# Quality Improvement Plan

| Work stream/ Group | Objective | Service | No | Key Actions | Cost Impact | Measure of success/Outcomes | Executive Board Lead/ Operational Leads | Date of Delivery/ RAG rating | Progress | Evidence | Strength of Current Evidence (i.e. Good / Weak/ insufficient) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **OVERARCHING EAST SUSSEX HEALTHCARE NHS TRUST** | | | | | | | | | | | |
| **Improve the relationship with its staff specifically the culture of the organisation with regard to people feeling able to speak out** | | | | | | | | | | | |
| Work force / Staff Engagement Group | Improve staff engagement and satisfaction.<br>Staff should be aware of the Trust vision and values and have an understanding of the Trust and 'direction of travel' for their service | Corporate | 1 | Develop a communication plan to support new ways of working and communicating by encouraging the use of appropriate social media<br><br>The Staff Engagement and Operations Group will develop actions, propose solutions, organise events, and provide reports etc. Time, energy and input will be required from staff across the organisation at all levels | 0 | Significant improvement in staff employee relations demonstrated through the annual staff survey | Monica Green<br><br>Op Lead<br>Lorraine Mason | Mar-16<br><br>A | Staff Engagement Operations Group established with representation from across the Trust.<br>Action Plan developed | | |
| | | | 2 | Trust wide Schwartz rounds to be implemented | 0 | Staff are supported to discuss psycho social and emotional issues | Alice Webster<br>Op Lead<br>Christian Lippiatt | Oct-15<br>A | Programme developed | | |
| | | | 3 | Improve multidisciplinary team working at the Conquest Hospital | 0 | Effective MDT working supporting better care | David Hughes<br>Op Lead<br>James Wilkinson | Sep-15<br>A | Discussions taking place with CU leads in the Clinical Leaders Forum | | |
| | | | 4 | Engage in effective listening with staff to improve efficiency. | 0 | Improve Ward to Board relationships by Senior professional managers visiting clinical areas on a regular basis to spend time with staff and patients and to listen to their thoughts, ideas and concerns | Monica Green / Alice Webster<br><br>Op Lead<br>Lorraine Mason | Jul-15<br><br>A | Exec leads aligned to each CU | | |

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| Board | Integrate Executive level staff with the workforce at a local level, allowing them to observe practice and assess the impact of changes at departmental and individual level. | Corporate | 5 | Review the quality walk process | 0 | Staff will feel valued and supported to deliver a high level of care and to our patients through a seamless ward to board approach to care | Amanda Harrison<br><br>Op Lead<br>Hilary White | May-15<br><br>G | Quality walks schedule available<br>Annual feedback at ESHT Board level schedule available | Schedule from board<br>Minutes of board meetings with quality walks feedback | |
| | | | 6 | Publicise the feedback from the quality walks within the organisation | | | | Oct-15<br><br>G | A copy of the feedback form completed by the Director undertaking the Quality Walk is sent to the Unit/Ward Manager/Matron and copied to the Head of Department so that it can be shared with relevant staff. | Feedback forms<br>Quality Walk Schedule | |
| | | | 7 | Ensure the quality walks are reported upon and any actions taken as a result of them recorded. | | | | Oct-15<br><br>G | A summary report of themes of findings is submitted to the Board and Quality and Standards Committee every 2 months. | Reports<br>Minutes of meetings | |

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| **MUST DO: Undertake a review of the culture specifically looking at the perceived bullying allegations** | | | | | | | | | | | |
| Workforce/Staff Engagement Group | Staff should work in an environment where the risk of harassment and bullying is assessed and minimised. Staff must feel able to raise concerns about bullying without any fear of recrimination. | Corporate | 8 | Identify and address inappropriate staff behaviour toward patients, relatives and staff. | 0 | Positive response to questions in the staff survey in relation to raising concerns. Trust can demonstrate year on year improvement to this aspect | Monica Green<br><br>Op Lead | Aug-15<br><br>A | Scope the problem by interrogating the complaints and datix reports triangulated with the staff survey and develop a plan of action | | |
| | | | 9 | Set up a series of Listening into Action events to engage staff in supporting solutions | 0 | Staff feel supported and able to say why some feel this is happening and influence changes to the culture of the organisation. | Monica Green<br><br>Op Lead<br>Lorraine Mason | Aug-15<br><br>A | LiA events being organised and publicised in CEO's weekly newsletter and other for a. | | |
| | | | 10 | Highlight to staff how they can report concerns and raise the profile and availability of the Trust Senior Independent Director | 0 | Staff fully aware of the process and options available to them | Monica Green<br><br>Op Lead<br>Lorraine Mason | Apr-15<br><br>G | Include detail in CEO Weekly Message | Weekly message 24.4.15 | |
| | | | 11 | Look at best practice from other Trusts in respect of "speak up guardians" to develop a similar model across the Trust | 3 | Independent process in place for staff to raise concerns with fear of recrimination and confidence that actions will be taken if appropriate. | Monica Green<br><br>Op Lead<br>Lorraine Mason | Aug-15<br><br>A | Exploring best practice. | | |

