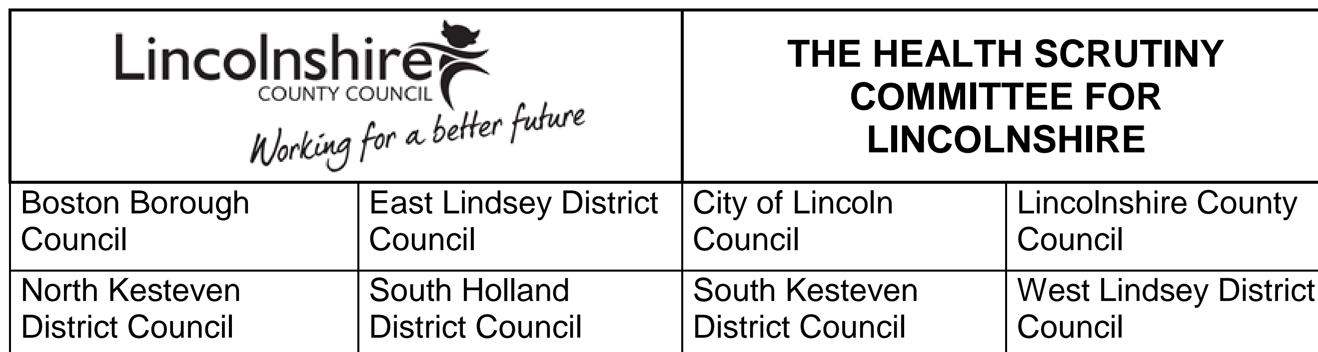
Agenda Item 5



Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of United Lincolnshire Hospitals NHS Trust

Report to:	**Health Scrutiny Committee for Lincolnshire**
Date:	**22 January 2020**
Subject:	**United Lincolnshire Hospitals NHS Trust – Update on Care Quality Commission Inspection**

Summary:

This paper provides an update on the Care Quality Commission Inspection at United Lincolnshire Hospitals NHS Trust.

Actions Required:

The Health Scrutiny Committee is asked to:

1) note the Care Quality Commission's findings on United Lincolnshire Hospitals NHS Trust;

2) note United Lincolnshire Hospitals NHS Trust's future plans for improving quality and safety; and

3) agree the frequency of updates on progress from United Lincolnshire Hospitals NHS Trust to the Committee.

1. Introduction

The Care Quality Commission (CQC) inspected the Trust during June 2019. A separate 'well-led' assessment took place during July 2019. The final inspection report was published in October 2019. This report is available on the CQC's website:

https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ4252.pdf

Not all services were inspected but all sites were. The services inspected included:

- urgent and emergency care at Lincoln and Pilgrim hospitals
- medical care at Lincoln and Pilgrim hospitals
- critical care at Lincoln and Pilgrim hospitals
- maternity services at Lincoln and Pilgrim hospitals
- children and young people's services inspected at Lincoln and Pilgrim hospitals

The CQC found the Trust to have remained with an overall rating of 'requires improvement'. Two of the four hospital locations are rated as 'good' overall and following an improvement in the ratings of Pilgrim Hospital two as 'requires improvement'. The CQC rates organisations on five domains as shown below. The four domains of safe, effective, responsive and well-led were rated as 'requires improvement', with caring rated as 'good'.

The CQC report details a mix of positive improvements and current challenges for the Trust, many of which were identified within the Trust prior to the inspection and formed part of the ongoing Quality and Safety Improvement Plan. Whilst improvements have been made in some areas the Trust has not made the improvements it wanted and were expected and will remain in special measures.

The Trust is in the process of developing an Integrated Improvement Plan and is reviewing the process and structure through which this plan is owned, delivered and assured. This plan will address those areas where both the Trust and external regulators have identified improvement is required. It will also ensure that the Trust achieve compliance against regulatory standards.

2. 2019 Care Quality Commission Ratings

The CQC identified the Trust ratings as following:

Overall rating for the Trust as Requires Improvement

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Requires improvement →← Oct 2019	Requires improvement →← Oct 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Individual ratings by hospital site are as detailed below:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lincoln County Hospital	Requires improvement ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019	Good ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019
Pilgrim Hospital	Inadequate ↓ Oct 2019	Requires improvement ➔🡐 Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
County Hospital, Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires improvement ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019	Good ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019	Requires improvement ➔🡐 Oct 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The CQC found the Trust to have remained with an overall rating of 'requires improvement'. Two of the four hospital locations are rated as 'good' overall and following an improvement in the rating of Pilgrim Hospital, two as 'requires improvement'. Our overall ratings for the Trust in each of the five domains have remained the same at this 2019 inspection.

Overall, our individual ratings for each hospital site are as follows:

- Lincoln County Hospital – requires improvement
- Pilgrim Hospital Boston – requires improvement
- Grantham and District Hospital – good
- County Hospital, Louth – good

Examples of Outstanding Practice

In their inspection report the CQC identified examples of outstanding practice and exemplary care across our services. This was recognised through the progress at Pilgrim hospital where the overall rating moved from 'Inadequate' to 'Requires Improvement' in addition the report overwhelmingly recognised how great Trust staff are positively identifying the care and compassion the inspectors witnessed during their visits. The report also recognised the significant improvements to reducing mortality within the Trust with the Hospital Standardised Mortality Rate (HSMR) being consistently below 100.

Concerns Recorded by the CQC

However, the CQC highlighted concerns related to structural issues including governance, staffing shortages, estates issues, lack of digital maturity and financial pressures. The Trust recognises there is additional a requirement to focus on recruitment, leadership, staff training and competencies, staff engagement and addressing workforce inequalities going forward.

3. Trust Progress

The CQC found a number of areas had significantly improved since their last visit and these were identified throughout the report with some specific aspects identified as 'outstanding'. Examples of these included:

- Critical care on at both Lincoln and Pilgrim Hospitals were identified as delivering exemplary care and teamwork. Bespoke care plans, patient follow up clinics and information for patients as areas where cited as example of how staff considered how they individualise and personalise care.
- The maternity services who were congratulated by inspectors for the bereavement care and support given to women and families.
- Older people's care praised for focus on dementia patients particularly the dignity campaign and the trusts development and utilization of dementia practitioners.
- Inspectors highlighted that most staff provided good care and treatment and worked well together for the benefit of patients.
- Most staff understood the vision and values and how to apply them in their work.

