Status

Not Completed
Completed / Signed Off

2021/2022 Trust Integrated Quality Improvement Plan
Updated 14 April 2021

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Strategic Priorities Improvement Plan

Executive Accountable Lead Officer	Caroline Shaw CEO
Operational lead	Lou Notley - Director of Patient Safety
Programme Lead	Sarah Davidson - Compliance Manager

Ref	Source i.e.. NHSI, etc.	Cross-reference	Area	CQC Domain	Applicable To	Milestone Description	Scheme Owner	easure of Success(key success indicators to understand success	Start Date	End Date	red by which Committee E	videnceAssuranc	vidence Locatio	STATUS	EAG Date
		1. Strategic Objective 01				To consistently provide safe and compassionate care for our patients and their families.									
001	M.01		1. Strategic Objective 01	Well Led	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.01: The trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff.	Director of Patient Safety	New operational improvements and closer working with the CCG, including action monitoring and evidence gathering to be captured in a new Procedural Document	01/01/2021	30/09/2021				Not Completed	
002	M.02		1. Strategic Objective 01	Well Led	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.02: The trust must ensure that processes for incident reporting, investigation, actions and learning improve and become embedded across all services.	Director of Patient Safety	This is the role of the Quality Improvement Sub Committee, part of the Integrated Governance and Assurance Framework being presented to the Board on 01/10/19	01/01/2021	31/03/2021	Quality Forum	Yes	LINK	Completed & Signed off	23/03/2021
003	M.03		1. Strategic Objective 01	Effective	Corporate (Medicine)	M.03: The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance.	Director of Patient Safety	Duty of Candour is consistently completed in line with Trust Standard	01/01/2021	30/06/2021				Not Completed	
004	29A.01, M.04, S.01	Linked to EoLC Workstream	1. Strategic Objective 01	Safe	Corporate	29A.01: There was a lack of palliative care consultant staffing compounded by a lack of ownership for end of life care by each speciality throughout the trust. M.04: The trust must address specialist palliative consultant staffing and put measures in place to improve in line with national standards. S.01: The trust should continue to address specialist palliative consultant staffing to put measures in place to improve in line with national standards.	Medical Director	Palliative care consultants and specialist consultant cover in place with long term workforce plan to be incorporated in the 2021/22 EoLC Improvement Plan	01/01/2021	31/07/2021				Not Completed	23/03/2021
005	S.02		1. Strategic Objective 01	Responsive	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	S.02: The service should ensure that staff take appropriate action for patient safety alerts.	Director of Patient Safety	The Trust complies with the deadline set for each alert.	01/01/2021	30/06/2021				Not Completed	
006	S.03	Linked to EoLC Workstream	1. Strategic Objective 01	Safe	Corporate (Medicine, Surgery)	S.03: The trust should continue to ensure completion of mental capacity assessments for all patients in end of life care.	Chief Nurse	Audit of patient notes, including ReSPECT (v0.3) will demonstrate a consistent approach to completing all relevant documentation with current and accurate information which has been agreed by the patient and their families and signed as appropriate. Patients and their families will report that they have been cared for in full accordance with their wishes.	01/01/2021	30/09/2021				Not Completed	
007	S.04	Linked to EoLC Workstream	1. Strategic Objective 01	Responsive	Corporate	S.04: The trust should ensure that waiting times from referral to achievement of preferred place of care and death are timely.	Chief Nurse	Conduct audit of time taken between assessment of patient, securing package of care and transfer to preferred place of care. Patients assessed early to ensure that package of care completed and place secured at preferred place of care.	01/01/2021	31/10/2021				Not Completed	
008	S.05		1. Strategic Objective 01	Safe	Corporate	S.05: The service should ensure that staffing levels are maintained to ensure patients safety.	Chief Nurse	Nurse staff vacancy factor be below X% Daily management of adverse staffing to be embedded in practice	01/01/2021	31/05/2021				Not Completed	
009	S.06		1. Strategic Objective 01	Safe	Corporate	S.06: The trust should ensure the service has enough support staff on all wards to provide the right care and treatment.	Director of People	(a) successful recruitment of 60 HCSW and 25 family liaison officers. (b) Review of ward workforce plans including ward clerks completed	01/01/2021	31/10/2021				Not Completed	
			2. Strategic Objective 02			Modernising our hospital (estate, digital infrastructure and medical equipment) to support the delivery of optimal care.									
