proposed review of quality governance at Group level.	Karen Jackson, Chief Executive	General Managers	31 March 2015	Completed	All groups to have undertaken a review of their arrangements.	Report of review and action plan of any actions identified	TGAC

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CL8	KPMG Clinical Leadership Report	Clinical engagement in decision making	The Medical Director should ensure that the Clinical Lead job description, job plan and appraisal encourages and acknowledges the contribution which this role has in developing, leading and delivering clinical engagement with the Quality Development Plan and Quality Strategy.	The proposed structure will include a specific role for a deputy MD to lead on Quality for the MD and a supervisory role over the proposed innovation faculty and clinical lead appraisal and performance management. The clinical leads will work with the faculty to specific projects with defined outcomes. These proposed roles will have clear links with existing quality leadership roles in the Chief Nurse Directorate and Performance Assurance Directorates, therefore ensuring existing arrangements are strengthened.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	31 December 2014	Completed	All clinical leads to have attended the development programme. Mandatory training target to be achieved for clinicians.	KPI90 (Monthly) KPI83 (Monthly) Workforce Review Group Minutes	QPEC
CL9	KPMG Clinical Leadership Report	Clinical engagement in decision making	The Trust should consider regular 'deep dives' into morale themes as a result of the barometer responses, to 'temperature check' staff resilience and well being during times of rapid pace and scale of change. Management should ensure that information and themes captured from the morale barometer and qualitative interviews is used to inform the Trust of where further cultural change work could be further developed.	A major piece of research is currently being undertaken with clinical staff around staff morale. To date approximately 60 senior clinicians have engaged with the initiative which is starting to generate several key themes which will in turn translate in to interventions/work streams. To test the arguments put forward in the research, a 360 viewpoint was sought from the management and leadership teams in late October and November with data integrated in December. The final report (which includes a series of recommendations to address the issues flagged, embed collective leadership and develop effective medical: managerial relationship) was provided to the CEO, Medical Director and Director of OD&W for consideration. In May 2015 the full report with draft recommendations/action plan was circulated under joint cover of CEO and MD to the medical and managementteams. All were invited to comment on the final report and proposed action by 12 June. From this 7 formal reposense were received. An OD, CEO and MD meeting is scheduled for 2 July from which the final action plan will be constructed and actions commence to address the issues within the report.	Neil Pease, Director of Workforce and Organisational Development	Simon Dunn, Assistant Director of OD and Workforce	31 March 2015	Completed	Improvement in the morale barometer scores.	KPI48 (Monthly) Vision and Values Report	QPEC
CL10	KPMG Clinical Leadership Report	Junior doctor engagement	The Medical Director should ensure that the Trust wide forum for the engagement of junior doctors is a regular event and that they are made aware of the timetable of meetings and have the opportunity to attend. This will encourage and strengthen the clinical voice within the new leadership structure and support cultural change efforts.	The meetings with the junior doctors are established. PGME will lead on the availability issue and the results of the meetings will feed into the quality agenda through to the clinical leads.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors/ Lynn Young, Trust Medical Education Manager	30 September 2014	Completed	Junior doctors are engaged in trust activities and feel that their views are taken into consideration.	Survey of Trainees (Quarterly)	QPEC