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| **Improve relationships with the population it serves specifically relating to their concerns about service configuration** | | | | | | | | | | | |
| Complaints / Patient Experience Group / PSCIG | Robust management of the complaints process. With Learning from complaints disseminated to staff ensuring changes are fully embedded | Corporate (Conquest and Eastbourne) | 12 | Fill vacancy for Trust complaints lead. | 0 | The Complaints and PALS Manager vacancy is filled to provide leadership and support to the Complaints Team | Alice Webster<br><br>Op Lead<br>Emily Keeble | May-15<br><br>A | Interim complaints advisor appointed, substantive complaints and PALS manager out to recruitment. Interviews to take place 22.5.15 | | |
| | | | 13 | Review the pathway for complaints management and develop an effective process | 0 | The revised Complaints Policy has been reviewed, updated, ratified and shared with staff.<br>Staff aware of the complaints process | Alice Webster<br><br>Op Lead<br>Emily Keeble | Jul-15<br><br>A | Complaints pathway currently being reviewed by the Interim Complaints Advisor. Once ratified clear communication and training will be provided to all staff | | |
| | | | 14 | Ensure that process is appropriately followed, complaints are prioritised within the CU and each complaint has an identifiable CU lead who will be responsible for the investigation and timely response | 0 | 100% of complaints answered within time.<br>Evidence of learning articulated through CU action plans and staff able to identify areas of learning/change in practice following complaints.<br>Positive patient feedback about the complaints process. | Alice Webster<br><br>Op Lead<br>Emily Keeble | Jul-15<br><br>A | Interim Complaints Advisor has met all Clinical Units, attended TNMAG and Grand Round. A new quality assurance process has been implemented to quality check responses before they are sent | | |

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| Patient Experience Group | Improve patient access to translation services and other forms of media | Corporate | 15 | Audit translation services to ensure that patients requirements is being fulfilled and act on recommendations | 3 | Improved process for access of translation services demonstrated by re audit of process for patient access to services | Alice Webster<br><br>Op Lead<br>Emily Keeble | Aug-15<br><br>A | The Equality and Diversity Lead is currently reviewing the translation services provided for patients | | |
| | | | 16 | Obtain patient experience feedback on the service | | A survey has been completed which provides the Trust with feedback on the translation services available | Alice Webster<br><br>Op Lead<br>Emily Keeble | Sep-15<br>A | A post translation service survey is being planned | | |
| | | | 17 | Ensure that patient information is available in languages other than English and in other formats so that it is accessible to people with disabilities. | | Patient information is available in languages other than English and in other formats | Alice Webster<br><br>Op Lead<br>Emily Keeble | Sep-15<br><br>A | Current information and formats is currently being reviewed | | |
| Patient Experience Group | Improve communication with stakeholders | Corporate | 18 | Communicate with stakeholders to raise awareness of the positive impact that have happened following changes to services | 2 | Effective communications plan in place | Amanda Harrison<br><br>Op Lead<br>Simon Purkiss | Oct-15<br><br>A | Communications strategy being developed | | |

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| **Review the reconfiguration of outpatient services to ensure that it meets the needs of those patients using the service** | | | | | | | | | | | |
| Outpatients Clinical Unit | Ensure that Resuscitation equipment provided in outpatients is fit for purpose | Conquest Outpatients | 19 | Remove any unnecessary equipment and ensure necessary equipment is available - i.e. resus equipment and suction machine | 0 | Equipment is readily available and is fit for purpose | Richard Sunley / Alice Webster<br><br>Op Lead Deidre Connors | Sep-14<br><br>G | Completed | Review of equipment in situ | |

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| Outpatients Clinical Unit | Ensure clear strategies are put into place to improve outpatient waiting times against the national average. | Outpatients | 20 | Develop a plan for managing Rheumatology / Gastroenterology specialism's | 5 | Compliant with National Guidance and best practice | Richard Sunley<br><br>Op Lead: Sandra Field | Jul-15<br><br>A | Rheumatology recovery plan implemented with support from medinet<br>Consultant posts out to advert<br>Implementation of weekend working<br>Job planning<br>Block booking of temporary and agency staff<br>Admin staff ensuring that all slots are booked<br>Reducing need for consultant follow up appointments, to be undertaken by Specialist nurse<br>Dermatology not breaching 18 weeks<br>Outsourcing of work<br>Used of advanced nurse practitioner capacity, consultant job planning and optimised theatre capacity to directly address the pressures in this crucial area. | Review by Snr Exec Group weekly. Review by CCG at least Monthly. Review by TDA weekly and, formally, monthly | |