010	S.07	Linked to U & E Care Programme	2. Strategic Objective 02	Safe	Corporate (Medicine)	S.07: The service should ensure that the design, maintenance, use of facilities, premises and equipment are suitable to ensure patient safety. This includes the needs of those patients presenting with mental health illnesses.	Chief Operating Officer	Design for new ED completed and ready to be operationalised	01/01/2021	31/07/2021				Not Completed	
			3. Strategic Objective 03			Strengthening staff engagement to create an open culture with trust at the centre.									
011	S.08, S.09	Linked to Culture Programme	3. Strategic Objective 03	Well Led	Corporate (Women and Children, Clinical Support Services)	S.08: The service should continue to work on the culture within the department. S.09: The trust should continue to improve staff engagement.	Deputy Chief Executive Officer	Improved staff survey results	01/01/2021	30/04/2022				Not Completed	
			4. Strategic Objective 04			Working with patients and system partners to improve patient pathways and ensure future financial and clinical sustainability.									
			5. Strategic Objective 05			Supporting our patients to improve health and clinical outcomes.									
012	M.05		5. Strategic Objective 05	Well Led	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.05: The trust must ensure that regulatory requirements, recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed effectively.	Director of Patient Safety	This is the role of the Quality Improvement Sub Committee, part of the Integrated Governance and Assurance Framework being presented to the Board on 01/10/19	01/01/2021	31/07/2021				Not Completed	
013	M.06		5. Strategic Objective 05	Well Led	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.06: The trust must ensure that risks are swiftly identified, mitigated and managed. There must be robust, consistent processes in place to ensure that action plans are enacted following audit, mortality reviews, incidents and complaints. There must be clear processes for review, analysis and identification of themes and shared learning.	Director of Patient Safety	regular monitoring and support in place from the Governance and Risk team and specific reporting to the Risk Committee	01/01/2021	30/09/2021				Not Completed	

014	M.07		5. Strategic Objective 05	Safe	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.07: The trust must ensure that patients at risk of deterioration are appropriately escalated for review.	Deputy Medical Director	2 hourly risk and safety assessments in place	01/01/2021	28/02/2021	Quality Forum	Yes	LINK	Completed & Signed off	23/02/2021
015	S.10, S.11, S.12		5. Strategic Objective 05	Responsive	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	S.10: The service should ensure that performance in national and local audits is in line with targets. S.11: The service should ensure that performance in national and local audits is in line with targets. S.12: The trust should ensure that compliance with national and local audits is in line with targets.	Director of Patient Safety	Full audit programme in place in line with national and local targets	01/01/2021	31/10/2021				Not Completed	
			6. Strategic Objective 06			**Maximising opportunities for our staff to achieve their true potential so that we deliver outstanding care.**									
016	M.08		6. Strategic Objective 06	Well Led	Corporate	M.08: The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are in place, ensuring timely management in line with trust policy.	Director of People	To see an improvement in employee relations issues, responsiveness, reduction in resolution time and reduction in the number of employee relations cases.	01/01/2021	31/08/2021				Not Completed	
017	M.09, M.10, S.13, S.14		6. Strategic Objective 06	Effective	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.09: The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target. M.10: The trust must ensure that staff receive an annual appraisal. S.13: The service should ensure that nursing appraisal rates are in line with trust targets. S.14: The service should ensure that nursing appraisal rates are in line with trust targets.	Director of People	To achieve the current Trust standard for Appraisals - 90% compliance by 31st March 2022	01/01/2021	30/11/2021				Not Completed	