CL11	KPMG Clinical Leadership Report	External stakeholders	Management should seek opportunities to strengthen commissioner relationships at all levels and ensure that they continue to develop at this important time in the Trust's development.	Examples exist of regular dialogue between senior Trust staff and commissioners. The MD is meeting regularly with CCG colleagues to ensure close working relationships. Examples include:- Unplanned Care Board (now SRG) NHSIQ Programmes x 2 Dermatology Group Unplanned Care Working Group Diabetes Working Group Stroke Steering Group Healthy Lives, Health Futures work Operational Resiliance Meetings Clinical Meetings with Chief Nurse	Executive Team / Trust Management Board	Trust Management Board Members	31 December 2014	Completed	Trust senior representation at relevant meetings.	Minutes of relevant meetings including Contract Compliance Meeting with Commissioners. (Monthly)	QPEC

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CL12	KPMG Clinical Leadership Report	Clinical accountability	The Medical Director should seek to appoint additional staff to support and strengthen the robustness of the current job planning, appraisal and revalidation processes.	The new proposed MD structure includes management and admin capacity to create robust validation/job planning process. This will embed learning and processes once the PMO resource completes its task. The Revalidation Assistant is in post and the Medical Directors Manager has been appointed to.	Lawrence Roberts, Interim Medical Director	To Be Agreed	31 December 2014	Completed	MD structure appointed to.	All posts appointed to	QPEC
CL13	KPMG Clinical Leadership Report	Clinical accountability	The Trust should ensure that job planning for all consultant staff is completed in accordance with the scheduled timescale. The monitoring of compliance and progress should be reported regularly to Board.	A comprehensive medical staffing work programme has been developed to encompass job planning and its link to capacity and demand. 3 extensive 'deep dives' have been undertaken with 4 eyes consultating to offer a robust means of informing job plans of individual teams. Replication of the work to other specialty areas is now considered. Job planning information is also been monitored centrally and weekly CEO oversight established. Team job planning takes place in Women and Childrens Group. The CIP planning governance group and medical CIP delivery group will amalgamate to oversee job planning. Team job planning has commenced. As at 20 March, 76% of consultants had a job plan. 92%	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	30 September 2014 (Review Phase) 31 March 2015 (Implementation Phase)	Completed	Job planning KPIs developed to support this.	KPI184 to KPI 189 (Monthly) Sustainability Plan (Monthly)	QPEC
CL14	KPMG Clinical Leadership Report	The new clinical leadership proposed structure	The Trust should seek to develop a portfolio of KPIs for each AMD linked to Trust wide issues as soon as possible. These should be included in the AMDs performance reviews , to ensure regular monitoring and responsive management of issues arising within Groups, engaging CLs where appropriate.	KPIs developed and in place. These will continue to be refined.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	31 December 2014	Completed and Ongoing	These have been incorporated into the Trust Quality Indicators	See Trust Quality Indicators (Monthly) Quality Report (Monthly)	QPEC
CL15	KPMG Clinical Leadership Report	The new clinical leadership proposed structure	The Medical Director should ensure that once the AMDs have formally discussed PA arrangements with CLs, that a formal agreement is put in place regarding the expectations of the roles and responsibilities of each individual CL.	The job description for the clinical lead is in place. KPIs developed and in place. These will continue to be refined.	Lawrence Roberts, Interim Medical Director	Associate Medical Directors	31 December 2014	Completed and Ongoing	Agreements in place with all clinical leads.	Copy of agreement	QPEC