4. Identified Challenges

The CQC has told the trust to make a number of improvements. These were all challenges that were known to the Trust, and the CQC report acknowledges that the Trust had already commenced improvement work against these areas of challenge. Specific areas of concern included:

- Urgent and emergency care at both Pilgrim Hospital and Lincoln Hospital was of significant concern. The rating for whether services were safe at Pilgrim Hospital is now Inadequate, where previously it was Requires Improvement, and the ratings in urgent and emergency care at Lincoln County Hospital have also declined, with the department being rated Inadequate overall.

- Children and young people's services at Pilgrim Hospital remained Inadequate.

As a result of their findings from the hospital inspection, the CQC imposed further conditions on the Trust's registration in the form of a Section 31 with regard to the emergency departments at both Lincoln County and Pilgrim Hospital. They issued a 29A Warning Notice with regard to its children and young people's services. Finally, in their inspection report the CQC identified a number of 'must do's' and 'should do's'.

Improvement related to these areas has been ongoing through the Divisions and monitored through the Trust's governance processes. Further improvement actions were commenced at the time of the CQC visit, when concerns were raised, and significant improvements have already been made. This work will continue and be monitored through the Integrated Improvement Plan.

The ten section 31 conditions applied following the previous CQC visit have been monitored continuously since the point at which they were applied in February 2018. The Director of Nursing and Director of Operations continuously review the detail of improvement work being undertaken within the Emergency Department. Following improvements, six conditions were lifted with regular weekly reports being changed to monthly.

Three conditions were applied following the 2019 inspection. These included:

- Timely screening and treatment of patients attending the Emergency Department suspected of having sepsis (Lincoln and Pilgrim Hospitals)
- Timely triage of all patient attending the Emergency Department (Lincoln and Pilgrim Hospitals)
- Ensuring the environment in the Emergency Department in which Children and Young People are cared for meets the national 'Facing the Future standards' (Lincoln Hospital)

These have been monitored continuously since the point at which they were applied and have demonstrated significant improvement.

Evidence and an associated improvement action plan was submitted at the time the warning notice was issued. Improvements against the action plan have been monitored through the Trust's Quality Governance Committee.

There is a requirement, by the CQC, to ensure that the Trust address all the must do's and to summit a comprehensive action plan to demonstrate this. All the must do's have all been mapped into the either the Integrated Improvement Plan or to specific individual improvement work. These focused programmes demonstrates how care is being delivered in line with the Health and Social Care Act 2008, improvements are being monitored closely by the Executive team and reported to Trust Board through its assurance committees.

Whilst the 'should do's', do not form a regulatory requirement, they represent aspects of patient care which regulators believe should be improved as they affect the quality of patient care. For this reason, mapping and monitoring of the delivery of improvements against the 'should do's' is being undertaken in the same manner as the 'must do's'.

The document at Appendix A identifies all '*must do's*' and '*should do's*' that are identified within the CQC inspection report. Map these to programmes within the trusts Integrated Improvement Plan and give a progress update as of January 2020.

5. Next Steps

The Trust is finalising an Integrated Improvement Plan following the inspection. This is a new structure through which the Trust describes, delivers and monitors improvements. Once agreed through the Trust governance processes this will be shared more widely. This plan is being supported by the system and regulators.

The plan contains specific actions we are taking to improve the areas where we are not delivering safe, responsive, effective outcomes. It also includes, as described above, a detailed set of actions around required regulatory improvements in urgent and emergency care, Children and Young People services and addresses compliance concerns identified through the 'Must' and 'Should do's'.

The process by which the Integrated Improvement Plan is managed has been altered to align to existing governance structures giving greater scrutiny of delivery and assurance of improvements to the monthly Quality Governance Committee (QGC). Upward escalation of issues and oversight by Trust Board will happen via QGC. The changed structure gives greater ownership of both challenges and improvements to our frontline teams, managers and leaders through our new Trust Operating Model (TOM).

We have a programme of work to support the development of our leaders and further embed our new TOM across the organisation (not just in divisions) to improve leadership, develop competencies and improve staff engagement across the Trust.

To improve our staffing position, the Trust is currently undertaking an extensive domestic and international recruitment programme, for both medical and nursing posts. The Trust is working with the universities to support further recruitment into nursing posts and in the development of the Lincoln Medical School.

6. Consultation

This is not a direct consultation item, although the Committee is asked to consider how it wishes to monitor progress.

7. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

Improving the quality and safety of care provided to patients at ULHT will help deliver the priorities in the Lincolnshire Joint Health and Wellbeing Strategy.

8. Conclusion

ULHT, supported by its partners, need to make continued progress to improve quality and safety across the Trust.

Since the inspection in July 2019 measurable progress has already been made to respond to the CQC's immediate concerns.

A full detailed plan will be shared once completed.

Trust Board and System oversight from NHSI is in place. A variety of support opportunities are being received by the Trust facilitated though NHSE/I.

9. Appendices

Appendix A	United Lincolnshire Hospitals NHS Trust Response to Care Quality Commission Must Do's and Should Do's – January 2020

10. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Victoria Bagshaw, the Director of Nursing, United Lincolnshire Hospitals NHS Trust, who can be contacted on 01522 573982 or via victoria.bagshaw@ulh.nhs.uk

CQC Must Do / Should Do

Executive Lead: Victoria Bagshaw, Director of Nursing
Progress Review Date: January 2020