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| | | | 21 | Develop robust team meetings to monitor the plan | | Compliant with National Guidance and best practice | Richard Sunley<br><br>Op Lead:<br>Sandra Field | Sep-15<br>A | Gastroenterology<br>Recovery plan in place<br>Full time consultant and 2 locums<br>18 week back log recovery by June 2015<br>Full recovery scheduled by Sept 2015<br>Weekly department meetings to discuss activity v capacity<br>Additional lists at weekend | | |
| Outpatients | Ensure that patients are managed effectively through the departments and patients are sent to the correct areas of the OPD and are expected by staff in those areas when they arrive. Staff should be able to track patient journeys through the department. | Outpatients | 22 | Patient pathway is understood by members of the OPD team | 0 | Improved Patient Experience for those attending the Trusts OPD | Alice Webster<br><br>Op Lead:<br>Jenny Crowe/<br>Deidre Connors /<br>Jayne Cannon | Mar-15<br><br>G | Completed | Minutes of meetings<br>Decrease in number of complaints and PALs contacts re OPD | |
| | | | 23 | Monitor the numbers of complaints and FFT comments and discuss at OPD meetings | 0 | OPD is robustly learning from complaints and making alterations as necessary. | Alice Webster<br><br>Op Lead:<br>Jenny Crowe/<br>Deidre Connors /<br>Jayne Cannon | Oct-15<br>A | In place through Clinical Unit meetings. | Minutes of meetings<br>Decrease in number of complaints and PALs contacts re OPD | |
| | | | 24 | Review the reconfiguration of outpatients services to ensure that it meets the needs of those patients using the service. | £100,000 | Optimal OPD configuration delivering good patient experience. | Richard Sunley<br><br>Op Lead:<br>Liz Fellows | Aug-15<br>A | Currently reporting a 50% reduction in PALS cases | Reductions of the numbers of complaints / pals contact relating to Patients | |

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| **Review the length of waiting time for outpatients appointments such that they meet the governments RTT waiting times** | | | | | | | | | | | |
| Outpatients | Ensure that the Trust is obtaining correct data regarding patient pathways and recording accurate data for 18 week pathways and two week waiting times | Outpatients | 25 | Review the length of waiting time for outpatients' appointments such that they meet the governments RTT waiting times. | 5 | Patients are seen within the governments RTT requirements | Richard Sunley<br><br>Op Lead:<br>Gary East | Jul-15<br>A | RTT and Cancer metrics reviewed and reports in place | Weekly cancer and RTT meetings with CUs | |
| **Review staffing levels across the organisation to ensure there are sufficient staff to meet the needs of the service** | | | | | | | | | | | |
| Work force Group | Review appropriate levels of staff for nursing and midwifery to ensure that patient acuity and turnover is taken into consideration | HR | 26 | Implement 'TRAC' recruitment system which allows recruitment managers real time information on how recruitment is progressing. | 0 | Improved patient care demonstrated through reduction in clinical incidents related to nursing and medical care | Monica Green<br><br>Op Lead:<br>Edel Cousins | Mar-15<br><br>G | TRAC recruitment system gone live March 15<br>Staffing levels are reported to each Board and we are currently meeting the majority of NICE indicators and on track to meet all. | System on extranet<br>Staff training | |
| | | | 27 | Establish a Safer Staffing and Workforce Capacity Group | 0 | | | Oct-14<br>G | Group established October 2014 which meets monthly to review safe staffing reports, and recruitment reports. | Minutes of meetings and reports | |

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| | | | 28 | Implement a generic recruitment process for nursing posts to speed up process. | 0 | | | Mar-15 G | Generic recruitment process in place | | |
| | | | 29 | Ensure that workforce considerations are fully integrated into service relocation plans. | 0 | Ensure that workforce considerations are an integral part of service redesign including relocation | Andy Slater<br><br>Op Lead: Pauline | May-15 A | | | |
| Work force Group | Appropriate management of staff sickness absence. | HR | 30 | Up date and review and fully implement current policy | 4 | Reduction of staff sickness to within national average | Monica Green<br><br>Op Lead: Moira Tenney | Apr-15 G | Policy ratified | Policy on extranet (1.4.15) | |
| | | | 31 | Develop and implement an on line training module for managers | | | | Sep-15 A | | | |
| | | | 32 | Develop and implement a Health and Wellbeing Action Plan | | | | Feb-15 G | Action plan developed and being implemented | Action plan and progress on extranet | |
| | | | 33 | Carry out an internal audit of sickness controls | | | | Mar-15 G | Audit undertaken, reasonable assurance given to Audit Committee | Audit report Audit Committee minutes | |
| | | | 34 | Review sickness absence trend data | | | | Mar-15 G | Data reviewed, report submitted to F&I committee with detailed actions | Report F&I minutes | |
| | | | 35 | Absence management workshops to be held with CU management. | | | | Sep-15<br><br>A | | | |
| | | | 36 | Proposed a 6 month project to support RTW interviews 2x Band 6 HR Advisers | | | | May-15<br><br>A | | | |