CL16	KPMG Clinical Leadership Report	External support to address skills gap	The Trust should ensure that the development of the central register to capture internal secondments/ skills/ interests is maintained and expands as more appraisals and job plan reviews are completed. This will inform service development, education and training investment and staff engagement with personal and professional development.	Central database in place and developed by the Head of Education and Training.	Neil Pease, Director of Organisational Development and Workforce	All General Managers/ Associate Medical Directors and Heads of Nursing/ Midwifery/ Harriet Stephens, Head of Education, Training and Development	31 March 2015	Completed	Register in place and utilised.	Register is in place and populated	QPEC
I7	Response to Incidents	Provide leadership training and awareness of what is expected of the role of 'nurse in charge' for all staff nurses leading a ward.	Plans underway.	A shift leader competency has been developed. A shift lead job description is being created. The leadership programme for Deputies has been agreed and dates planned to run 4 cohorts from September 2015 (80 staff in total). A pre-programme assessment via survey monkey has been developed and will be sent to participants in July 2015.	Karen Dunderdale, Chief Nurse	Tara Filby, Deputy Chief Nurse	31 March 2015	Completed	All ward managers and deputy ward managers to have attended leadership training.	Training records Workforce Review Group Minutes (Monthly) NMAF Minutes	QPEC
Improved Record Keeping and Clinical Documentation											

ACTION PLAN NUMBER	SOURCE	RECOMMENDATION	ACTION	PROGRESS	EXECUTIVE LEAD	OPERATIONAL LEAD	TIMESCALE	IMPLEMENTATION OF ACTIONS PROGRESS RAG RATING	VERIFICATION OF ACHIEVEMENT/ EVIDENCE OF IMPACT	METHOD OF MEASUREMENT	BOARD SUB COMMIITTEE OVERSIGHT
CQC41	CQC	Ensure that the World Health Organisation Safety Checklist is fully embedded and audited appropriately in Theatres.	Compliance with the WHO Surgical Safety Checklist is extensively audited and progress with embedding this tool has been monitored by the Trust Governance & Assurance Committee during 2013/14 & 2014/15 to date.	Compliance with the WHO Surgical Safety Checklist continues to be audited and monitored by the Trust Governance and Assurance Committee. A paper was presented at the TGAC meeting in April which demonstrated that the recent audit had shown 100% compliance with the Checklist.	Karen Griffiths, Chief Operating Officer / Wendy Booth, Director of Performance Assurance	Kate Wood, Associate Medical Director/ Lawrence Roberts, Associate Medical Director, Claire Phillips, General Manager	30 September 2014 (Team Brief implemented)	Completed (compliance to be audited)	100% of cases audited have a completed WHO Surgical Safety Checklist.	Clinical Audit (June 2015)	TGAC
CQC42	CQC		The Theatre Board and the Trust Governance & Assurance Committee recently mandated the use of Team Brief and this requirement is included in and will be reinforced via the Trust's 'Zero Tolerance' Framework.	Compliance with the WHO Surgical Safety Checklist continues to be audited and monitored by the Trust Governance and Assurance Committee. A paper was presented at the TGAC meeting in April which demonstrated that the recent audit had shown 73% compliance with the Team Brief. Work is ongoing to improve recording in this area.	Karen Griffiths, Chief Operating Officer / Wendy Booth, Director of Performance Assurance	Kate Wood, Associate Medical Director/ Claire Phillips, General Manager	30 September 2014 (Team Brief implemented)	Completed (compliance to be audited)	Team brief to be undertaken for 100% of theatre lists.	Clinical Audit (June 2015)	TGAC