018	M.11, M.12, S.15, S.16, S.17, S.18, S.19, S.20, S.21, S.22, S.23, S.24		6. Strategic Objective 06	Effective	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	M.11: The trust must ensure that mandatory training attendance, including training on infection prevention and control and safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level. M.12: The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards S.15: The trust should ensure that mandatory training compliance meets the trust target for all staff groups. S.16: The service should ensure that all staff complete mandatory training in key skills. S.17: The service should ensure that all staff complete safeguarding adults and children's' training. S.18: The service should ensure that staff have completed the relevant life support training for their clinical roles. S.19: The trust should ensure staffs mandatory and safeguarding training compliance meets the trust target. S.20: The service should ensure that staff complete mandatory training. S.21: The service should improve medical staff compliance with safeguarding training. S.22: The service should ensure that all staff complete mandatory training to improve compliance in line with the trust target. S.23: The service should ensure that safeguarding adults and children's training compliance is in line with the trust target.	Director of People	Mandatory training levels achieved. Target 85%	01/01/2021	30/09/2021				Not Completed	
			7. Section or Warning Notice												
019	29A.02, S.25, M.13		7. Section or Warning Notice	Safe	Corporate (Medicine, Surgery, Women and Children)	29A.02: Records did not provide a full plan of individualised care and did not accurately reflect the needs or wishes of patients. Patients preferences and individual needs were not considered. There was inconsistent and incomplete record keeping in the emergency department. An individualised plan of care was not established for patients at the end of life. Patients requiring end of life care did not always receive appropriate care that met their needs. S.25: The trust should ensure all patient care records are completed in line with national standards. M.13: The trust must ensure patient care records are accurate, complete and contemporaneous and stored securely.	Head of Nursing Medicine	Training (a blend of online, virtual meetings and videos) delivered to all relevant staff. ReSPECT documentation completed appropriately and acted upon. Develop collaborative approach across all 3 Norfolk sites as part of the Convergence and Alignment programme	01/01/2021	31/01/2022				Not Completed	23/02/2021
020	29A.03		7. Section or Warning Notice	Safe	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	29A.03: Staff understanding of and the application of the Mental Capacity Act 2005 was inconsistent in medical care and the emergency department. Training information supporting staff knowledge and understanding of the Deprivation of Liberty Safeguards (DoLS) was incorrect and not in line with the Act.	Chief Nurse	MCA/DoLS training plan in place Training material reviewed	01/01/2021	30/09/2021				Not Completed	23/02/2021
021	29A.04		7. Section or Warning Notice	Safe	Medicine	29A.04: Staff understanding of the safeguarding process was inconsistent. We identified a serious safeguarding concern that we escalated to senior ward management. We had no confidence that they would take the required action. We escalated this concern to yourself for immediate action.	Safeguarding Adults and Children Lead	Staff consistently follow safeguarding procedures and report concerns without delay	30/04/2019	31/07/2020	Quality Forum	Yes	LINK	Completed & Signed off	24/07/2020
022	29A.05		7. Section or Warning Notice	Well Led	Medicine	29A.05: There was a lack of management oversight and assurance in relation to the risks identified during the inspection in medical care, the emergency department, end of life care and gynaecology services. There was no clear leadership for the end of life care service.	DLT Medicine	Four divisional model, DLT's is in place.	30/04/2019	31/10/2020	Quality Forum	Yes	LINK	Completed & Signed off	31/10/2020
023	29A.06		7. Section or Warning Notice	Responsive	Women and Children	29A.06: There was a lack of ownership for care planning for high-risk service-users by consultants. Service-users with high-risk care pathways, such as twin pregnancies, did not routinely see the same consultant and experienced delays in care planning.	Clinical Lead Obstetrics & Gynaecology	Lead consultant in place	31/07/2018	31/03/2020	Quality Forum	Yes	LINK	Completed & Signed off	24/02/2020