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
1.	The Trust must ensure the executive leadership team have the capacity and capability to deliver current priorities and challenges	CEO	Must Do	Yes Objective- People Workstream – Well Led		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD Committee	1. DoF post filled substantively. 2. DoN recruitment process undertaken. Process paused in order to allow time for alternative solution to be found. 3. Director/Directorate/Portfolio changes proposed. This going to Remcom on 7/1/20 for sign off. 4. Senior leadership capacity and capability to be formally reviewed. Discussed with Remcom on 7/1/20.
2.	The Trust must ensure the leadership team have oversight of current priorities and challenges and are taking actions to address them.	CEO	Must Do	Yes Objective – People Workstream – Well Led		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD Committee	1. New leadership structures (ELT/TLT/LTF) being implemented to ensure improved focus and grip. Part of Improving ULHT proposals. 2. Revised ToR, agendas and reports for ELT and TLT will ensure better assurance, focus and grip. 3. Integrated Improvement Plan will have supporting PMO and progress reporting to ELT, Board assurance committees and the Board.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
3.	The Trust must ensure leadership structures have a continued focus to ensure they embed across the organisation.	Deputy CEO	Must Do	Yes Objective – People Workstream – Well Led		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD Committee	Development programmes in place and underway for: - Divisional Triumvirates - General/Business Managers/Matrons - Clinical Leads OD support in place from for Divisional Triumvirates delivered by Be Effective. Supportive infrastructure reinforces organisational wide approach. Middle management forum met for the first time in December. Further meetings planned in February and March
4.	The Trust must ensure staff understand how their role contributes to achieving the strategy.	Deputy CEO)	Must Do	Yes Objective – People Workstream – Well Led		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD Committee	Organisational strategy has been refreshed. Trust Board to receive and adopt in February with launch in organisation in March. Revised strategy aligning annual planning for 2020/21.
5.	The Trust must ensure there is timely progress against delivery of the strategy and local plans continue to be monitored and reviewed.	Deputy CEO	Must Do	Yes Objective – People Workstream -Well Led		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD Committee	Work underway with KPMG to align their Operational Excellence model to align strategy to local delivery plans with robust oversight arrangements through to Trust Board.
6.	The Trust must ensure action is taken to ensure staff feel respected, supported and valued and are always focused on the needs of patients receiving care.	HRD	Must Do	Yes Objective- People Workstream – Making ULHT best place to work		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD Committee	Staff charter workshops continue – to date 1460 staff have attended Bullying and harassment (respect) project in place. 100 day challenge ("Building Respectful Teams") to launch in February Review of Dignity at Work policy underway – review to reflect "Just Culture" approach. Small improvement in NSS scores in 2019 across majority of questions. Awaiting further analysis and index scores

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
7.	The Trust must work at pace to ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical and nursing staff across all services.	HRD	Must Do	Yes Objective – People Workstream – Modern, Progressive Workforce		Executive Team (monthly IIP oversight) Workforce Strategy Group	WOD Committee	Pipeline of medical staff remains strong. First appointments made under contract for international nurse recruitment. Actively pursuing HEE Global Learners Programme for nursing. Aiming for monthly minimum of 15 RNs (10 RN's already recruited in Jan20) DoN commenced a zero vacancy approach to HCA posts. Expected to have recruited to all outstanding posts by 17/1/20 Potential to participate in Refugee Doctors Project with HEE funding to support. Small but steady improvements in vacancy and turnover rates over last six months, but "hot-spot" areas remain.
8.	The Trust must ensure there are effective governance processes throughout the service and with partner organisations.	CEO	Must Do	Yes Objective – People Workstream – Well Led		Executive Team (monthly IIP oversight)	WOD Committee	1. New leadership structures (ELT/TLT/LTF) being implemented to ensure improved focus and grip. Part of Improving ULHT proposals. 2. Revised quality governance structure being put in place below QGC. 3. LCB has agreed new system governance and assurance processes involving NEDs and lay members. 4. JWEG and SET are agreeing the revised management governance and accountability arrangements prior to shadow ICS in April 2020. Next SET discussion is on 8/1/20. 5. New SOP to be put in place for the operation of Divisions. Part of Improving ULHT proposals.
9.	The Trust must ensure systems to manage performance are embedded across the organisation.	DoF	Must Do	Yes Objective – People Workstream – Well Led		Executive Team (monthly IIP oversight)	FPEC	Work underway with KPMG to align their Operational Excellence model to align strategy to local delivery plans with robust oversight arrangements through to Trust Board.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
10.	The Trust must ensure leaders and teams, across all services, always identify and escalate relevant risks and issues and identify actions to reduce their impact.	MD	Must Do	Yes Objective – People Workstream – Well Led		Executive Team (monthly IIP oversight) ↑ QSOG	QGC	This process is in place. The issues are consistency of reporting, the assessment of the appropriate level of risk and taking ownership to mitigate the risk, rather than simply recording it. Currently the risk team have concentrated on compiling the register and now will move on to the next phase of education and training of the Divisions.
11.	The Trust must ensure all staff are committed to continually learning and improving services.	HRD	Must Do	Yes Objective – People Workstream – Modern, progressive workforce		Executive Team (monthly IIP oversight ↑ Workforce Strategy Group	WOD	Pilot of shared governance approach in place – 4 areas United Lincolnshire Hospitals NHS Trust, was awarded QSIR Faculty Status in June 2019 by NHS Improvement – 50 staff have attended QSIR training to date. Additionally, around 70 people have delivered QI projects in year and a number of them have show-cased their projects at a sharing event on 16th December. 7 members of staff visited UCLH 07/01/20 to learn about their work on improving safety. Group will be set up to take work forward at ULHT. Accredited as first FAB Trust in November.
12.	The Trust must ensure systems or processes are established and operated effectively, across all services, in line with national guidance.	MD	Must Do	Yes Objective – Patients Workstream – Improve clinical outcomes		Executive Team (monthly IIP oversight)	QGC	Specific focus on clinical effectiveness and embedding this at a Divisional level with robust reporting through to QGC. Programme in place for National, specialty focused and local audits. Need to ensure that the learning from these are embedded at a speciality level. Overseen by Clinical Effectiveness group chaired by DMD Development of guidelines overseen by Clinical Effectiveness group chaired by DMD. Well-established process for managing GIRFT reviews.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
13.	The Trust must ensure premises across all services are suitable for the purpose for which they are being used and properly maintained.	Director of Estates	Must Do	Yes Objective – Services Workstream – fit for purpose environment		Executive Team (monthly IIP oversight)	FPEC	30k investment in car park surfaces across all three sites. 33k investment in spot repairs to paintwork in patient areas. 27k investment in floor and expansion joint repairs. PLACE Action Plan developed with nursing with oversight by DoN. Improving Aesthetics of Patient Environment paper presented to ET, which identifies budget costs to improve the aesthetics of all patient areas and cost for a Handyman service and admin support for series of 3 PLACE Lite visits per year. PLACE inspection has been completed for this year's PLACE assessments, which included a training /information session for patient representatives, volunteers and senior nursing staff.
14.	The Trust should ensure the causes of workforce inequality are sufficiently addressed to ensure staff from a BAME background are supported through their career development.	HRD	Should Do	Yes Objective – People Workstream – Making ULHT best place to work		Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD	Talent Management plan for the Trust drafted and will be considered by ET first in January. This incorporates developing the careers of under-represented groups and ensuring there is equality of opportunity for our diverse talent
15.	The Trust should ensure there is an increased awareness of the role of the Freedom to Speak Up Guardian role.	CEO	Should Do	No	Trust Wide IIP Objective – People, Workstream - Making ULHT best place to work	Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD	1. FTSU champions appointed x 12. 2. Staff awareness campaign was run in October 2019 as part of the national campaign. 3. FTSUG has put in place increased visits to sites and teams. 4. CEO has highlighted FTSUG role in Team Brief blog.
16.	The Trust should ensure there is a clear process for the GOSW report to the board and that issues raised through the GOSW are appropriately addressed.	MD	Should Do	No	Trust Wide IIP Objective – People, Workstream - Making ULHT best place to work	Executive Team (monthly IIP oversight) ↑ Workforce Strategy Group	WOD	There is a clear reporting framework and an interim guardian with admin support. Current issues relate to rota management and SOP now produced and disseminated.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
17.	The Trust should ensure divisional leads are fully engaged in decisions about financial improvement and have oversight of their divisional budgets.	DoF	Should Do	Yes Objective – Services Workstream – Efficient use of resources		Executive Team (monthly IIP oversight)	FPEC	Divisions have clear oversight of their budget through the monthly reporting cycle, further work being undertaken to embed the ownership of this in division. 20/21 planning process engaging divisions in the design of CIP plans to ensure local ownership, target will be stretching based on evidence benchmarking.
18.	The Trust should ensure leaders and staff strive for continuous learning, improvement and innovation through participation in appropriate research projects.	MD	Should Do	Yes Objective – Partners Workstream- Become a University Teaching Hospital		Executive Team	QGC	A fundamental review of the Research and Innovation Department is planned for 2020. An external audit has been undertaken by the CRN and a financial audit by Grant Thompson (draft report only). The strategy prepared in 2019 will be re-written and an implementation plan developed in conjunction with CRN and other partners.
Urgent and Emergency Care								
19.	The Trust must ensure all patients who attend the department are admitted, transferred and discharged from the department within four hours.	COO	Must Do	Yes Objective – Services Workstream – Evidence based care pathways		Executive Team ↑ Performance Reviews	FPEC	The focus of improvement for ED is : Ambulance handover – a dedicated system wide project-working group reviewing opportunities to reduce conveyance and improve handover. This reports to UEC Delivery Board. UTC – GP streaming has formally been commissioned into an urgent treatment centre at Lincoln and Pilgrim and we have seen a sharp rise in patients seen by this service. As part of the reconfiguration the footprint of the UTC has been increased and this has contributed to their ability to be able to see and treat more patients. Triage – this has vastly improved at Pilgrim. The same model is being implemented at Lincoln through engagement with staff, which is starting to show signs of improvement. SDEC – Same day emergency care pathways have been implemented in addition to a new SDEC facility as part of the Lincoln reconfiguration. There are on average 20 patients per day currently being seen through this facility and this number is expected to rise.