CQC43	CQC	Ensure that all patient documentation is appropriately updated and maintained including documentation for mental capacity assessments and risk assessments.	There is a clear framework in place for the completion of mental capacity assessments and risk assessments. In light of the CQC feedback, this framework will be refreshed and re-launched.	The Trust has a clear framework for the completion of mental capacity assessment and risk assessments and this was relaunched and reinforced at training sessions commissioned from an external provider which took place on 3 February 2015 and 9 March 2015. Representatives from the Trust have recently met with the local NE Lincs MCA Lead Officer) and we are sharing training packages. The Trust is also participating in the multi agency group meetings. This will enable us to give consistant messages across the Trust. In addition to this, DOLS awareness sesssions are being incorporated into staff meetings such as Q&S day and Senior Nurse meetings.	Karen Griffiths, Chief Operating Officer / Karen Dunderdale, Chief Nurse, Wendy Booth, Director of Performance Assurance	Dawn Ojadi, Head of Complaints, Claims and Legal Services/ Craig Ferris, Head of Safeguarding	30 September 2014	Completed	Audit demonstrates that the mental capacity act and risk assessment documentation is being completed appropriately	Audit	TGAC
CQC44	CQC	Ensure that reasons for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) are recorded and are in line with good practice and guidelines.	The Trust has in place a long-standing 'Decisions in Relation to Cardio Pulmonary Resuscitation Policy' and DNAR orders are audited annually to ensure adherence to Trust policy and best practice and remedial actions are progressed via the governance framework. However, the Trust is currently consulting on a joint multi-agency DNACPR Policy (the Trust already uses the regional DNAR form). The requirements highlighted by the CQC will be reinforced as part of the publication and promotion of the above policy and, as above, will be audited.	The policy has been completed and ratified at the Trust Governance and Assurance Committee. This Policy will be taken to Trust Management Board in October and training sessions have been delivered by the Trust Solicitors during September. All the planned training to the acute and community nursing staff and allied professionals has been completed in relation to DNACPR and advanced care planning as part of the Multi Professional and Education Training funding (MPET) . 1 session was undertaken with GPs and one targeted at the consultants. Additional training dates to be offered towards the end of the year, following the same format. Training has commenced for community advanced nurses (Band 6/7/8a) who work as unscheduled care practitioners, community matrons and district nurse case load holders, regarding the signing and completing of the DNACPR forms and holding the conversations with the patient and family at the end of life. This was part of the integrated policy to prevent the conversations having to be duplicated and causing additional anguish to the patient and their family.	Lawrence Roberts, Interim Medical Director / Wendy Booth, Director of Performance Assurance	Helen Mumby, Macmillan End of Life Co-ordinator - Community	30 September 2014	Completed	Audit demonstrates that DNAR documentation is being completed appropriately	Clinical Audit (Q2 2015/16)	TGAC

ACTION PLAN NUMBER	SOURCE	RECOMMENDATION	ACTION	PROGRESS	EXECUTIVE LEAD	OPERATIONAL LEAD	TIMESCALE	IMPLEMENTATION OF ACTIONS PROGRESS RAG RATING	VERIFICATION OF ACHIEVEMENT/ EVIDENCE OF IMPACT	METHOD OF MEASUREMENT	BOARD SUB COMMIITTEE OVERSIGHT
CQC45	CQC	Ensure that DNACPR orders confirm discussion with patients or family members and whether multidisciplinary teams are involved before an order is put in place.	To co-incide with the publication and promotion of the above policy and in light of the recent High Court ruling on DNAR, awareness / training sessions for all relevant clinical staff are being provided by the Trust's Legal Advisors. The requirements highlighted by the CQC will be reinforced as part of that process and, as above, will be audited. In view of the above changes, the frequency of audits will be increased.	The policy has been completed and ratified at the Trust Governance and Assurance Committee. This Policy will be taken to Trust Management Board in October and training sessions have been delivered by the Trust Solicitors during September.	Lawrence Roberts, Interim Medical Director / Wendy Booth, Director of Performance Assurance	Dawn Ojadi, Head of Complaints, Claims and Legal Services	31 September 2014	Completed	Audit demonstrates that relevant discussions have taken place.	Clinical Audit (Q2 2015/16)	TGAC
