Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Private and Confidential – DRAFT

Action Plan in response to CQC Hospital Inspection Visit January 2014 and Quality Summit 28th March 2014

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Date: May 2014

Version 5

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Medical Records – Compliance Action **Regulation 20 (1) a: Records – People who use services and others were not protected against the risks associated with poor record keeping. Records must be legible, clearly Ordered so important information is easy to find and accessible for all clinical requirements.**						
To improve the Medical Record.	• Explore option to provide a separate section in the medical record for all clinical correspondence until the EDMS is implemented.	April 14	Medical Director Nurse Director	• Execs and Senior Clinicians (Trust Management Team) agreed to introduction of the new section and costs for new dividers.	April 14	G
	• All clinical correspondence generated by the Trust to be accessed electronically via the vision portal.	April 14	Medical Director Nurse Director	• All Medical staff has individual 'log in' to access the vision portal.	April 14	G
	• Quality of Medical Record to be discussed with Clinical Policy Forum	April 14	Medical Director	• Discussed at Clinical Policy Forum on 4th April 2014 and the Medical Director met with FY2 doctors on 8th April 2014.	April 14	G
	• Audit compliance with the Trust procedure for closing volumes, repairing and opening new case notes • (Corporate Procedure no.448)	May 14	Associate Director of Information		Not yet due	
	• Improve timeliness of access to medical records	May14	Associate Director of Information	• An availability audit and report by specialty will be compiled to determine 'hot spot' areas.	Not yet due	
	• Establish Medical Records Improvement Task and Finish Group	April 14	Director of Strategy/ Medical Director/ Nurse Director	• Task and finish group established and first meeting taken place. • Outputs from the group will report to Health Informatics Committee.	April 14	G

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Continued	• Review best practice of other Trusts using a paper medical record	May 14	Director of Strategy/ Associate Director of Information	• Task and Finish group is identifying best practice Trusts and arranging visits.	**Not yet due**	
Improve Record Keeping	• Communicate to all medical, nursing and AHP's standards for clinical record keeping	April 14	Medical Director / Nurse Director	• Clinical Record Keeping Standards is provided to all staff at induction. • Reminder to be issued via Trust Team Brief (April 14)	April 14	G
	• Audit standards of clinical record keeping - legibility	May 14	Medical Director Nurse Director	• Revision of current record keeping audit to include audit and reporting by professional group.	**Not yet due**	
Implement an integrated Electronic Record	• Electronic Document Management Solution (EDMS)	By Dec 15	Director of Strategy/ Deputy Chief Executive	• EDMS project currently out to tender with responses from suppliers anticipated in May 2014. Funding received from Safer Hospital Safer Wards Technology Fund to support implementation.	**Not yet due**	
	• Electronic patient record (EPR)	By Dec 15	Director of Strategy/ Deputy Chief Executive	• Electronic Prescribing and Medicines Administration (EPMA) – in final stages of agreeing costs / hosting model with suppliers. Funding received from Safer Hospital Safer Wards Technology Fund to support implementation. Initial deployment anticipated in Q3/4 of 2014/15. • EPR for community services – in final stages of agreeing costs / hosting model with suppliers. Initial deployment anticipated in Q3/4 of 2014/15.	**Not yet due**	