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								A frailty service has been implemented at the front door offering comprehensive geriatric assessment and triage for frail patients which is leading to improved pathways for patients. Seen within 60 minutes – this requires further work and clinical engagement Transfer of patients – capacity meetings have been redesigned to take account of the cross-site capacity opportunities. A 30-minute target has been established from decision to admit to a bed being identified and a patient moving. Extra transport resources have been commissioned to enhance resilience and flow. Medical and nursing staffing – a medical staffing 'perfect week' was held and as a result a business case is being developed to implement the staffing appropriate for the size of the department. Nurse staffing has been reconfigured to improve the level of seniority and experience on the floor with the additional posts being advertised wk. commencing 13/1/20 Culture and Behaviour – staff have been engaged on cultures, behaviours and feelings. This is leading to a larger piece of work with medical and nurse staffing being brought together with external facilitation to identify solutions and improvements to the department that are led by the department.

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20.	The Trust must ensure information is readily available for patients to take away that details what signs or symptoms they needed to look out for that would prompt a return to hospital or seeking further advice.	COO	Must Do	No	Medicine - Divisional IIP Objective - Services, Evidence based Care pathways (Urgent care improvement)	Performance Reviews ↑ Divisional Board	FPEC	Planned Care / Surgery has been trialling EIDO leaflets – now rolled out across all 4 sites. Review of how other high performing Trusts in the region meet this aspect of care. Decision to adopt across all sites the process used at Sherwood Forest NHS Trust who do not give out any written advice to discharged patients but offer verbal “safety netting” advice. This will be as an adjunct to our current information leaflets. A further planned visit to Sherwood to observe their system in action. DoN leading a piece of work to ensure all C&YP are provided with wider health promotion and safety information when attending ED’s.
21.	The Trust should ensure governance and performance monitoring and management are strengthened at operational level.	DoF	Should Do	Yes Objective – People Workstream – Well Led		Executive Team ↑ Performance Reviews/QSOG	FPEC/QGC	Operational Excellence work commissioned with work commencing on site on 13th January. It will deliver a clear performance management system and provide coaching to all levels of staff to ensure the processes are run effectively.
22.	The Trust should ensure consistent arrangements for pain relief and nutrition are developed for patients who are in the emergency department.	DoN	Should Do	No	Medicine- Divisional IIP Objective - Patients	Performance Reviews/QSOG ↑ Divisional Board	QGC	The ED accreditation process occurs monthly and gives oversight of all aspects of care and safety in the department. The DoN has reviewed the detailed improvement plans, developed by the Division. An amended process has been put in place to ensure actions are being implemented and have a sustained positive impact. With specific focus on regular rounding and improved documentation of actions taken in response to discussions with pts. Nutrition and Hydration group has supported the ED team to make a variety of foods are safely available in the ED.

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23.	The Trust should review pathways and processes in the emergency department to ensure they are efficient and communicate processes to staff so that there is a consistent understanding.	COO	Should Do	Yes Objective – Services Workstream – Evidence based care pathways		Executive Team ↑ Performance Reviews	FPEC	The Urgent and Emergency Care Improvement Programme (UEC) has 6 workstreams designed to improve the overall quality of care for patients and performance. The programme workstreams are as follows: ED processes and Systems, Site management, SDEC, Red2Green and SAFER, Discharge and Reconfiguration. The UEC Programme has a defined and embedded Governance structure reporting through A&E Delivery Board and Finance, Performance and Estates Committee, a sub-committee of Trust board. A large engagement piece taken place in ED with all levels of staff to understand the pressures and barriers to delivering the pathways that have been introduced which has highlighted the need for improvements to culture. This is being facilitated with external support as well as internal OD. Other of platforms for communicating improvements to staff, include improvement workshops specifically in terms of the reconfiguration, project pop-up shops, divisional and departmental meetings, huddles, project meetings, social media and 1:1s. A ‘closing the loop’ check-back process is being developed to ensure that communication is reaching all levels and that staff are able to confidently describe changes and their involvement in them.