024	29A.07		7. Section or Warning Notice	Safe	Women and Children	29A.07: Vulnerable service users were not prioritised by the service. The service ran a limited number of vulnerable service-user antenatal clinics and the demand exceeded the number of appointments available. There was not an effective system in place for women who could not be offered an appointment at vulnerable women clinics.	Clinical Lead Obstetrics & Gynaecology	Lead consultant in place	31/07/2018	31/01/2020	Quality Forum	Yes	LINK	Completed & Signed off	07/10/2019
025	29A.08		7. Section or Warning Notice	Safe	Women and Children	29A.08: The maternity clinic facilities at North Cambridgeshire Hospital were not fit for purpose and risked the safety of service users. The facilities had only one entrance/exit which involved accessing the service through a narrow staircase with no lift access. Service-users could not be safely evacuated from this area in the event of a medical emergency or fire.	EPAU Lead	Emergency drill taken place	31/07/2018	31/10/2019	Quality Forum	Yes	LINK	Completed & Signed off	08/08/2019

026	29A.09		7. Section or Warning Notice	Safe	Women and Children	29A.09: The environment in the Early Pregnancy Assessment Unit (EPAU) was not fit for purpose and risked the safety of service users. There was a wall between the scan room and the door, which meant that women could not be safely transferred in the event of a medical emergency. There was nowhere to lay down a miscarrying woman should they deteriorate.	Deputy Head of Midwifery	Declutter and emergency training drill.	31/07/2018	31/10/2019	Quality Forum	Yes	LINK	Completed & Signed off	07/10/2019
027	29A.10		7. Section or Warning Notice	Effective	Women and Children	29A.10: The booking process for consultant-led antenatal clinics was not effective; there was no tracking or monitoring of referrals. Referrals were regularly lost resulting in high-risk service-users experiencing delayed or missed appointments.	Divisional General Manager Women & Children	Closed	31/07/2018	08/08/2019	Quality Forum	Yes	LINK	Completed & Signed off	08/08/2019
028	29A.11		7. Section or Warning Notice	Responsive	Women and Children	29A.11: The waiting area arrangements for antenatal clinics on Brancaster were unsuitable. The waiting room was shared with gynaecology which meant that gynaecological patients with fertility concerns were seated with pregnant women attending antenatal clinics.	Divisional General Manager Women & Children	Closed	31/07/2018	08/08/2019	Quality Forum	Yes	LINK	Completed & Signed off	08/08/2019
029	29A.12		7. Section or Warning Notice	Safe	Women and Children	29A.12: Arrangements for women who miscarried up to 16 weeks were unsuitable. Women who miscarry up to 16 weeks gestation were placed on Elm ward which is a surgical ward.	Divisional General Manager Women & Children	Closed	31/07/2018	08/08/2019	Quality Forum	Yes	LINK	Completed & Signed off	08/08/2019
030	29A.13		7. Section or Warning Notice	Safe	Women and Children	29A.13: Systems and processes for identifying and managing risk were neither properly established nor operating effectively. We were not assured that duty of candour was being undertaken as required by the regulations. We were not assured that incidents were being investigated or graded to the appropriate level.	Risk & Governance Matron Women & Children	Compliance reports	31/07/2018	31/07/2020	Quality Forum	Yes	LINK	Completed & Signed off	27/07/2020
031	29A.14, 29A.15		7. Section or Warning Notice	Well Led	Women and Children	29A.14: The culture of the service was poor. The relationship between midwifery and obstetrics staff was challenged. Medical staff were disengaged in the safe provision of obstetric care. 29A.15: The leadership of the service had broken down.	Divisional General Manager Women & Children	Improved staff survey	31/07/2018	31/03/2020	Quality Forum	Yes	LINK	Completed & Signed off	30/03/2020
032	29A.16		7. Section or Warning Notice	Safe	Clinical Support Services	29A.16: Incidents in the diagnostic imaging department were not appropriately reported or escalated. We did not see evidence of themes identified and lessons learned. Lessons learnt from incidents were not shared effectively.	Radiology Manager	Lifting of the Section 31 Condition notice by the CQC. Continued evidence of incident learning and governance processes from the departments clinical governance meeting.	01/06/2019	30/06/2020	Quality Forum	Yes	LINK	Completed & Signed off	22/06/2020