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Incident Reporting – Compliance Action **Regulation 20 (1) b Assessing and monitoring the quality of service provision.** **People were not protected from risk through poor incident reporting systems and failure to report near misses. Valuable learning for assessment of risk and improvement of future care has been lost. All staff should be responsible for incident reporting and staff should report near misses as well as actual incidents.**						
The Trust must improve its incident reporting service, All staff must be aware of their responsibilities to report both incidents and near misses	• To improve incident reporting training Trust-wide.	July 2014	Deputy Director Of Governance	• A new and improved training package is being completed, with additional modules on completion of RCA's, ○ Reporting near misses, ○ Identifying lead author notifications, ○ Duty of candour, ○ Identifying cause groups, ○ Criteria awareness ○ Clinical staff identification for re-validation purposes. • Incident reporting training is currently provided at Trust Corporate Induction, mandatory training through the Workbook and e-learning and through ad-hoc one to one and group training sessions.	**Not yet due**	
	• To raise awareness of the importance of incident reporting at all staffing levels.	July 2014	Deputy Director of Governance	• The team is working with groups such as ISS cleaning contractors to include safety and hazard risks to staff and patients onto the Safeguard system. • The issue of staff of lower grades not reporting incidents to be raised at the next LIRC Committee meeting (24/06/14). • A section is being added to the Lessons Learned monthly newsletter reiterating the importance of incident reporting and to include feedback on lower level incidents, not just SUI's.	**Not yet due**	
	• Improve Near Miss reporting	July 2014	Deputy Director of Governance	• Working with Pharmacy to encourage near miss reporting of prescription errors onto the Safeguard system. A meeting has been set up with Risk Management, IT and Pharmacy for 21/05/14 to initiate a new process. • Near Miss training incorporated into new training package for all staff. Trajectory agreed with Commissioners for 14/15.	**Not yet due**	
	• Improved IT access in clinical areas to improve timely incident reporting.	Dec 15	Head of IM&T	• Review of number of PC's in clinical areas underway with plans to increase infrastructure. Project completed to replace clinical PCs within Ward and Outpatient areas. • Funding has been agreed for an upgrade of PCs in the North and the plan is at the fact gathering stage. New equipment has been ordered with a target date for completion of the project by the end of the financial year. This will enable all staff in the North to access the Safeguard Incident reporting system and other Trust clinical systems.	**Not yet due**	

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Continued	• Review and streamline corporate incident reporting policies and procedures and align with Divisional procedures. Streamline processes and re-launch Trust-wide.	August 2014	Deputy Director of Governance	• Corporate policies and procedures are being reviewed in line with streamlining processes for incident reporting. These will be aligned with current internal Divisional procedures. The Divisions are currently re-aligning their processes utilising the best practice processes identified within the Families Division, as highlighted by the Keogh report. • A Trust-wide staff survey has been undertaken relating to the current incident reporting processes. A very positive response level has been received with over 400 submissions. The Risk Team are reviewing the responses and will align the feedback with the proposed changes to policies, procedures and processes.	**Not yet due**	
Staffing Levels – Compliance Action **Regulation 22 Staffing – People are at risk through the failure to provide sufficient numbers of suitably qualified, skilled and experienced persons in some clinical areas. The Provider must regularly review staffing and skills mix in all its clinical and non clinical areas. An agreed staffing level should be set and maintained.**						
Appropriate Clinical Staffing Levels	• Finalise Workforce Strategy (inc AHPs)	June 14	Director of Human Resources	• Draft Workforce Strategy to be submitted to May Workforce Committee for discussion and approval prior to submission to Board of Directors - Workforce strategy submitted to Workforce Committee.	**13 May 2014**	**G**
	• Deliver 2014/15 Workforce Plan	September 14	Director of Human Resources Director of Nursing and Quality Medical Director	• Complete annual return for Education Commissioning Return to HEE NW by mid July 2014. • Divisional workforce plans to be completed by September 2014 • Workforce Committee to review divisional workforce plans bi-annually	**Not yet due**	
	• Implement National Quality Board requirements – Publication Nurse Staffing	June 14	Director of Nursing and Quality	• February 2014 – Nursing and Midwifery Staffing Review presented to Quality Committee. • March 2014 – Finance Committee agreed £1 million investment • April 2014 – Nursing and Midwifery 6 monthly Staffing Review presented to the Trust Board • 23rd April 2014 NHS England Stock Take completed and returned. • 22nd April met with Allocate E Roster provider regarding potential to report from e-roster • 16th May 2014 – participated in NHS England Web ex – further information on requirements for publishing	**June 2014** Not yet due	