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| | | | 37 | Review occupational health and HR support mechanisms and resources for staff on long-term sick leave who require support to ensure the trust can meet its duty of care to its workforce | | | | Aug-15<br><br>A | | | |
| Work force Group | Review Maternity staffing | Maternity | 38 | Undertake a thorough review of midwifery workforce and skill mix and models to include community<br>. | £250,000 | BR+ labour ward acuity tool will demonstrate 1:1 care in labour 100% of the time. Specialist midwives in post Community midwives have caseloads of 100 and are working within EWTD | Monica Green / Alice Webster<br><br>Op Lead:<br>Jenny Crowe | Jul-15<br><br>A | Birth-rate Plus to be reviewed, models of care paper currently being developed. Vacancies being recruited to, an education /preceptor ship midwife now in post, specialist midwives being recruited to.<br>Infant feeding specialist out to advert for second time.<br>Mental health specialist mw to be advertised in April along with bereavement specialist. Obesity/diabetes specialist to follow. Community mw caseloads currently being reviewed due to appointment of new staff. EWTD not yet compliant | | |
| | | | 39 | Develop a staffing model of care to enable one to one care in labour | | Reduction in the use of the escalation policy for maternity and usage of temporary workforce | | May-15<br>A | 1:1 care in labour at both MLU's and homebirths is 100%.<br>Conquest labour ward currently 55-78%. | | |

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| Work force / Senior HR Group | Improve compliance for attendance at Trust mandatory training and appraisals for all staff groups this must include long term temporary staff | Corporate | 40 | Review all roles and associated competencies to give assurance that each role has the right level and frequency of mandatory training. | 0 | 90% compliance to mandatory training evidence in annual training report produced for the Trust board CU Directors accountable for meeting the 90% Trust Target. | Monica Green<br><br>Op Lead: Edel Cousins | Oct-15 A | Review currently underway | | |
| | | | 41 | Focus on areas with lowest compliance. | 0 | | | Apr-15 G | CEO/HRD meetings with areas/units that have lowest compliance taken place Feb/March 2015. Additional large group sessions have run from Nov 14 to April 15. | Mandatory training audit attendance. Reports on attendance rates provided for CU Performance Reviews. Action Plans to address any non compliance to training. | |
| | | | 42 | Develop e-assessments to reduce no's of staff needing to be released for training. | 0 | | | Oct-15 A | These continue to be developed and enable staff to do a quick online assessment of their competency in their work location to avoid having to do further classroom or e-learning training | | |
| | | | 43 | Ensure all staff have an appraisal | 0 | | | Oct-15 A | Focussed actions in place and appraisal rate improving | | |
| | | | 44 | Ensure all agency and transient staff have a full induction in clinical areas which is formally recorded. | 0 | | | Jun-15 A | Pilot in place | | |

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| **Review the impact of the maternity reconfiguration** | | | | | | | | | | | |
| Estates Group | Improve security of labour and postnatal ward Conquest. | Maternity | 45 | Daily audit of unit to ensure security has not been breeched. Purchase electronic baby tagging system | 0 | Baby tagging system in place. Signs on fire door, regular security patrols. | Richard Sunley<br>Op Lead: Jenny Crowe | Apr-15<br>A | Review of emergency doors at Conquest on Security Patrol SOP. Signage and possible alarm to be introduced. Security tagging system in place but not used. Risk assessment to be completed by HoM | Reviewed 25/3. Achieved by regular security patrols. There is a single fire door that must remain secured, remaining three fires doors are not fire doors and can be opened. Additional prohibitive signs ordered 25 March 2015. | |
| Estates Group | Improve labour ward environments for low risk women. | Maternity | 46 | Capital investment to be considered to provide appropriate low risk birth facilities | 5 | Appropriate low risk birth rooms on all sites | Richard Sunley<br>Op Lead: Jenny Crowe | Aug-15<br>A | Changes have been agreed. Programme of work with CCGs. Midwifery Lead treatment. | | |
| | | | 47 | Investigate providing facilities to accommodate the needs of women in early labour where repeated journeys between their home and the hospital may be inadvisable. | | Appropriate availability of places to stay | Richard Sunley<br>Op Lead: Jenny Crowe | Sep-15<br>A | Currently considered on a case by case basis | | |
| Women & Children / Estates Group | Ensure appropriate area on labour ward at Conquest for hand over of care. | Maternity | 48 | Obstetric and midwifery staff to undertake hand over in the consultants office on labour ward. | 1 | Confidential hand over undertaken at all times | Alice Webster<br>Op Lead: Jenny Crowe | Feb-15<br>G | Handover takes place in office | | |

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| | | | 49 | TV screens to be purchased and placed on labour ward wall in place of white board and one in consultant office. | 1 | Equipment available to support the provision of confidential hand over | Alice Webster<br><br>Op Lead: Jenny Crowe | Jun-15<br>A | | | |
| | Develop a clear and explicit vision for maternity services | Corporate | 50 | Develop a strategic plan created in collaboration with key stakeholders, staff and service users | 0 | Strategy in place aligned to commissioning intentions. | Amanda Harrison<br><br>Op Lead: Jenny Crowe | Ongoing engagement taking place. Review Mar-16<br><br>A | Trust obstetric and midwifery managers are working closely with the CCG's on a project 'Better Beginnings' for re-modelling of maternity care for low risk women. This includes review of the working patterns of community midwifery staff to provide care within the community and the midwife led units and to support midwives on the acute site to provide midwife led care to low risk women. | | |
| | | | 51 | Make comprehensive written information available to women using services in relation to the choices of place of birth available | £10,000 | Women aware of the choices available for place of birth | Amanda Harrison<br><br>Op Lead: Jenny Crowe | Sep-15<br><br>A | Information available for women considering birth at Crowborough Birth Centre. 'Virtual' tours available for Conquest and CBC on the Trust web site | | |
| | Review the impact of the maternity reconfiguration | Corporate | 52 | Review data available of patient outcomes | 0 | Impact reviewed and considered by the Board. | Richard Sunley<br><br>Op Lead: Dexter Pascall | Apr-15<br>G | Data collection and presentation to Board Seminar | Minutes Board Seminar 25.3.15 HOSC Minutes 22.3.15 | |