Complaints and PALs											
CQC46	CQC	Review access to British Sign Language interpreters.	The Trust has access to British Sign Language Interpreters and these can and are routinely booked via the PALS Office. Promotion of these arrangements is however required as, from the CQC feedback, not all staff appear to be aware of the existence of this service.	A review of both sign language and interpreters has taken place and arrangements have been circulated to staff.	Wendy Booth, Director of Performance Assurance	Dawn Ojadi, Head of Complaints, Claims and Legal Services	31 August 2014	Completed	Increase in number of staff who know how to access British Sign Language Interpreters. No complaints received in relation to no access to sign language.	CQC Mock Visit Process/ Director Visits (Quarterly) KPI91 (Monthly)	TGAC
Greater Focus on the Quality Agenda											
CQC47	CQC	No specific issues.	Refresh & re-launch the Trust's Quality Strategy.	The Quality Strategy has been completed . It was consulted on during Quarter 4 and will be presented to QPEC in June 2015. The Strategy was presented to QPEC in June as planned and comments were received. This is to be submitted to QPEC for final ratification in July, following which it will be presented to Trust Board.	Karen Dunderdale, Chief Nurse	Angie Davies, Assistant Director of Nursing and Head of Quality	31 December 2014	Completed	All staff are able to talk about elements of the Strategy.	CQC Mock Visit Process/ Director Visits (Quarterly)	QPEC
CQC48	CQC		Plans are being developed for quality governance reviews of individual operational groups during 2014/15 (once CQC actions complete) utilising Monitor's Quality Governance Framework.	KPMG have now completed their review and the findings have been shared with TGAC. Any actions arising from this report will be included in the QDP in future.	Wendy Booth, Director of Performance Assurance/ Karen Griffiths, Chief Operating Officer	Jeremy Daws, Head of Quality Assurance	January – March 2015	Completed	All groups to have reviewed their quality governance arrangements by the end of March 2015.	Copy of report from review and action plan to address any issues identified	TGAC
CQC49	CQC		Quality KPIs are being reviewed and refined & will be aligned to relevant Board sub-committees for oversight and challenge.	The KPIs have been reviewed and will be reported to the Trust Board in their new format at the October Board meeting.	Wendy Booth, Director of Performance Assurance	Lisa Jamieson, Head of Performance	31 August 2014	Completed	100% of KPIs to be aligned to a Board Sub Committee	See KPI schedule (Monthly)	QPEC/TGAC
EVDR6.1	Enter and View Dignity and Respect Report	Listening to Staff	Continue staff engagement methods including Director Visits, CEO meetings, Dragons Den.	Deputy Chief Nurse and the Assistant Director of OD&W undertook some walk-rounds in January 2015. Staff experience information to feature as a standing item on the agenda of the Patient Experience Group. Director visits continue to occur, as do CEO briefing sessions. Other examples include ward reviews, CQC Mock Visits, etc.	Executive Team	Simon Dunn, Assistant Director of OD and Workforce	Ongoing	Completed			QPEC
EVDR6.2	Enter and View Dignity and Respect Report		Increase staff engagement activities	See above.	Neil Pease, Director of OD and Workforce	Simon Dunn, Assistant Director of OD and Workforce	Ongoing	Completed			QPEC
Improved Levels of Mandatory Training and Appraisal											

QUALITY DEVELOPMENT PLAN INDICATORS
For The Period 1st April 2015 to 31st October 2015

	Performance Metric	Threshold	Threshold Type	Sept 15 Performance	Oct 15 Performance	In month movement	Month End Position Oct 15	