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Sickness Levels						
Review any higher than expected sickness rates	• Review rates and agree associated action plans	May 14	Director of Human Resources	• Detailed sickness absence report to be discussed at Workforce Committee – 22.4.14. Report discussed and high level actions agreed report now going to Board on 21st May 2014. • Divisional Action Plans to be developed and agreed at Workforce Committee – 13.5.14. Plans discussed and agreed at the Workforce Committee meeting and will be monitored on a quarterly basis.	**13 May 2014**	**G**
Maternity **Regulation 10 (1) b Assessing and monitoring the quality of service provision – People were not protected against the risks associated with outcomes from their pregnancy. There is a high rate of Primary Postpartum Haemorrhage and associated Hysterectomy. Action has been taken to begin assessing this, but this requires urgent resolution.**						
People were not protected against the high risks associated with outcomes from their pregnancy. There is a high rate of Primary Post Partum Haemorrhage and associated Hysterectomy. Action has been taken to begin assessing this, but this requires urgent resolution	• RCOG to undertake case note review of PPH and Peripartum Hysterectomy cases	30.4.14	Head of Department, Women's Health	• Date arranged, to feedback report to Trust Board, CCGs and CQC		**G**
	• Review provision of Interventional Radiology		Head of Department, Women's Health	• Concerns highlighted to NHS England, Local Area Team. Risk Assessment completed. Discussion initiated with tertiary centre for high risk cases		**A**
	• Review provision of cell salvage	May 2014	Head of Department	• Option appraisal for cell salvage being completed	**Not yet due**	
	• Ongoing review of action plan following 'Postpartum Hemorrhage review 2012/13'	April 2014	Head of Department, Women's Health	• Multi-disciplinary review of action plan to identify actions completed and provide assurance to the team and Trust Board		**G**
	• Develop training package, to include Human Factors' training	May 2014	Head of Midwifery	• Meeting arranged 14.4.14. Training Needs Analysis 2014/15 updated to include 'Human factors' training	April 2014	G
	• Theatre training to be developed including risk assessment, leadership	June 14	Head of Midwifery	• Team Development Programme planned with OD Department • NHS Leadership course arranged June 2014.	**Not yet due**	
Distribution of midwifery staff, staffing levels and the organisation of staff were at time less than adequate	• Midwifery staff meeting held to agree actions:	April 2014	Head of Service	• Meeting held and agreed local actions, follow up meeting arranged 9.5.14 to assurance progress		G
	• Review midwifery model	May 2014	Head of Midwifery	• Development of integrated teams, to include Community Midwives, ongoing	**Not yet due**	
	• Review complex /specialist midwifery teams	May 2014	Head of Midwifery	• Structure and review of specialist midwifery teams ongoing, to integrate with Safeguarding team	**Not yet due**	

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Continued Continued	• Review administration/documentation processes	May 2014	Head of Service	• Team identified to review administrative and Euroking processes. Better Information meetings to be set up	**Not yet due**	
	• Ensure effective use of Maternity Support Workers/ Healthcare Assistants	June 2014	Head of Midwifery	• Training package developed and training days arranged	**Not yet due**	
	• Review provision of antenatal education	May 2014	Head of Midwifery	• Review underway, baseline data collated. Maximise opportunities of integration and use of voluntary sector (NSPCC)	**Not yet due**	
	• Coordination of sickness/absence	May 2014	Head of Midwifery	• Staff identified to manage sickness, absence including short term sickness	April 2014	
	• Complete option appraisal for staffing maternity theatre	May 2014	Head of Midwifery	• Review meeting taken place 10.4.14, to develop option appraisal (including risk assessment)	**Not yet due**	
Maternity dashboard	• Quality assurance of maternity dashboard prior to publication	April 2014	Head of Department	• Monthly multidisciplinary meetings held to quality check maternity dashboard prior to publication. • Monthly review with Commissioners	April 2014	**G**
A&E Equipment –Compliance Action **Regulation 10 (1) b Assessing and monitoring the quality of service provision – People were not protected against the risks associated with defective equipment because the systems for checking essential equipment were ineffective. In A&E, there were not effective procedures to check key items of clinical equipment such as defibrillators. Clear procedures are required that are audited regularly.**						
Improved Compliance with Trust's standard's for cleaning and checking of equipment.	• Review cleaning contract regarding trolleys to agree expectations and roles and responsibilities.	April 14	Infection prevention Consultant Nurse/ Emergency Department Matron	• Cleaning services provider to clean trolleys and tag to identify review date. Nursing staff to clean in between patient episodes. • Completed	11.04.2014	G
	• Review of cleaning services maximiser results and internal assessment results which reflect the potential of requiring enhancing cleaning input to the department.	May 14	Emergency Department Matron/ Head of cleaning services provider.	• Cleaning services provision meets the needs of the Emergency Department. • Cleaning Services provision has been reviewed and the department is now receiving enhanced provision out of hours and further provision in the early evening.	**12.05.2014**	G