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24.	The Trust should consider training key staff in customer care skills.	HRD	Should Do	No	Trust wide IPP Objective – Patients Workstream- Improve patient experience	Executive Team	WOD	"Customer First" training is in place. To date 465 staff have been trained. Review currently underway to assess impact (completion February 2020), exploring the following: - Refreshing the Communication First training s that it dovetails with the OD work around sta charter, behavioural framework - Whilst keeping Communication First training open for anyone to attend, ensuring staff members who have had their communicatio skills questioned are required to attend - Exploring the option of having a mandatory customer care/communications module Monitoring of effectiveness of staffs skills in customer care occurs PALS and formal complaints. The RCN leadership programme, which all ward /dept sisters and Charge Nurses are undertaking, includes work on frontline resolution of issues.
25.	The Trust should formulate a formal clinical audit plan with identified roles and responsibilities and review dates.	MD	Should Do	No	Trust wide IIP Objective – Patients Workstream- Improve Clinical Outcomes	Executive Team QSOG	QGC	A current audit plan has been prepared, however there is a gap between National audits, Trust audits and local audits. This will be brought together into an single integrated plan and will align to Trust and Divisional improvement work.
26.	The Trust should consider how sound levels might be reduced in the department. (ED Pilgrim)	Director of Estates	Should Do	No	Medicine – Divisional IPP Objective – Services Workstream – Fit for purpose environment	Performance Reviews ↑ Divisional Board	FPEC	The new £23.6m master plan, which is being developed for the Pilgrim ED, will incorporate a UTC designed to comply with current HTMs and HBNs building design standards. In respect of this patient flows through the ED will be improved, along with waiting and treatment spaces all of which will see a more highly considered spatial design. The Trust will also be utilising the DH design briefing HBNs (Health Building Note 00-01 General design guidance for healthcare buildings - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pdf) to support the specification of a high quality patient environment. This will offer improved patient privacy and dignity incorporating

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								measures to control sound levels within the department – key to this strategy will be i) Improved physical patient flows through the ED thereby creating a calm patient environment ii) Improved spatial standards and acoustic measures incorporated in between rooms and within doors. iii) The use of materials and sound deadening barriers within the environment to improve acoustics. iv) Waiting and circulation spaces, which support a movement strategy, aimed at introducing calming quiet environments. Improvements will also ensure alignment to *'Facing the Future- standards for children & young people in emergency care settings'*.
Medical Care (including Older Peoples Care)								
27.	The Trust must ensure patients receive timely review by specialist consultants when required, including speech and language therapy.	COO	Must Do	No	Medicine- Divisional IPP Objective – Patients Workstream – Improve clinical outcomes	Performance Reviews ↑ Divisional Board	FPEC	SaLT provision to the Trust is through and SLA with LCHS. For ED, improving performance is linked to embedding a process of internal professional standards. This work has taken shape and is being supported by the Chief Operating Officer and the Medical Director. For the wards, SAFER and Red2Green is being rolled out. This is now supported by an electronic system that links into Red2Green to help monitor what actions are outstanding and what needs to happen to make a difference to the patient's stay. This includes 'waiting to be seen by Consultant' or 'awaiting SaLT review'. The improvement team are supporting with the embedding of this process. There is an embedding plan for Red2Green and a roll out plan for SAFER. SaLT recruitment is improving. Management of change process is being undertaken by LCHS currently to review skill mix. Meeting with ICU colleagues to progress business case for SaLT provision to the units.

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28.	The Trust must ensure that processes are being followed related to proper and safe management of medicines.	MD	Must Do	Yes Objective – Patients Workstream- Deliver harm free care		Executive Team ↑ QSOG	QGC	This is currently audited through pharmacy and results are shared with Divisions. The Medicines Quality Group has been designed to address the issues relating to medicine safety and administration, reconciliation etc. This is also audited through ward accreditation (WA). The WA 2020 programme has revised criteria with the medicines standard and has been amended – any ward/dept failing this standard will fail accreditation.
29.	The Trust must ensure patients are treated with dignity and respect at all times.	DoN	Must Do	Yes Objective – Patients Workstream – Improve patient experience		Executive Team ↑ QSOG	QGC	Improvement work (described in 19 &23) is focussed on improving the patient flow through the ED to prevent patients being cared for in inappropriate areas. The ED accreditation process occurs monthly and gives oversight of all aspects of care and safety in the department. The DoN has reviewed the detailed improvement plans, developed by the Division. An amended process has been put in place to ensure actions are being implemented and have a sustained positive impact. With specific focus on regular rounding and ensuring care is delivered in appropriate areas. The DoN/Dep DoN have met and discussed with the Divisional and local ward team where the specific incident was highlighted by CQC, to share her expectations of patient care. This is being continuously monitored through the nursing quality processes including daily golden hour, ward accreditation and patient experience visits by the quality matrons. The revised WA 2020 standards includes expectation that information relating to dignity, respect and compassion is included in ward/department safety huddles. DoN has a weekly trust-wide meeting with ward/dept. Sisters and Charge Nurses and has discussed further actions. As a result, a trust-wide programme of work '*what matters to me most'* is being developed and rolled out.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
30.	Ensure beds ring-fenced for non-invasive ventilation and for thrombolysis are available for these patients and have trained, competent staff always available.	COO	Must Do	Yes Objective – Patients Workstream – Improve clinical Outcomes		Performance Reviews ↑ Divisional Boards	FPEC	The Trust has NIV and stroke ring-fenced beds on both the Pilgrim and Lincoln sites. A new process has been implemented whereby if a ring-fenced bed is used to outlie a patient due to capacity constraints, the capacity team work with the Consultants and business units to re-create alternative ring-fenced capacity within 2 hours. NIV bed availability have improved significantly over recent months and this can be demonstrated through the national data submission. Ring-fenced capacity availability is audited twice a day 0800 and 1200 as part of the national audit. To ensure that clinicians and managers are aware of the ring-fenced capacity position, an email is distributed daily outlining this information. These new processes are documented in the newly developed Clinical Operational Flow Policy which has recently been approved.
31.	The Trust should ensure an up to date policy and training to staff in the cardiac catheter lab is implemented for the use of conscious sedation for patients.	DoN	Should Do	No	Medicine- Divisional IIP Objective – Patients Workstream – Improve clinical outcomes	Performance Reviews ↑ Divisional Boards	FPEC	Conscious sedation policy has been written and is in the final stages of the Trust agreed governance sign off process. Expected completion end March 2020.