033	S31.01		7. Section or Warning Notice	Safe	Medicine	S31.01: The registered provider must ensure that risk assessments are undertaken for all patients presenting in the emergency department, including children, with mental health concerns and/or at risk of deliberate self-harm or suicide. The registered provider must ensure that risk assessments are completed in full, risk score aggregated and ensure that action is taken to mitigate the identified level of risk. This includes ensuring that appropriate levels of observation are undertaken by suitably qualified staff, when necessary.	ED Matron, ED Clinical Educators	New triage Sept. MH action plan collaborative working with MH Team, Engagement with mental health underway - escalation process in place, Task and Finish Group in place, Department reviewed for mental health suitability, Risk assessments reviewed, Practice drills in place, Training plan in place	22/03/2019	31/12/2019	Quality Forum	Yes	LINK	CQC Removed	12/12/2019
034	S31.02		7. Section or Warning Notice	Safe	Medicine	S31.02: The registered provider must ensure that all areas utilised for patients, including children, at risk of deliberate self-harm or suicide have had an environmental risk assessment. This includes toilet and shower facilities which these patients may use, as well as other clinical areas where patients may be treated. The provider must ensure that actions are undertaken, as identified in the risk assessment, and that all staff are aware of and adhere to protocols.	Head of Nursing Paediatrics, ED Matron	Action plan - Carley, Alison Webb, Jo Fields, NSFT, Departmental risk assessments completed in all areas,	22/03/2019	31/01/2020	Quality Forum	Yes	LINK	CQC Removed	27/01/2020
035	S31.03		7. Section or Warning Notice	Safe	Medicine	S31.03: The registered provider must ensure that effective systems are in place for booking-in walk-in patients to ensure that patients at risk of deterioration are identified and escalated appropriately. Non-clinical staff responsible for booking in patients must have a clear set of written criteria which would require them to escalate patients to clinical staff and be trained and assessed in its use.	ED Matron, Head of Business Support	Red flag system training - completed, Triage reviewed, Training and competency plan in place, Plan for 360 vision.	22/03/2019	31/10/2019	Quality Forum	Yes	LINK	CQC Removed	11/11/2019
036	S31.04		7. Section or Warning Notice	Safe	Medicine	S31.04: The registered provider must ensure that an effective system is in place for the regular oversight of the waiting area for walk-in patients to ensure that patient needs are being met and patients at risk of deterioration are identified and escalated appropriately.	ED Matron	Streaming business case submitted, 2hourly risk and safety assessments in place, Plan for 360° visibility in place.	22/03/2019	31/05/2020	Quality Forum	Yes	LINK	CQC Removed	27/04/2020
037	S31.05		7. Section or Warning Notice	Safe	Medicine	S31.05: The registered provider must ensure that there is an effective system in place to robustly clinically assess all patients who present to the emergency department in line with relevant national clinical guidelines within 15 minutes of arrival. The registered provider must ensure that the staff required to implement the system are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.	ED Matron	Streamline ENP double up triage, Noted Nurse in Charge, Escalation plan in place, Triage plan in place, Clear role definition in place in the dept.	22/03/2019	30/09/2020	Quality Forum	Yes	LINK	Completed & Signed off	30/09/2020
038	S31.06		7. Section or Warning Notice	Safe	Medicine	S31.06: The registered provider must ensure that clear inclusion and exclusion criteria is in place for the 'fit to sit' area in minors. The registered provider must ensure that there are sufficient numbers of staff available to monitor and review patients who have been placed in the 'fit to sit' area.	ED Matron, ED Operational Manager	No ambulatory sitting area. Inclusion/visible and shared, Standard Operating Procedure (SOP) in place, Skill mix completed, Training in place.	22/03/2019	29/02/2020	Quality Forum	Yes	LINK	Completed & Signed off	24/02/2020
039	S31.07		7. Section or Warning Notice	Safe	Medicine	S31.07: The registered provider must devise and implement an effective system to ensure that there are sufficient numbers of suitably qualified, skilled and experienced clinical staff throughout the emergency department to support the care and treatment of patients.	ED Matron, ED Clinical Lead	Staffing uplift submitted - awaiting response, Skill mix completed, Monitored twice daily by senior nurse, Unify data, Individual training plans in place, Vacancy, mat leave and study leave monitored at 1:1 meetings, Overseas recruitment and training plan in place, Resus trolley: Daily/weekly checking processes in place.	22/03/2019	31/03/2020	Quality Forum	Yes	LINK	CQC Removed	27/01/2020