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Continued	• Equipment / device lead role identified and budget agreed.	May 14	Emergency Department Matron & Senior nurse.	• Lead nurse to drive compliance with Trust standard's and ensure that all equipment is prepared for use. • Currently advertising for Band 5 to fill this post. • As interim measure person identified to assist and monitor	**Not yet due**	
	• Continue with heightened spot checks with environmental audits.	May 14	Emergency Department Matron.	• Improved hand hygiene compliance to move towards 100% compliance. • Audits due to commence 14/04/2014.		G
	• Agenda item on department governance meetings.	May 14	Emergency Department Matron.	• Improved compliance in cleaning and checking equipment moving towards 100%. • Added to Emergency Department governance agenda.	11.04.2014	**G**
Maintenance of patient's privacy and dignity during periods of escalation.	• GP divert stopped with implementation of GP assessment area and ring fenced GP admission bed on AMU.	March 14	Matron Emergency Department /Deputy Director of Operations.	• An enhanced effective flow with minimised use of escalation trolley areas. • Completed	24.03.2014	**G**
	• Observational walk round to undertake options appraisal of Initial Assessment (IAN) location.	May 14	Matron & Senior nurse of Emergency Department/ Head of Estates.	• IAN process is undertaken in optimum area on the department. • Plans from estates department due to be provided by 14/4/14 for team to assess if this is a viable option. • Met with Estates on 09/05/14, awaiting further detailed plan for assessment of way forward.	**Not yet due**	
	• Senior nurses to reinforce use of existing privacy screens when escalated.	March 14	Matron Emergency Department	• Patient privacy & dignity maintained. • Completed	31.03.2014	**G**
	• Additional privacy screens to be purchased to support times of escalation	May 14	Matron Emergency Department	• Patient privacy & dignity maintained • Procurement working with departmental senior nurse to source and cost mobile dignity screens, financial costing to be provided. • Costings obtained. Double check of areas to ensure we do not have some already available.	**Not yet due**	
	• Part of waiting area transformed into four assessment areas for utilisation by the nurse practitioners and advanced nurse	March 14	Emergency department Matron/Head of Estates.	• An enhanced effective flow with minimised use of escalation trolley areas. • Completed	31.03.2014	**G**

	practitioners.					
Recommended action	**Action**	**Timescale**	**Person Responsible**	**Progress**	**Date Completed**	**RAG Rating**
100% Compliance with Trust Standard's for Hand Hygiene.	• Training and awareness sessions on the 5 moments of hand hygiene to be provided for all Emergency Department staff.	May 14	Emergency Department Matron / Head of Department	• All emergency department staff aware of the 5 moments of hand hygiene and adhere to standard. • Infection prevention team assisting with training in the department.	**Not yet due**	
	• Hand Hygiene guidelines to be redistributed to all Emergency Department staff for signature of understanding and agreement of compliance.	May 14	Emergency Department Matron / Head of Department	• All staff have Trust standard reaffirmed and have signed to adhere to the guidelines. • Guidelines currently being distributed amongst nursing and medical staff	**Not yet due**	
	• Interim programme of weekly audits to be facilitated by senior nurses, Acute Response Team to perform out of hours checks for an interim period of time.	April 14	Emergency Department Matron.	• Improved hand hygiene compliance to move towards 100% compliance.		G
	• Agenda item on departmental governance meeting	April 14	Emergency Department Matron.	• Robust monitoring of compliance in place. • Added to Emergency Department Governance agenda	11.04.2014	G
Pre-operative Orthogeriatric Assessment – Compliance Action **Regulation 10 (1) b Assessing and monitoring the quality of service provision – People were not protected against the risks associated with failure to carry out timely and appropriate pre-operative assessments by a specialist. Where appropriate, patients should have a preoperative assessment by an orthopaedic geriatrician**						
Appropriate/ timely Orthogeriatric Pre-operative assessment	• Review and agree service model	June 14	Medical Director	• This action to be reviewed once the Trust has had a response from the central hip fracture database team regarding pre-op assessment. • Clinical pathway discussed with CCG's agreed to prepare a paper setting out the patient pathway and compliance against blue book standards.	**Not yet due**	
	• Agree plan to implement any required changes • Improve the % rate of patients undergoing hip surgery within 48 hours.	June 14	Medical Director	• As above	**Not yet due**	