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32.	The Trust should ensure that patient notes and confidential information are stored securely.	MD	Should Do	No	Medicine - Divisional IIP Objective – Services Workstream – Enhanced data and digital capability	Performance Reviews Divisional Boards	FPEC	Patient records committee to oversee specific of incident that generated this situation and ensure the issues are resolved and that information regarding good practice is shared across the Trust. Accreditation process review safe storage of patient confidential information. Forensic analysis of this standard to be undertaken, themes and learning to be shared with ward and dept. teams through the DoN weekly meeting with Strs and ChNs.
33.	The Trust should ensure that there is an inpatient adult pain team that is sufficiently staffed for patients to be referred to.	DoN	Should Do	No	Trust wide IIP Objective – Patients Workstream – Improve patient Experience	Executive Team QSOG	QGC	Adult pain team is in place and visiting patients. DoN has met with nurses from the team to offer personal support and link them with high performing teams in other Trusts. Review of service at 6 and 12 months is scheduled to ensure appropriate service specification, capacity and capability of team to meet patient needs.
34.	The Trust should ensure patients are appropriately assessed for self-administration of medicines and that their own medicines are in date.	MD	Should Do	Yes Objective – Patients Workstream – Harm free care		Executive Team QSOG	QGC	All actions as action 28. The Medicines Quality Group has been designed to address and have oversight of the issues relating to medicine safety and administration, reconciliation.
35.	The Trust should establish a process that identifies patients on MEAU that require a specialist consultant review.	COO	Should Do	No	Medicine - Divisional IIP Objective – Patients Workstream – Improve Clinical Outcomes	Performance Reviews Divisional Boards	FPEC	This is achieved through Red2Green, SAFER and ward/board rounds.

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36.	The Trust should consider reducing the amount of patient moves during the night.	COO	Should Do	Yes Objective-Services Workstream- Evidence Based care pathways		Executive Team	FPEC	This information is collected on WebV Trust system. Patients in an assessment area are transferred to base wards 24 hours a day, however transfers out of base ward areas, unless clinically determined, are minimised. The use of the information captured on WebV requires more development to ensure there is adequate monitoring. The process is described in the newly approved Clinical Operations Policy.
37.	The Trust should review arrangements for discharge to ensure that there are no delays due to transport or waits for to take away medications.	COO	Should Do	Yes Objective-Services Workstream- Evidence Based care pathways		Executive Team	FPEC	This is part of the Red2Green actions which are reviewed twice daily by the improvement workstream and fed back into capacity meetings. Early escalation means that issues can be dealt with promptly ensuring that patients are able to progress through their pathway as swiftly as possible. There has been an increase in the number of patients identified for discharge at 10am which can be attributed to the introduction of Red2Green. The plan over the next 8 weeks is to embed this practice within CBUs to ensure sustainability. MADE events have happened in January on the Lincoln and Pilgrim sites and are scheduled through to mid-year and have enhanced partnership working.
38.	The Trust should ensure robust communication and referral standards in the IAC are established so that senior staff understand who is responsible for each patient and to reduce delays in specialist review.	COO	Should Do	No	Medicine – Divisional Plan Objective – Services Workstream – Improve clinical outcomes	Performance Reviews ↑ Divisional Boards	FPEC	There is an IAC SOP in place. The review date for this is January 2020 and it is currently under review.
39.	The Trust should ensure the leadership team in the stroke service are supported to resolve the backlog of open incident reports.	MD	Should Do	No	Medicine- Divisional IIP Objective – People Workstream – Well Led	Performance Reviews ↑ Divisional Boards	QGC	There is a programme of work to reduce the back log of all incident reports, these are steadily reducing.