Staffing Levels								
KPI28	Reduction in nursing vacancy rate	6%	Local	9.60%	8.03%	↑		
KPI29	Reduction in medical staffing vacancy rate (compared to April 15)	14.17%	Local	13.05%	14.60%	↓		
KPI30	Reduction in AHP vacancy rate (compared to April 15)	6.86%	Local	5.21%	5.05%	↑		
KPI31	Reduction in average monthly spend on nursing locum & agency staff	£476,000	Local	£953,000	£909,000	↑		
KPI32	Reduction in average monthly spend on locum & agency medical staff	£1,467,000	Local	£1,511,000	£1,509,000	↑		
KPI33	Reduction in sickness levels (month in arrears)	4.00%	National	4.20%	4.40%	↓		
Clinical Strategies & Pathways								
KPI03	Adherence to NICE guidance (all guidance)	90%	Local	82%	80%	↓		
KPI59	Reduction in % ward transfers due to capacity reasons	20%	Local	12%	11%	↑		
Caring								
KPI CB17	Mixed Sex Accommodation Breaches	0	Contract	0	0	→		
KPI50	Relevant staff to have received dementia awareness training by December 2015	45%	CQUIN	60%	64%	↑		
KPI1(2a)	Increase or maintain FFT response rates in acute inpatient services	40%	Local	23%	26%	↑		
KPI1(2b)	Increase or maintain FFT response rates in A&E services	20%	Local	13%	12%	↓		
Responsive								
KPI53	Fractured Neck of Femur patients operated on within 36 hours	75%	Local	61.5%	61.5%	→		
KPI64	Trust DNA Rate at or less than national benchmark rate	6.0%	National	9.8%	8.5%	↑		
KPI62	Reduction in outliers on adult wards	3.0%	Local	3.9%	3.7%	↑		
Well Led								
KPI10	50% Reduction in zero tolerance incidents by March 2016	2	Local	1	1	→		
KPI90	Appropriate AMDs & Clinical Leads to have attended development programme	100%	Local	100%	100%	→		
KPI81	Clinical lead roles appointed to	90%	Local	93%	94%	↑		
KPI83	Mandatory training target to be achieved for clinicians.	95%	Contract	62%	66%	↑		
KPI48	2.5% quarterly Improvement in the morale barometer scores	5.8	Local	5.5	N			
KPI84	Relevant doctors to have a refreshed and reviewed job plan	100%	Local	22%	23%	↑		
KPI85	Completed JPs to be recorded on the central database	100%	Local	100%	100%	→		
KPI86	Job plan clearly differentiates between DCC and SPA activity	100%	Local	100%	100%	→		
KPI87	All PAs > 10 to be clearly identified as additional PAs on a fixed term basis	100%	Local	N	N	→		
KPI89	Job plans to be Quality Assured by AMDs each year	100%	Local	N	N	→		
KPI88	Doctors have undertaken appraisal	95%	Local	90%	93%	↑		
KPI91	Number of complaints received in relation to no access to sign language	0	Local	0	0	→		
KPI92	Mandatory training compliance rate by 31.12.15	95%	Contract	86%	87%	↑		
KPI52	Compliance with resuscitation mandatory training	95%	Local	72%	74%	↑		
KPI53	All relevant wards & departments to have a nominated LD champion	100%	Local	89%	94%	↑		
KPI54	All LD champions to have received relevant training	100%	Local	57%	55%	↓		
KPI55	All staff to have undertaken a Vision & Values PADR by 31.12.1	95%	CQUIN	78%	76%	↓		
KPI56	Nurses to have received supervision by 31.12.15	95%	Local	66%	68%	↑		
KPI51 a	Compliance with safeguarding children mandatory training Level 1	95%	Local	92.5%	93.2%	↑		
KPI51 b	Compliance with safeguarding children mandatory training Level 2	95%	Local	90.1%	91.3%	↑		
KPI51 c	Compliance with safeguarding children mandatory training Level 3	95%	Local	78.7%	80.4%	↑		

* Included within the Performance KPIs to demonstrate the 2 ~NOF measures reported on by the Trust.

Movement in month key;-

↑ Improvement

SECTION 5
QUALITY DEVELOPMENT PLAN INDICATORS
For The Period 1st November 2014 to 31st October 2015

	Performance Metric	Threshold	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Trend Analysis
Staffing Levels															
KPI28	Reduction in nursing vacancy rate	6%	4.6%	6.4%	6.6%	7.2%	7.8%	7.6%	8.9%	10.6%	10.5%	10.7%	9.6%	8.03%	
KPI29	Reduction in medical staffing vacancy rate	14.17%	13.8%	13.0%	13.5%	14.8%	14.2%	16.5%	16.6%	15.8%	16.1%	16.3%	13.1%	14.6%	
KPI30	Reduction in AHP vacancy rate	6.86%	3.9%	4.2%	3.8%	3.7%	4.5%	4.2%	4.9%	4.9%	4.9%	4.8%	5.2%	5.1%	
KPI31	Reduction in average monthly spend on nursing locum & agency staff	£467,000	£754,000	£685,000	£733,000	£757,000	£908,000	£880,000	£958,000	£1,043,000	£1,142,000	£1,045,000	£953,000	£909,000	