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Well Led						
Develop & communicate a strategy for the new acute and community service	• Facilitated review of strategic context including local, regional and national issues to enable the development of Trust strategy for the next 5 years	February 14	Chief Executive	• Board Away Day held, facilitated by Mike Farrar CBE, former Chief Executive of the NHS Confederation and former CEO of the North West Strategic Health Authority	**11th February**	**G**
	• Discuss/agree draft Trust Strategic Direction with key clinical staff, Governors and CCGs	February to March 14	Director of Strategy	• A series of discussions have been held with members of the Trust Executive Team, Governors (both in full open sessions and in workshops), and with CCGs • A plan on a page has been finalised and approved by the Board	**Complete**	**G**
	• Communication to Trust through CEO Blog & Team Brief	March 14	Chief Executive	• Included in both CEO Blog & Team Brief, with a number of email conversations following the former	**March**	**G**
	• Submit agreed Strategic Direction to Monitor as part of the APR	April 14	Director of Strategy	• APR developed and submitted	**6th April**	**G**
	• Ensure that Trust is fully engaged with, and influencing, developments across Lancashire particularly in Morecambe Bay and also takes due account of national developments	Ongoing	Chief Executive Director of Strategy	• Director of Strategy is a member of the Morecambe Bay Strategic Board and CEO attends the "Stakes in the Ground" sessions • CEO is lead Chief Executive for Vascular reconfiguration • CEO is one of the members of the Lancashire Transformation Executive Group • Early engagement with Oliver Wyman to accelerate strategic thinking locally – now recognised as a key potential future direction for the NHS • As part of our out of hospital strategy, discussion held with Professor Robert Harris, Director of Strategy for NHS England	**Ongoing**	**A**
	• Hold interactive staff engagement events to communicate agreed strategy	Beginning in April 14	Chief Executive	• Format/comment/approach revised to incorporate enhanced overall engagement as well as communicating agreed strategy. Revised approach to commence in June. • Roadshows have now been planned to take place during June and July with staff invited to attend.	**Ongoing**	**A**

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Continued	• Submit 5 year strategic plan	June 14	Director of Strategy/ Deputy Chief Executive	• 3 work-stream groups established (community, in-hospital, regional) with NED, ED and clinical members to develop 5-year plans • Supporting work-streams on estates and IT established • Board Seminars being used to develop the strategy with NEDs and EDs • Clinical Policy Forum being used to develop the strategy with DDs and HoDs • LHE involvement in strategic plans though Fylde Coast Commissioning Advisory Board • Director of Strategy involvement in development of plans for Better Care Fund for Blackpool and Lancashire • A Fylde Coast out of hospital steering group has been established. • A detailed piece of work has now commenced with a Clinical Redesign Group which is due to complete in July 2014.	**Not yet due**	
Medical engagement	• Agree method for monitoring progress	May 14	Medical Director Director of Human Resources	• Agree formal measure of medical engagement including consideration of Staff FFT alongside other national medical engagement measures. Systems for measuring engagement particularly designed for medical staff being reviewed to ascertain which system best suits the Trust. • Conduct baseline benchmark of current level of engagement once measure agreed. • Undertake quarterly collation of engagement measure agreed including Staff FFT focused on medical workforce with additional questions.	**Not yet due**	

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Continued	• Develop an agreed Medical Engagement plan	May 14	Medical Director Director of Human Resources	• 5th March 14 - facilitated session at Clinical Policy Forum with Heads of Department on what they want to contribute to clinical engagement. • Produce detailed engagement plan building on outputs from facilitated session by 31st May. Draft engagement plan with Director of Workforce and OD to discuss with Medical Director • Examine opportunities for doctors to lead key quality and safety initiatives. • Identify medical leadership champions to support medical engagement. • Launch of new values integral to changing culture and embrace engagement. • Review job profiles of Divisional Directors and Heads of Department to provide clarity of contribution and expectations of role, including a review of current medical leadership structure. • Job profile for Divisional Director reviewed and out for comment with current postholders.	**Not yet due**	
				• Continue formal opportunities for engagement including Clinical policy forum, regular meetings with doctors in training, regular meetings with Divisional Directors. • Engaging medical workforce in the development of a clinical strategy.	**Not yet due**	
	• Implement agreed plan	From May 14	Medical Director Director of Human Resources	• Engagement events to be held regularly with the medical workforce to engage in dialogue and listen to issues raised and act upon them proactively. First events will be part of the overall engagement events launching strategic direction and values.	**Not yet due**	