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| **Ensure that health records are available and that patient data is confidentially managed** | | | | | | | | | | | |
| Health Records Steering Group | Review the management; storage and movement of medical records ensuring data confidentiality is maintained. | Corporate | 53 | Full revision of the current process with the design team and the clinical unit service managers/general managers to discuss storage and filing of notes in clinical areas and possible options for significant improvement | £800,000 | Significant improvement demonstrated with reduction in datix reported incidents around lack of available patient notes<br>Management of health records meets both the national standards and requirements and does not impinge on clinic activity | Richard Sunley<br><br>Op Lead:<br>Liz Fellows | Jul-15<br>A | Staff asked to report incidents (an increase has been noted) and monitor with medical records the numbers of incidents and actions taken. Temporary sets of notes are provided by admin staff as soon as they are made aware<br>Gp surgeries are willing to fax referral letters with reason for referral and patients medical history<br>Previous clinics letters pathology radiology and endoscopy results are available to view and down load from e-searcher | Storage increase in Apex Way in September. RFDI tagging of all Medical Records from July | |
| | | | 54 | Purchase lockable trolleys for relevant areas and remind staff of the need to ensure records are removed or securely stored | 2 | Fully Compliant with national and local policy | Richard Sunley<br><br>Op Lead:<br>Deidre Connors | Mar-15<br><br>G | Lockable trolleys purchased<br>Staff at reminded of the need to ensure records are removed when finished and areas re stocked and locked. | Trolleys in situ | |

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| Health records | Improve issues with the storage and accessibility of patient health records. | Corporate | 55 | Ensure robust process implemented re the management of health records being tracked and risks to be clearly identified and managed within the CU and escalated as necessary | £800,000 | Management of health records meets both the national standards and requirements and does not impinge on clinic activity Active and up to date Risk Register for clinical admin | Richard Sunley<br><br>Op Lead: Deirdre Connors and Liz Fellows | Jul-15<br>A | Interim measure:<br>Matrons working with service manager and Admin managers to improve this risk. Risk register reviewed at clinical admin meetings.<br>Temporary sets of notes provided by admin staff as soon as they are made aware Gp surgeries willing to fax referral letters with reason for referral and patients medical history<br>Previous clinics letters pathology radiology and endoscopy results are available to view and down load from e-searcher<br>See box below for EDM update. | Storage space increased at Apex Way in September. RFDI tagging of all records from July. OPD Matrons to report on Date weekly on incidents in relation to records | |
| | | | 56 | Improve state of repair of health records | | Health records will be adequately maintained | Richard Sunley<br><br>Op Lead: Deirdre Connors and Liz Fellows | Apr-16<br><br>A | A rolling programme to repair/mend records in preparation for barcoding goes live in July 15.<br>Electronic document management commences April 16 | | |

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| | | | 57 | Support staff in medical records to report incidents consistently through online system and review incidents at weekly central admin meeting. | 0 | Data on datix shows reviews of incidents and actions | Richard Sunley<br><br>Op Lead:<br>Deirdre Connors and Liz Fellows | Jun-15<br>A | Staff encouraged to report incidents there has been an increase<br>Staff to report to the CU to monitor with medical records numbers of incidents and actions taken. | | |
| **Review pharmacy services, specifically ensuring they undertake activity appropriate to their licence** | | | | | | | | | | | |
| Pharmacy / Senior Pharmacy Team | Review pharmacy services specifically to ensure that activity undertaken is appropriate to current licences | Pharmacy | 58 | Decide if ESHT should be in the business of supplying medicines to 3rd parties | 0 | Review undertaken and decision taken as to appropriate business model. | David Hughes<br><br>Op Lead:<br>Ian Bourns | Mar-15<br>G | Paper about pros and cons to be presented to CME at March meeting - agreed to withdraw providing services | Paper and minutes | |