040	S31.08		7. Section or Warning Notice	Safe	Women and Children	S31.08: The Registered Provider will ensure that there is appropriate escalation of deteriorating patients in line with current guidelines and best practice with full medical handover at 9am and 7pm, with ward rounds at 12.30pm and 5pm.	Clinical Lead Obstetrics & Gynaecology	Guidelines and hand over records	31/07/2018	31/05/2020	Quality Forum	Yes	LINK	Completed & Signed off	27/04/2020
041	S31.09		7. Section or Warning Notice	Safe	Women and Children	S31.09: The Registered Provider must ensure that a senior daily clinical review is undertaken for every birth in the unit.	Inpatient Matron Women & Children, Clinical Lead	Audit of compliance	31/07/2018	31/03/2020	Quality Forum	Yes	LINK	Completed & Signed off	23/03/2020
042	S31.10		7. Section or Warning Notice	Well Led	Women and Children	S31.10: The Registered Provider must ensure there is executive director oversight and a system of monitoring and recording to ensure that senior clinical review is in place.	DLT Women & Children	Badger net audit and governance meetings	31/07/2018	31/03/2020	Quality Forum	Yes	LINK	Completed & Signed off	23/03/2020
043	S31.11		7. Section or Warning Notice	Safe	Women and Children	S31.11: The Registered Provider will ensure that all incidents within the maternity service are reported and investigated in line with trust policy.	Risk & Governance Matron Women & Children	Operational Governance group log	31/07/2018	31/07/2020	Quality Forum	Yes	LINK	CQC Removed	27/07/2020
044	S31.12		7. Section or Warning Notice	Effective	Women and Children	S31.12: The Registered Provider must ensure that all policies and procedures are in line with national best practice and are current.	Risk & Governance Matron Women & Children	All guidelines up to date	31/07/2018	31/07/2020	Quality Forum	Yes	LINK	CQC Removed	27/07/2020
045	S31.13		7. Section or Warning Notice	Effective	Women and Children	S31.13: The registered provider must ensure that there is an effective system in place to monitor and follow up patients within the Gynae/oncology service post surgery, review or investigations.	Divisional General Manager Women & Children	Flow chart and Panda minutes	22/03/2019	31/10/2019	Quality Forum	Yes	LINK	CQC Removed	11/11/2019

046	S31.14		7. Section or Warning Notice	Safe	Clinical Support Services	S31.14: The registered provider must ensure that relevant clinical policies and guidelines are in place across the diagnostic imaging department to support operational activity. This includes policies related to scope of practice and patient care. The registered provider must ensure that policies and guidelines are in line with national guidance, legislation and best practice. Regular audit must take place to ensure compliance.	Radiology Manager	Closed	01/06/2019	31/12/2019	Quality Forum	Yes	LINK	CQC Removed	12/12/2019
047	S31.15		7. Section or Warning Notice	Safe	Clinical Support Services	S31.15: The registered provider must ensure that all Patient Group Directions (PGDs) are fit for purpose and all staff working under a PGD have received the appropriate training and competency assessments. This includes annual competency assessments.	Radiology Manager	Lifting of the Section 31 Condition notice by the CQC. Continued PGD audit compliance.	01/06/2019	30/01/2020	Quality Forum	Yes	LINK	CQC Removed	27/01/2020
048	S31.16		7. Section or Warning Notice	Safe	Clinical Support Services	S31.16: The registered provider must ensure that an effective system is in place for the regular oversight of the appropriate escalation of significant findings. This should include diagnostic imaging undertaken out of hours to ensure that any patients at risk are escalated appropriately.	Radiology Manager	Closed	01/06/2019	30/03/2020	Quality Forum	Yes	LINK	Completed & Signed off	11/11/2019
049	S31.17		7. Section or Warning Notice	Well Led	Clinical Support Services	S31.17: The registered provider must ensure that there is robust system in place to facilitate effective clinical governance within the diagnostic imaging department. This is to include oversight of training, compliance to scope of practice, learning from incidents and escalation processes. The registered provider must ensure that there is a systematic approach to audit to measure compliance with protocols, processes and professional standards. The registered provider must ensure that there are processes in place for effective communication within the diagnostic imaging department.	Clinical Lead Clinical Support Services	Lifting of the Section 31 Condition notice by the CQC. Continued evidence of incident learning and governance processes from the departments clinical governance meeting.	01/06/2019	30/06/2020	Quality Forum	Yes	LINK	Completed & Signed off	22/06/2020