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Evaluating good ideas	• Identification, evaluation and roll out of good ideas	May 14	Chief Executive Director of Strategy/ Deputy Chief Executive	• ½ day each month for individuals / teams to pitch - 'good ideas in practice' – ideas that have been successful in one area that could be scaled across the Trust - Cost-saving ideas - Quality improvement ideas • Re-launch 'bright ideas' scheme – on-line suggestion box for good ideas in alignment with above • Sponsorship will be sought from local companies to support rewards for individuals / teams and implementation of ideas • All Trust-funded education to include a project designed to improve services at the Trust (e.g. Masters, PG Cert) – make this part of the criteria for being awarded funding • Clinical and Management Leadership Programmes – participants asked to identify ideas for improvement and where appropriate asked to lead / participate in implementation	**Not yet due**	
	• Question Time	May 14	Chief Executive All EDs	• Re-energise CEO Question Time by holding themed sessions in alignment with strategic direction and/or particular challenges. • Involve all EDs in Question Time, dependent upon theme, and utilise question time to encourage new ideas	**Not yet due**	
Reduce Bed occupancy	• Monitor bed occupancy monthly	April 14	Head of Midwifery	• Following opening of the Midwife Led Unit bed occupancy reduced to 70%	April 2014	**G**
Complaints						
The Trust should improve awareness of the complaints and comments process and encourage patients to use them.	• Produce a patient leaflet that details all the different ways to leave feedback about the Trust. Issue it with all admission letters and place it around the hospital sites to raise awareness.	June 14	Director of Nursing / Assistant Director of Nursing Patient Experience	• Develop a patient information leaflet as part of the 'Tell Us' campaign • Explore possibility of leaflet going in all appointment letters sent from the Trust. • The leaflet will cost: ○ 1000 copies - £226 ○ 5000 copies - £568 • Leaflets on order	**Not yet due**	**A**
	• New information stand to be placed in the main entrance of our hospital sites advertising how to leave feedback.	June 14	Assistant Director of Nursing Patient Experience	• Explore possibility of purchasing a pop up stand with the key messages of the 'Tell Us' campaign on. The cost per stand will be £125. • Liaise with Public Health, Health Watch and Commissioners to explore possibility of joint working. • Project plan being submitted to chief nurse of Blackpool CCG by 16th May 2014, for consideration and possibility of joint working	**Not yet due**	**A**

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Continued	• New hot board to be placed outside the Patient Relations office detailing the different feedback processes, useful contact numbers; you said we did examples and monthly performance results.	June 14	Assistant Director of Nursing (Patient Experience)	• Meeting held with hot board. They have quoted £1395 for the board we require which included leaflets dispensers and a comment box. • Display this board in prominent position within the Trust for staff, patient and visitors to access. • Develop the use of the internet and intranet to raise awareness of raising concerns and giving feedback. • Project plan being submitted to chief nurse of Blackpool CCG by 16th May 2014, for consideration and possibility of joint working	**Not yet due**	**A**
	• Produce a hospital TV advert advising people what to do if they have a concern.	June 2014	Assistant Director of Nursing (patient Experience)	• Meet with Gov.Tv who has offered to produce a 30 second advert for £750, to use it in hospital, but it will also in Community settings. • Discuss possible joint funding with CCG's • Project plan being submitted to chief nurse of Blackpool CCG by 16th May 2014, for consideration and possibility of joint working	**Not yet due**	**A**
	• Explore the possibility of feedback processes being introduced and enhanced in the mandatory training and induction of staff.	June 14	Assistant Director of Nursing (patient Experience) Head of L&D	• Initial meeting set up with head of L&D on 16/04/14. • Develop staff workshop to raise awareness of process and updates • Staff bulletin drafted for CEO to send out to raise awareness of complaints process and upcoming campaign. • Explore the possibility of developing a e-learning resource • Develop training guide in handling complaints for staff to access on the intranet. • Plans being drawn up for 75 minute session within Trust induction (commencing June 2014) relating to patient experience and raising complaints • E-learning module being researched and written this will form the basis of the annual mandatory training workbook.	**Not yet due**	**A**
	• Educate volunteers who perform 'spot surveys' at ward/dept level to be aware of process and to promote options to patients. Carers and staff.	June 14	Assistant Director of Nursing Patient Experience	• Education to be built into the volunteers induction and as team develops and grows to update team members regularly • Liaise with Blue Skies to the possibilities of having an insert placed in the comfort packs to raise awareness of feedback to patients. • Volunteer numbers increased and training on going • Patient experience evaluation questions placed in comfort packs for patients to send back feedback	**Not yet due**	**G**