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| | | | 59 | Continue with existing MHRA WDL application | 1 | Licence in place if required | David Hughes<br><br>Op Lead:<br>Ian Bourns | Sep-15<br>A | Discussions taking place with current customers about switch of supplier to obviate need for license. Until that is confirmed application still in place | | |
| | | | 60 | Continue with existing Home Office CD Licence applications | 1 | Licence in place if required | David Hughes<br><br>Op Lead:<br>Ian Bourns | Sep-15<br>A | Discussions taking place with current customers about switch of supplier to obviate need for license. Until that is conformed application is being progressed and DBS being acquired by HR in support of that. | | |
| | | | 61 | Discuss other dispensing options regarding hand off 3rd party dispensing services<br>If other options not possible begin GPhC registration process for Conquest site | 0 | Review undertaken and decision taken as to appropriate business model. | David Hughes<br><br>Op Lead:<br>Ian Bourns | May-15<br>A | Discussions taking place and data about supply volumes are being shared and costings developed. | | |
| **Review and improve the trusts management of medicines in clinical areas** | | | | | | | | | | | |
| Pharmacy / Senior Pharmacy Team | Ensure that medicines particularly controlled drugs on the maternity unit at Conquest are managed in accordance with the Trust Policy | Maternity | 62 | HONs to monitor that all areas using CDs are aware of their responsibilities regarding CDs and that their staff are complying with that policy | 0 | Staff are aware of their responsibilities and audit of controlled drugs evidences compliance with Trust policy. | Alice Webster<br><br>Op Leads:<br>HON's | Apr-15<br>G | Communication sent to staff, monitored by matrons | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 63 | Confirm pharmacy oversight is working by Pharmacist carrying out quarterly CD audits to be cross checked against areas being supplied with CD stocks to ensure none are missed. Audits look at documentation as well as stock balances | 0 | Audit of controlled drugs evidences compliance with Trust policy. | David Hughes<br><br>Op Lead:<br>Ian Bourns | Mar-15<br>G | Audits confirm compliance, CD incident now closed following review. | | |
| Crowborough War Memorial Hospital | To ensure accurate recording of medicine administration at Crowborough | Community inpatients | 64 | Advise staff of their responsibilities and accountabilities Ensure all staff have received the current guidance and policy information<br>Audit as part of the meridian process | 0 | Area fully compliant with medicines administration. | David Hughes<br><br>Op Lead:<br>Debbie Cooke | Oct-15<br>G | Completed | Audit available | |
| Pharmacy / Senior Pharmacy Team | Ensure safe processes are in place for prescribing in ophthalmology outpatients | Outpatients | 65 | Eye drops issued to patients by the department must be labelled in accordance with legal requirements. | 0 | Evidence that opthalmology medication is appropriately labelled. | David Hughes<br><br>Op Lead:<br>Ian Bourns | Mar-15<br>G | Issue discussed with Assistant Director of Nursing (East) and interim plan implemented to address labelling requirements.. | | |
| Pharmacy / Senior Pharmacy Team | Minimise medicines omissions where not clinically justified | Pharmacy | 66 | Continue to audit medicines omissions, assess impact on this of new drug chart and identify any lessons for further corrective action | 0 | Omitted medicines minimised to greater than 90% | David Hughes<br><br>Op Lead:<br>Ian Bourns | Apr-15<br>A | January and February audit data has been collected and audit report will be considered by SPT in April meeting | Feb 2015 data shows 96.3% | |

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| Pharmacy / Senior Pharmacy Team | Ensure there are robust systems in place for medicines deliveries to community hospitals | Pharmacy | 67 | Community Health Pharmacy team to audit the timeliness of supply from community pharmacy providers and assess the scale of risk for dispensed items | 0 | Risk appropriately assessed and actions in place if required | David Hughes<br><br>Op Lead:<br>Ian Bourns | Oct-15<br>A | Meeting 13.4.15 | Risk assessments | |
| | | | 68 | Review the arrangements for delivery of stock medicines and implement a stock delivery audit trail apply corrective action if required | 0 | Effective process in place for the delivery of medicines across the Trust | David Hughes<br><br>Op Lead:<br>Ian Bourns | Jun-15<br>A | | | |
| Pharmacy / Senior Pharmacy Team | Out of temperature storage of ward medicines | Pharmacy | 69 | Advise nursing staff to ensure ward and outpatient meds are stored at correct temperature at all times | 0 | Evidence of compliance with Policy and Guideline | Alice Webster<br><br>Op Leads:<br>Jenny Crowe/ Deidre Connors / Jayne Cannon | Oct-15<br>G | Completed | Recording sheets available | |
| Pharmacy / Senior Pharmacy Team | Ensure fridge storage is effective by implementing temperature checks and recording of all medication fridges in line with policy | Pharmacy | 70 | Implement monitoring process of ward and outpatient fridge & freezer temperature recording and audit its effectiveness | 0 | Full compliance with equipment checks | Alice Webster<br><br>Op Leads:<br>Jenny Crowe/ Deidre Connors / Jayne Cannon | Oct-15<br>G | Conquest A&E (now resolved as automatically recorded by Omincell cabinet with electronic alert of out of temperature states to both nursing and pharmacy staff) other areas completed | Recording sheets available | |

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| | | | 71 | Submit application to CAG for funding to implement enhanced ward medicines storage (Omnicell) | £900,000 | Application submitted and funding in place | David Hughes<br><br>Op Lead:<br>Ian Bourns | May-15<br>A | Time frame is dependent upon capital allocation. This would address all security, CD record keeping and cold storage monitoring issues | | |
| **TRUST WIDE ACTION - Ensure appropriate reporting and learning from incidents** | | | | | | | | | | | |
| Incident Reporting / PSCIG | Ensure appropriate reporting of incidents | Corporate | 72 | Update policy | 0 | Updated Policy is approved and available on the Trust Extranet | Alice Webster<br><br>Op Lead:<br>Emily Keeble | Apr-15<br>G | Policy approved by CME 13.04.15<br>Available on extranet 27.04.15 | Minutes of CME meeting<br>Policy on extranet | |
| | | | 73 | Audit incidents to determine that correct process is followed | 0 | Cross referencing of data demonstrate appropriate reporting | Alice Webster<br><br>Op Lead:<br>Emily Keeble | Jun-15<br>A | Datix team review incidents and provide feedback to the incident handler to ensure appropriate processes are followed - to date this has not been audited but will be. | | |