			8. Divisional												
050	S.26		8. Divisional	Safe	Corporate (Medicine, Surgery, Women and Children, Clinical Support Services)	S.26: The trust should ensure staff store patient records securely.	Director of Finance	IG Training in place. Confidentiality audit programme in place	01/01/2021	31/10/2021				Not Completed	23/02/2021
051	M.14		8. Divisional	Safe	Medicine (Surgery)	M.14: The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	Updated Perfect ward audit questions live with evidence of improving fluid balance compliance. Data evidencing increase in training compliance.	01/01/2021	30/06/2021				Not Completed	23/02/2021
052	M.15		8. Divisional	Safe	Medicine (Surgery, Women and Children, Clinical Support Services)	M.15: The trust must ensure mental capacity assessments are consistently and competently carried out where required.	Chief Nurse	MCA training plan in place Training material reviewed	01/01/2021	30/09/2021				Not Completed	23/02/2021
053	M.16		8. Divisional	Safe	Medicine (Surgery, Women and Children, Clinical Support Services)	M.16: The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes.	Chief Nurse	MCA/DoOLS training plan in place Training material reviewed	01/01/2021	28/02/2021	Quality Forum	Yes	LINK	Completed & Signed off	23/02/2021
054	M.17		8. Divisional	Safe	Medicine (Surgery)	M.17: The trust must continue to monitor and take action to improve completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms and that appropriate mental capacity assessments are undertaken for patients with a DNACPR in place.	Clinical Director Acute Medicine	DNA CPR completion monitored and challenged locally. Audit plan in place.	01/01/2021	28/02/2021	Quality Forum	Yes	LINK	Completed & Signed off	23/02/2021
055	M.18, S.27	Linked to U & E Care Programme	8. Divisional	Responsive	Medicine	M.18: The trust must improve its performance times in relation to ambulance turnaround delays, four-hour target, patients waiting more than four hours from the decision to admit until being admitted and monthly median total time in A&E. S.27: The service should ensure that care and treatment are accessible at the time of need and referral to treatment times and waiting times are in line with national standards.	Chief Operating Officer	Trustwide Project to support flow	01/01/2021	31/10/2021				Not Completed	
056	M.19	Linked to Maternity Improvement Plan	8. Divisional	Safe	Women and Children	M.19: The trust must ensure that anaesthetists complete PROMPT (Practical Obstetric Multi-Professional Training) training.	DLT Women & Children	Anaesthetist fully compliance with Prompt. This work is linked to the Maternity Improvement Plan.	21/12/2020	31/05/2021				Not Completed	
057	M.20		8. Divisional	Safe	Clinical Support Services	M.20: The trust must ensure that staffing levels are adequate to provide safe care and treatment to patients in a timely way.	DLT Clinical Support Services	There are sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the Radiology Department's staffing requirments. The measure of success will be having 90% of WTE Radiologist posts filled; 100% of WTE Radiographer posts; 85% of Cross-sectional posts; 85% of Sonographers posts; and 100% of Support Worker posts filled, which should provide roughly 90% capacity across the department. With the goal of ensuring no higher vacancy rate than 10% moving forward.	11/01/2021	31/12/2021				Not Completed	
058	M.21		8. Divisional	Safe	Clinical Support Services	M.21: The trust must be assured that the out of hours staffing arrangement is sustainable and robust to provide safe care and treatment to patients.	DLT Clinical Support Services	There are sufficient numbers of suitably qualified, competent, skilled and experienced staff covering the out of hours Radiology provision. The measure of success will be having 90% of WTE Radiologist posts filled; 100% of WTE Radiographer posts; 85% of Cross-sectional posts; 85% of Sonographers posts; and 100% of Support Worker posts filled, which should provide roughly 90% capacity across the department. With the goal of ensuring no higher vacancy rate than 10% moving forward.	11/01/2021	31/12/2021				Not Completed	