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Awareness of complaints procedures	• Approach other Trusts to share good practice	April 14 and ongoing	Director of Nursing and Quality	• Other Trusts contacted – Salford, Wigan, Northumbria		G
Car Park Patient Communication.	• Review/publicise facilities for patients	April 14	Director of Nursing and Quality	• The signage for the car park has now been completed.		G
Data reconciliation	• Review areas within the report & address any outstanding issues	May 14	Director of Strategy		**Not yet due**	
	• Review all external data submissions, agreeing action plans as appropriate, and establish a Trust wide sign-off system	June 14	Director of Strategy		**Not yet due**	
Vulnerable adolescents	• Review observation on new unit • Continue to include the unit in the patient safety walkabout visits.	May 14	Director of Nursing and Quality Head of Service, Families Division	• Director of Nursing, Head of Midwifery and Paediatric Nurse Manager visited the Unit on 6th May. It is a small unit with single rooms. All patients are risk assessed and highest risk patient placed inside room opposite nurses' station. Staffing levels are adjusted in line with risk assessments. • Team agreed to produce an escalation plan detailing the arrangements that are put in place to safeguard all patients on the unit.	**Not yet due**	
Mortality rates	• Agree 2014/15 target reduction in SHMI rates • Continue monitoring of Actual versus Plan for the Keogh Care Pathways. ○ Stroke ○ Pneumonia ○ Sepsis ○ Cardiac Chest Pain ○ Acute Kidney Injury	May 14 Ongoing	Chief Executive	• SHMI for Trust as a whole and for individual identified pathways is reviewed regularly at the Mortality Group. • Further target reduction in SHMI has been agreed for the next year – 107.5 by end of April 2015 • April SHMI rate is lowest ever achieved.	**Not yet due**	

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Continued	• Audit Mortality Review meetings & address any issues arising • Participate in Health Economy Mortality Interface Audits (30 day post discharge)	Ongoing – Weekly & Quarterly	Medical Director	• Weekly meetings of Trust Mortality Steering Group continue. • Mortality review meetings now well established in the Trust and audited.		**G**

Infection Control	• Additional education sessions	April 14 & ongoing	Director of Nursing and Quality	• Induction Programme continues face to face including Hand washing technique practical session.
				• Mandatory training via workbook and electronic
				• Student/cadet training on site and within the University
				• Tailored Infection Prevention training provided on the wards include:
				  • New Updates on the revised CPE policy and screening protocol,
				  • Technique for taking nasal swabs,
				  • Technique for applying decolonisation treatment.
				• Link Champions receive training and education at the Link Champion meetings.
						A

	• Increased covert audits	April 14 & Ongoing	Director of Nursing and Quality	• Covert hand hygiene audits to change to quarterly to include a minimum of 10 observations of all disciplines of staff and also patients. Audits to be conducted over the three months • The Infection Prevention team will supplement the audits by observing practice and any non-compliance will be incorporated into the quarterly audits. • The Infection Prevention team will also conduct random checks on staff, asking them what the five moments are, the results of which will be reported alongside the covert audits.		**G**
Other key actions	• Agree new measures of success and any other carry over actions from Keogh Review	April 14	Chief Executive	• Quality Summit attendees agreed that the Trust develops one quality improvement action plan going forward.	**April 2014**	**G**
Reduc**e Diabetic foot clinic overcrowding**	• Review activity levels & agree action plan	May 14	Director of Operations		**Not yet due**	

Recommended action	Action	Timescale	Person Responsible	Progress	Date Completed	RAG Rating
Monitor Endocrinology and diabetes clinical effectiveness data (Amputation rates)	• Keep under formal review at Quality Committee	Bi- monthly	Medical Director	• Amputation data being reviewed by Medical Director and Trust Audit Lead		**A**

RAG Rating	
Green	**Complete Within Date for Delivery**
Amber	**Incomplete but within date for delivery**
Red	**Not complete and beyond the date for delivery**
White	**Not yet due**