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40.	The Trust should consider implementing more robust medical handover processes for patients being cared for as inpatients on haematology or oncology wards.	MD	Should Do	No	Medicine – Divisional IIP Objective – Services Workstream – Evidence based care pathways	Performance Reviews ↑ Divisional Boards	FPEC	A paper based process for medical handover has been trialled a review is being undertaken to see how this could be implemented. An electronic tool is available as part of the electronic observation tool the Trust will be using and once in place this will be rolled out as a priority.
41.	The Trust should review medical staffing on the IAC so that junior doctors have appropriate support and can provide care safely within their abilities.	COO	Should Do	No	Medicine Divisional IIP Objective- People Workstream – Modern, progressive workforce	Performance Reviews ↑ Divisional Boards	FPEC	A workforce review is to be undertaken which will identify the requirements needing to be built into a training programme and clarity around competence.
Children and Young People's Services								
42.	The Trust must ensure there are suitable arrangements in place to support people who are in a transition phase between services and/or other providers.	DoN	Must Do	Yes Objective – Services Workstream – Evidence based care pathways		Executive Team ↑ QSOG	QGC	The Trust has been successful in its bid to be part of the 3rd wave NHSE/I Improving Healthcare Transition Collaborative. The programme commences January 2020 with DoN as executive sponsor. *The ToR, membership, chair and functionality of the Trust-wide Children & Young Group were reviewed* in October2019 and the group re-established and includes membership from the CCG Chief Nurse. The group works in close relationship with the system-wide children & young people transformation group, which is chaired by the CCG.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
43.	The Trust must ensure all staff comply with good hand hygiene practice.	DoN	Must Do	Yes Objective – Patients Workstream- Harm free care		Executive Team ⇧ QSOG	QGC	A variety of communications have been used to remind all staff trust-wide of their responsibility to adhere to hand hygiene practice. This includes through the Divisional Cabinet meetings and the IPC group. Additional training and monitoring is in place through the IPC team. Non-compliance with hand hygiene practice is addressed at time. Repeated non-compliance is flagged to the individuals line manager and is managed through a clear escalation process which results in action taken by MD or DoN. Compliance with Hand hygiene audits is reviewed monthly at the IPC group chaired by DIPC.
44.	The Trust should ensure that they have robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight with overall responsibility held by the board.	DoN	Must Do	Yes Objective- Patients Workstream – Harm free care		Executive Team ⇧ QSOG	QGC	The ToR, membership and functionality of the Trust-wide safeguarding group have been reviewed. This includes ensuring better information flow between the safeguarding group and frontline teams and frontline teams understanding their individual responsibilities. A revised comprehensive programme of work has been devised which is based on a gap analysis of where the Trust is against all aspects of safeguarding legislation and mandatory requirements.
45.	The Trust should ensure children's safeguarding lead is in receipt of regular one to one safeguarding supervision.	DoN	Must Do	Yes Objective- Patients Workstream – Harm free care		Executive Team ⇧ QSOG	QGC	Supervisor identified and in place. Frequency of Supervision being monitored by the safeguarding lead's line manager.
46.	The Trust should ensure staff are in receipt of regular group supervision.	DoN	Must Do	Yes Objective -Patients Workstream – Harm free care		Executive Team ⇧ QSOG	QGC	Safeguarding supervision is provided to nursing and medical staff through the children's safeguarding lead and team. Ensuring that there is appropriate uptake of supervision is being monitored through the safeguarding group.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
47.	The Trust should ensure there is a medical lead for safeguarding.	MD	Must Do	Yes Objective – Patients Workstream – Harm free care		Executive Team ↑ QSOG	QGC	Completed. The lead for paediatric safeguarding is Dr Margaret Crawford who has allocated PA time for this role. There is a Trust wide non-medical lead who is responsible for all safeguarding issues and co-ordinates appropriate professional responses as required.
48.	The Trust should ensure plans are in place to assess staff adherence to infection prevention and control principles, in particular in relation to infection control high impact interventions.	DoN	Should Do	Yes Objective – Patients Workstream- Harm free care		Executive Team ↑ QSOG	QGC	Comprehensive plans for oversight of staff adherence to IPC requirements is through both the IPC team and nursing quality process eg golden hour, IPC audit, quality metrics (SQD). These are reported through to Divisional governance and IPC Group.
49.	The Trust should ensure it improves the separation of children and young people from adults in the operating recovery areas.	COO	Should Do	No	Surgical Division	Performance Reviews ↑ Divisional Boards	QGC	This is now fully compliant on both the Lincoln and Pilgrim sites. Unannounced audits undertaken by the Quality matron team to ensure compliance is maintained and reported through the Children and Young People's Group. Accreditation programme for operating theatres in development and will include this as a standard. Completion and pilot due in Q1/Q2 of 2020/21
50.	The Trust should review the provision of paediatric emergency drugs in the operating theatres.	MD	Should Do	No	Surgical – Divisional IIP Objective – Patients Workstream- Deliver harm free care	Performance Reviews ↑ QSOG	QGC	This review was undertaken by Dr Joachim following the CQC visit. The conclusion was the current arrangements are appropriate.
51.	The Trust should improve processes for the communication of learning from incidents to ensure they are robust.	MD	Should Do	Yes Objective – Patients Workstream – Harm free care		Executive Team ↑ QSOG	QGC	A variety of methods are currently used, this will be developed further as part of the Safety Culture workstream.

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52.	The Trust should improve facilities for children and young people visiting adult outpatient areas.	Director of Estates and Facilities	Should Do	No	Family Health- Divisional IIP Objective – Services Workstream – Evidence based care pathways	Performance Reviews ↑ Divisional Boards	QGC	A programme of improvement work related to the 'hidden child' i.e. those children who experience care outside Childrens Services, is in place led by the paediatric lead nurse. Where children will be attending for appointments, clinical areas will be checked to ensure they are age group appropriate for children and young people. This work is monitored through the Children and Young Peoples Group. The Trust will undertake an audit of outpatient physical environments to develop a strategy to comply with HBN12 Outpatients Departments. Focus will be on developing measures to deliver environments appropriate for children and young people who are visiting adult outpatient areas that address the best practice found in guidance such as 'Friendly healthcare environments for children and young people'(NHS Estates, 2003) and HBN 23, 'Hospital accommodation for children and young people'. The Trust recognises that children may accompany adults to an OPD and will seek to have suitable play and recreational equipment, provision of access to infant/baby feeding and access to nappy changing facilities for parents.
53.	The Trust should improve systems for alerting staff to patients such as those with a learning disability, or autism, who may need adjustments to improve access to care and services.	DoN	Should Do	Yes Objective – Patients Workstream – Harm free care (vulnerable patients)		Executive Team ↑ QSOG	QGC	The Trust is reviewing through the patient experience committee how improvements can be made and embedded.
54.	The Trust should improve training of staff in the requirements of children and young people with learning disabilities and/or autism.	DoN	Should Do	Yes Trust wide IIP Objective – Patients Workstream – Harm free care (vulnerable patients		Executive Team ↑ QSOG	QGC	Review of training to be undertaken and ensure this aligns to the 2 frameworks launched in Nov by HEE /Skills for Health. Continue to promote sign up to MENCAP '*treat me well*' campaign.
Critical Care								
55.	The Trust should ensure there is adequate pharmacist cover for the critical care unit at Lincoln Hospital.	MD	Should Do	No	Surgical/CSS - Divisional IIP's Objective – Patients Workstream-	Performance Reviews ↑ Divisional Boards	FPEC	MD to agree with Chief Pharmacist how this will be achieved

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
					Improve clinical outcomes			
56.	The Trust should ensure a pharmacist attends multidisciplinary ward handover meeting daily.	MD	Should Do	Yes Trust wide IIP Objective – Patients Workstream- Improve clinical outcomes		Executive Team ↑ QSOG	QGC	MD to agree with Chief Pharmacist how this will be achieved
57.	The Trust should ensure therapist cover includes dietetics, physiotherapists and speech and language therapists seven days a week.	COO	Should Do	No	CSS -Divisional IIP Objective – Services Workstream – Evidence based care pathways	Performance Reviews ↑ Divisional Boards	FPEC	7 day Physiotherapy provision in place on ICU SaLT recruitment improving. Meeting with ICU colleagues to progress business case for SaLT and Dietetic provision to the units. (As per comments in 27)
58.	The Trust should ensure the new senior leadership team has oversight of the critical care unit, as this level was not currently robust.	COO	Should Do	No	Surgical- Divisional IIP Objective- People Workstream- Well Led	Performance Reviews ↑ Divisional Boards	FPEC	Completed. Monthly CBU performance meetings in place. Monthly Divisional Clinical Governance meetings in place.
59.	The Trust should ensure finances for the ventilator replacement programme.	DoF	Should Do	No	Surgical- Divisional IIP Objective – Services Workstream- Efficient Use of resources	Performance Reviews ↑ Divisional Boards	FPEC	This will form part of the 20/21 budgeting process on a risk managed basis.
60.	The Trust should consider identifying support with staff moves to improve morale on the unit.(Lincoln ICU)	HRD	Should Do	No	Surgical Divisional IIP Objective- People Workstream- Make ULHT best place to work	Performance Reviews ↑ Divisional Boards	WOD	Issue has been raised with DoN who has visited the ICU to discuss with the nursing team. Process in place to ensure staff are only moved when necessary. Moving staff to ensure overall patient safety is an inevitability due to Trustwide staffing levels. We are looking at minimising the impact on staff skill levels to address a key issue affecting morale.
61.	The Trust should ensure staff record all patient care such as oral care and tissue viability assessments on the clinical information system to assure managers these have been carried out.	DoN	Should Do	No	Surgical – Divisional IIP Objective – Services Workstream- Enhance data and digital capability	Performance Reviews ↑ Divisional Boards	QGC	Accountability Handover process being rolled out through the Trust which ensures all actions from previous shift have been undertaken and documented Accreditation process for ICU in final stages of development, which will audit care and documentation processes.