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| | | | 74 | Support staff to report incidents | 0 | Staff feel confident and able to report incidents with appropriate means or access to reporting | Alice Webster<br><br>Op Lead:<br>Emily Keeble | Oct-15<br>A | Training of staff to use datix system continues. The Trust Lead has developed a new train programme.<br>A series of LIA Staff Conversations on Incident Reporting runs through May and June 2015. | | |
| | | | 75 | EOLC incidents to be reported to the End of Life Steering Group | 0 | EOLC Incidents are extracted from Datix and presented to the Steering Group | Alice Webster<br><br>Op Lead:<br>Emily Keeble | Apr-15<br>G | The Datix Team have set up search queries on Datix to search incidents on key words (rather than adding a specific question or using a sub category which can be subjective). The EOLC team have been trained to use these search queries to run reports and have advised this is working well and reports are going to the group | Incident reports at EOLC Steering Group | |
| | Ensure learning from incidents are communicated to all staff | Corporate | 76 | Review how serious medical incidents are managed and escalated to ensure there is oversight from doctors with appropriate training to enable an in-depth analysis to be completed and clear learning identified and that management staff are involved at an early stage to oversee actions | 0 | Appropriate medical engagement with clear learning objectives. | David Hughes<br><br>Op Lead:<br>Emily Keeble | May-15<br>A | In light of new National Framework and revised Trust Policy, Head of Governance, Patient Safety Lead and Medical Director to review process for management of Serious Medical Incidents | | |

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| | | | 77 | Further develop the Quality Improvements Plan to incorporate shared learning from incidents and the way in safety initiatives and developments are shared across the organisation and learning embedded | 0 | Clear evidence in clinical areas that learning has taken place obtained through minutes of meetings PDR's and other forms of staff communication. | Alice Webster<br><br>Op Lead:<br>Emily Keeble | 1st review Oct-15<br><br>A | Head of Governance and Workforce development manager are developing human factors and simulation training provision within the trust<br>The Trust joined the 'Sign up to Safety' initiatives in Sept 14, following this the Safety Improvement Plan was submitted to the NHSLA Jan 2015<br>The trust is actively participating in the KSS Safety collaborative programme e DON and MD to meet with the KSS patient safety collaborative co director May 2015 | | |
| | | | 78 | Develop a Patient Safety Lead Programme to include Medicines Management Leads to foster cross unit learning and access to expertise | 0 | Lead nurses identified | Alice Webster<br><br>Op Lead:<br>Emily Keeble | Jul-15<br><br>A | May/June 2015 a series of events is being held to determine progress key challenges and developments required regarding incident management | | |

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| | | | 79 | Provide monthly feedback reports for each ward area and across CU as necessary Cross CU learning to be shared via Trust induction; through e-learning; Trust wide meetings i.e. matrons meeting and Nursing and Quality meetings | 4 | Ensure that staff receive feedback from managers and supervisors on practice. | Alice Webster<br><br>Op Lead:<br>Emily Keeble | Apr-15<br><br>A | Clinical Units receive monthly incidents reports for discussion at their monthly risk meetings.<br>Version 12.3 of datix installed Oct 2014 prompting incident handlers to provide feedback to the incident reporter.<br>Looking at automated feed back to incident reporters - at a cost to manage the 'final approval' process<br>Q3 'You said, we did' report drafted | | |
| | | | 80 | Develop a Patient Safety page on the Extranet. | 0 | Patient Safety page developed and updated | Alice Webster<br><br>Op Lead: | Jul-15<br><br>A | | | |
| | | | 81 | Local CQUINs to be negotiated that reflect the area of need in terms of safety and quality | 0 | Agreed CQUINS in place | Alice Webster<br><br>Op Lead:<br>Lindsey Stevens | Apr-15<br><br>G | CQUINs agreed with commissioners to reflect high priority quality and safety areas. | CQUIN information | |
| | Improve the way information is collected and used | Corporate | 82 | Strengthen and streamline the governance and incident reporting structure to ensure that data is sufficiently accurate and robust to be used to inform service improvements | £180,000 | A Learning organisation able to utilize data from incidents to improve care. | David Hughes /Alice Webster<br><br>Op Lead:<br>Emily Keeble | Jul-15<br><br>A | Governance Team centralised Oct 14 and in interim structure. Formal consultation on proposed permanent structure commences 28.04.15 | | |