059	S.28	(See 061)	8. Divisional	Responsive	Surgery	S.28: The trust should ensure patients on the 62-day pathway receive treatment in line with the national target.	Chief Operating Officer	Restoration and Recovery Programme in line with NHSE requirement	01/01/2021	30/09/2021				Not Completed	
060	S.29		8. Divisional	Well Led	Surgery	S.29: The service should develop and implement a clear vision and strategy.	DLT Surgery	Strategy Developed and implemented	01/01/2021	31/05/2021				Not Completed	
061	S.30	(See 059)	8. Divisional	Responsive	Surgery	S.30: The trust should ensure that patients commence treatment for cancer within 62 days in line with national guidance.	Chief Operating Officer	Restoration and Recovery Programme in line with NHSE requirement	01/01/2021	30/09/2021				Not Completed	
062	S.31		8. Divisional	Well Led	Medicine	S.31: The trust should ensure that plans in relation to the development of a strategy for the urgent and emergency service are implemented.	DLT Medicine	Strategy Developed and implemented	01/01/2021	30/09/2021				Not Completed	
063	S.32		8. Divisional	Safe	Medicine	S.32: The trust should ensure staff complete appropriate resuscitation equipment checks.	DLT Medicine	Improved audit results. Training Programme in place	01/01/2021	30/06/2021				Not Completed	
064	S.33	Linked to Maternity Improvement Plan	8. Divisional	Well Led	Women and Children	S.33: The service should monitor the progress of the implementation of the strategy.	DLT Women & Children	Completed strategy Strategy shared with all staff Progress monitoring against the Strategy This work is linked to the Maternity Improvement Plan.	01/01/2021	31/07/2021				Not Completed	

065	S.34	Linked to Maternity Improvement Plan	8. Divisional	Safe	Women and Children	S.34: The service should ensure that there are enough maternity staff with the right qualifications, skills, training and experience to provide the service.	DLT Women & Children	Business case completed Business case approved Successful recruitment Full establishment This work is linked to the Maternity Improvement Plan.	01/01/2021	31/10/2021				Not Completed	
066	S.35	Linked to Maternity Improvement Plan	8. Divisional	Effective	Women and Children	S.35: The service should work towards achieving 100% labour ward co-ordinator supernumerary status at all times.	DLT Women & Children	fully recruited band 7 establishment 2 x band 7 on each shift – this will be monitored via the maternity dashboard This work is linked to the Maternity Improvement Plan.	01/01/2021	31/12/2021				Not Completed	
067	S.36	Linked to Maternity Improvement Plan	8. Divisional	Effective	Women and Children	S.36: The service should ensure that there is midwifery representation at the Cardiotocography (CTG) meetings.	DLT Women & Children	Midwife representation at all CTG meeting. This work is linked to the Maternity Improvement Plan.	01/01/2021	31/05/2021				Not Completed	
068	S.37		8. Divisional	Responsive	Clinical Support Services	S.37: The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.	DLT Clinical Support Services	The measure of success will be an improvement in position on the data provided to NHS Digital that is utilised to inform the Model Hospital data, which will also enable us to benchmark, and measure performance against peer Trusts.	01/01/2021	31/12/2021				Not Completed	23/03/2021
069	S.38		8. Divisional	Safe	Clinical Support Services	S.38: The trust should continue to embed the governance and risk management processes.	DLT Clinical Support Services	An embedded governance and risk management structure, and associated processes, that is measured through a decrease in patient safety incidents that result in harm; a decrease in complaints; improved oversight and evidence of risk mitigation; and an improvement in the diagnostic imaging (and wider CSS Division) CQC ratings for Safe, Effective, Responsive and Well Led domains	01/01/2021	30/09/2021				Not Completed	
070	S.39		8. Divisional	Well Led	Clinical Support Services	S.39: The trust should develop a formalised vision and strategy in radiology.	DLT Clinical Support Services	A published and promoted Vision statement and Work Plan for the CSS Division, and each of its associated services and departments, that is linked to the Trust Vision and Strategy, and is both understood and embraced by the staff in the Division. This will be measured by the services performance against, and compliance with the agreed Vison and Work Plan.	01/01/2021	30/09/2021				Not Completed	