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
62.	The Trust should ensure a pharmacist attends the Pilgrim Hospital critical care unit daily multidisciplinary handover meeting.	MD	Should Do	No	Surgical and CSS- Divisional IIP's Objective – Patients Workstream – Improve clinical outcomes	Performance Reviews ↑ Divisional Boards	QGC	MD to pick up with Chief Pharmacist
63.	The Trust should ensure a critical care pharmacist attends the Pilgrim Hospital critical care unit for an agreed time each week to review patient medicines.	MD	Should Do	No	Surgical and CSS - Divisional IIP's Objective -Patients Workstream- Improve clinical outcomes	Performance Reviews ↑ Divisional Boards	QGC	MD to pick up with Chief Pharmacist
64.	The Trust should ensure the on-call pharmacist is available to attend the Pilgrim Hospital critical care unit when necessary.	MD	Should Do	No	Surgical and CSS - Divisional IIP's Objective -Patients Workstream- Improve clinical outcomes	Performance Reviews ↑ Divisional Boards	FPEC	MD to pick up with Chief Pharmacist
65.	The Trust should ensure swallowing assessments are carried out to prevent delays with patient weaning.	DoN	Should Do	No	Surgical -Divisional IIP Objective – Patients Workstream- Improve clinical outcomes	Performance Reviews/QSOG ↑ Divisional Boards	QGC	Improvements to access of SaLT team being undertaken as per actions 27 & 57. Training and competency assessment programme for swallow assessments, undertaken by nursing staff, in place. Expectation to get to situation where all areas which may have patients who require swallow assessments will at least 1 member of staff, each shift, who has appropriate competency. Reviewing if this can be captured on the electronic Healthroster system to give transparency.
66.	The Trust should ensure policies and guidelines used by critical care staff are within review dates and dated to ensure they are in line with the most recent national guidance.	MD	Should Do	Yes Objective – People Workstream- Well Led		Executive Team (monthly IIP oversight)	QGC	A workstream is in place to review all clinical guidelines. These will be prioritised. As per action 12.
67.	The Trust should consider administrative support for risk and governance for the Pilgrim Hospital critical care service.	MD	Should Do	Yes Objective – People Workstream – Well Led		Performance Reviews ↑ Divisional Boards	QGC	The administrative support for risk and governance was recently reviewed, there are some vacant posts awaiting recruitment. The way this work is undertaken will be reviewed

Ref No	Action	Executive Lead	Must Do / Should Do	Is action covered by Integrated Improvement Plan? If Yes, which section?	If No- where should the action sit?	Reporting/ monitoring group	Assurance Committee	Progress January 2020
Maternity								
68.	The Trust should ensure they continually review audits and implement measures to improve patient outcomes for low performance metrics.	MD	Should Do	Yes Objective – Patients Workstream – Improve clinical outcomes	Family Health- Divisional IIP	Executive Team ↑ QSOG	QGC	Audits are reviewed, action plans produced and tracked. As per action 12
69.	The Trust should ensure mandatory training is completed by medical staff in line with Trust policy, in particular mental capacity and deprivation of liberty safeguarding training.	MD	Should Do	Yes Objective – People Workstream- Modern, Progressive workforce		Performance Reviews ↑ Divisional Boards	WOD	Divisional team reviewing internal process to make sure that all staff are compliant with training.
70.	The Trust should ensure they implement systems to monitor waiting times in line with national standards.	COO	Should Do	No	Family Health- Divisional IIP Objective – Services Workstream- Enhance data and digital capability	Performance Reviews ↑ Divisional Boards	FPEC	The Trust audit waiting times in AAU and will undertake further audits. An audit of the admission time and time seen on the delivery suite will be undertaken to evidence service compliance with the specified time frames.
71.	The Trust should ensure risks are clearly identified and documented in an appropriate format.	MD	Should Do	Yes Objective – People Workstream -Well Led	*Family Health- Divisional IIP Ensure this is covered	Performance Reviews ↑ Divisional Boards	QGC	This is the same as all risks, maternity is part of the Trust wide plan of work
72.	The Trust should ensure they collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour.	DoF (Data issue)	Should Do	No	Family Health- Divisional IIP Objective – Services Workstream – Enhance data and digital capability	Performance Reviews ↑ Divisional Boards	QGC	Data collected relating to admission and time seen in AAU, however most labouring women are seen on labour ward. Current situation is: The trust has considered implementing a triage system by using the traffic light system, however women are seen within the specified times frames so a triage system is not used and currently data is not collected. Should the timeframe to be seen by either midwife or consultant exceed the recommendations an incident report through datix would be completed and the incident reviewed and responded to. An audit review is being developed to demonstrate compliance.
73.	The Trust should ensure labour ward coordinators are supernumerary in line with national guidance.	DoN	Should Do	No	Family Health – Divisional IIP Objective – People Workstream – Modern, progressive workforce	Performance Reviews ↑ Divisional Boards	WOD	DoN reviewing staffing process with HoM to ensure supernumery status of labour ward co-ordinators is maintained even in extreme staffing / service pressures.

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74.	The Trust should continually review audits and implement measures to improve patient outcomes for low performance metrics. This include still birth rates, proportion of women having induction of labour and proportion of blood loss (greater than 1500mls).	MD	Should Do	No	Family Health- Divisional IIP Objective – Patients Workstream- Improve clinical outcomes	Performance Reviews ⇧ Divisional Boards	QGC	Audit plan to be checked to ensure all areas covered