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| **TRUST WIDE ACTIONS - (CONQUEST/EASTBOURNE)** | | | | | | | | | | | |
| Estates Group | Make sure privacy and dignity of patients is upheld by avoiding same sex breaches in CDU's | A&E | 83 | PLACE assessments to be reviewed and acted upon within Estates and Facilities and the CU. | 0 | Full compliance to PLACE audits actions<br>No mixed sex breaches<br>Separate toilet facilities | Richard Sunley<br><br>Op Lead:<br><br>Sarah Wilmer | Jun-15<br>A | Requires capital investment in Both EDs | | |
| | | | 84 | Separate areas/cubicles to be used at all times to maintain patient dignity and privacy | * | Dependent on outcomes of Full Business Case | | Apr-15<br>A | Requires capital investment in Both EDs | | |
| | | | 85 | Separate toilet facilities to be made available | * | Dependent on outcomes of Full Business Case | | Mar-15<br>G | Made available through interim building work. | New build. | |
| Estates Group | Ensure emergency bell in Day Surgery EDGH is audible | Surgery | 86 | Repair or replace bell | 0 | Completed bell now audible | Richard Sunley<br><br>Op Lead:<br>Paul Relf | Apr-15<br>A | Likely to be Littlington. Needs to link to Main Theatres Coordinators desk. Director of Nursing chasing progress. | | |

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| Consent Group | Improve the understanding of staff around the processes for consent to treatment ensuring that staff understand the need for robust recording and documentation in particular around capacity to consent. | | 87 | Review and update Policy | 0 | Updated Policy | David Hughes<br><br>Op Leads: Simon Walton Brenda Lynes-O'Meara | Apr-15 A | Policy being reviewed | Policy on extranet | |
| | | | 88 | Develop and implement an audit to monitor adherence to policy by audit | 0 | Fully compliant with policy through Audit reports | | Apr-15 A | Consent group reviewing | Compliance with audits | |
| | | | 89 | Develop a shared learning in practice on Consent to care and treatment | 0 | Greater knowledge of 'consent' through the organisation | Op Lead: Emily Keeble | May-15 A | Discussed at PSCIG - need to raise awareness following recent Supreme Court legal case. | | |
| Safeguarding Group | Ensure that MCA assessment are of a high quality | | 90 | Regularly review the quality of MCA (mental capacity act) assessments and ensure that they are clearly documented. | 0 | Compliance with MCA | Alice Webster<br><br>Op Lead: Brenda Lynes-O Meara | Aug-15 A | MCA training audits being completed | | |
| Critical Care | Improve bed management processes to ensure that patients do not remain in ITU longer than required, which can impact on their privacy and dignity | Eastbourne Surgery | 91 | All exceptions are reported and reviews completed on all exceptions to identify key learning and implement actions | 0 | Once a critical care patient has a plan for transfer to a more appropriate setting this occurs within 4 hours. | Richard Sunley<br><br>Op Lead: Michele Elphick | Oct-15 A | CQUIN to deliver discharge within 12 and then 4 hours. Reported to Start the Week meetings weekly. Reported to Site Meetings 4 times a day. Escalation plans in place | Delivery of CQUIN | |
| Clinical Unit Governance meeting | Address the long waiting times for oral and maxillofacial surgery for adults with learning disabilities | Surgery | 92 | Reviewing waiting list and pathway for adults with learning disabilities requiring oral and maxillofacial surgery | 0 | Effective pathway in place | Richard Sunley<br><br>Op Lead: Michele Elphick | Apr-15 G | Continue to run theatre 11 . | Evidence of no long waiters | |

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| Audit Working Group | To undertake audits in order to comply with national and local guidelines and regulations such as NBM, VTE and Pre-eclampsia. | Corporate | 93 | Conduct a Trust wide review of venous thromboembolism (VTE) compliance as a matter of urgency | 0 | Completed audit reports | David Hughes<br><br>Op Lead: Emma Jones-Davies | Jun-15<br>A | There have been VTE and audits covering pre-eclampsia on the clinical audit forward plan in 2014/15. No evidence of NBM audits however they will be added to the 20/15 forward plan | | |
| **COMMUNITY** | | | | | | | | | | | |
| | Ensure effective management information systems are in place | Community Children's services | 94 | Review the Child Health Information Systems (CHIS) so that robust and reliable data is produced | 0 | CHIS provides reliable and robust data | Vanessa Harris<br><br>Op Lead: Anne Singer | Sep-15<br><br>G | System now able to provide robust and reliable data | No incidents reported relating to inaccurate data | |
| | | | 95 | Review the establishment of administrative staff and ensure there are sufficient numbers to support the service, especially during periods of unstable CHIS and delays in the implementation of | 0 | Appropriate levels of administrative support in place | Richard Sunley<br><br>Op Lead: Anne Singer | Sep-15<br><br>G | Staff recruited and at full establishment April 15 | | |
| | | | 96 | Implement a system to monitor key performance indicators (KPIs) and service delivery to meet service specification. | 0 | KPI metrics developed and reviewed to support effective service delivery | Richard Sunley<br><br>Op Lead: Anne Singer | Sep-15<br><br>A | Being developed as part of project in conjunction with knowledge management | | |
| | | | 97 | Develop an audit programme to monitor quality and safety of service. | 0 | Effective audit programme in place and learning shared. | Richard Sunley<br><br>Op Lead: Anne Singer | Sep-15<br><br>A | Being developed as part of project | | |