KPI32	Reduction in average monthly spend on locum & agency medical staff	£1,467,000	£1,704,000	£1,866,000	£1,562,000	£1,560,000	£1,467,000	£1,568,000	£1,489,000	£1,562,000	£1,600,000	£1,595,000	£1,511,000	£1,509,000	
KPI33	Reduction in sickness levels (National Benchmarking threshold) (month in arrears)	4%	4.2%	4.4%	4.5%	4.2%	3.8%	4.0%	4.1%	3.8%	3.9%	3.9%	4.2%	4.4%	
Clinical Strategies & Pathways															
KPI03	Adherence to NICE guidance (all guidance)	90%	80.1%	80.8%	81.4%	81.9%	82.8%	83.3%	83.7%	81.4%	80.2%	82.0%	82.3%	79.7%	
KPI59	Reduction in % ward transfers due to capacity reasons	20%	11.0%	11.0%	9.0%	11.0%	9.0%	10.0%	8.0%	8.0%	9%	9%	12%	11%	
Caring															
CB17	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
KPI50	Relevant staff to have received dementia awareness training by December 2015	45%		19.0%	19.3%	19.0%	37.0%	46.0%	49.0%	54.1%	56.5%	57.1%	60.4%	63.7%	
1(2a)	Increasing or maintaining FFT response rates in acute inpatient services	40%	39.2%	35.0%	44.9%	43.1%	44.8%	42.8%	43.4%	41.0%	43.8%	40.8%	44.7%	49.3%	
1(2b)	Increasing or maintaining FFT response rates in A&E services	20%	23.0%	17.8%	17.7%	16.6%	19.7%	14.1%	13.1%	11.0%	13.9%	13.3%	13.0%	12.4%	
Responsive															
53	Fractured Neck of Femur patients operated on within 36 hours	75%	76.0%	53.8%	65.4%	78.3%	35.5%	69.4%	66.7%	68.8%	75.7%	88.9%	61.5%	61.5%	
KPI64	Trust DNA Rate	6%	10.4%	11.0%	11.0%	10.3%	10.0%	10.6%	9.7%	10.0%	9.4%	9.2%	9.8%	8.5%	
KPI62	Outliers on medical and surgical wards	3%	2.9%	3.1%	3.5%	3.0%	3.0%	3.1%	2.2%	2.4%	3.0%	4.1%	3.9%	3.7%	
Well Led															
KPI10	50% Reduction in zero tolerance incidents by March 2016	2	6	4	7	11	9	2	6	2	4	1	1	1	
KPI90	Appropriate AMDs & Clinical Leads to have attended development programme	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
KPI81	Clinical lead roles appointed to	90%	100%	100%	96.0%	87.0%	94.9%	91.8%	92.59%	84.9%	90.7%	90.7%	92.6%	94.4%	
KPI83	Mandatory training target to be achieved for clinicians.	95%	66.0%	83.0%	72.7%	72.3%	70.0%	74.7%	74.9%	74.6%	70.7%	60.6%	62.0%	65.6%	
KPI84	Relevant doctors to have a refreshed and reviewed job plan by April 2016	100%		34.0%	34.0%	63.8%	95.7%	26.0%	27.0%	25.0%	28.0%	24.0%	22.0%	23.0%	
KPI85	Completed JPs to be recorded on the central database by April 2016	100%		N	N	100%	100%	100%	100%	100%	100%	100%	100%	100%	
KPI86	Job plan clearly differentiates between DCC and SPA activity	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
KPI87	All PAs > 10 to be clearly identified as additional PAs on a fixed term basis	100%		N	N	N	N	N	N	N	N	N	N	N	
KPI88	Doctors have undertaken appraisal	95%	64.9%	78.0%	70.5%	80.0%	94.0%	94.0%	92.0%	88.0%	78.0%	90.7%	90.1%	93.0%	
KPI89	Job plans to be Quality Assured by AMDs each year	100%		N	N	N	N	N	N	N	N	N	N	N	
KPI91	Number of complaints received in relation to no access to sign language	0	0	0	0	0	0	0	1	0	1	0	0	0	
31	Mandatory training compliance rate by 31.12.15	95%	88.0%	95.0%	86.7%	93.0%	92.6%	92.0%	91.9%	92.0%	92.0%	89.3%	86.4%	86.8%	
KPI52	Compliance with resuscitation mandatory training	95%	67.0%	70.5%	71.5%	73.7%	76.0%	78.0%	78.0%	78.5%	76.7%	75.0%	72.4%	74.1%	
KPI53	All relevant wards & departments to have a nominated LD champion	100%		58.0%	72.0%	80.9%	85.0%	85.0%	85.1%	85.1%	85.1%	85.1%	89.4%	94%	
KPI54	All LD champions to have received relevant training	100%		44.0%	48.0%	52.6%	42.0%	42.0%	57.5%	60.0%	60.0%	60.0%	57.1%	55%	
KPI55	All staff to have undertaken a Vision & Values PADR by 31.12.15	95%	79.4%	95.0%	89.0%	91.1%	90.0%	88.0%	85.0%	83.0%	81.0%	79.4%	77.6%	76.4%	
KPI56	Nurses to have received supervision by 31.12.15	95%	38.0%	45.0%	50.2%	50.2%	53.0%	56.0%	60.0%	60.8%	61.3%	61.5%	65.8%	67.9%	
KPI51 a	Compliance with safeguarding children mandatory training Level 1	95%										93.4%	92.5%	93.2%	
KPI51 b	Compliance with safeguarding children mandatory training Level 2	95%										90.5%	90.1%	91.3%	
KPI51 c	Compliance with safeguarding children mandatory training Level 3	95%										77.3%	78.7%	80.4%	

Together
we care, we respect, we deliver