Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSWs	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure it is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day Surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres. Targets for vacancy rates on ESR (tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at board level, there is an identified lead with the responsibility for services for Children and Young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NLMS/ESR. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of Sep 14, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by Mar 15 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

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M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. CCG Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing with a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	Director of Strategic Development	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) aligned with local refurbishment programmes are in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

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M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance and are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials Management - stock reordered process is being republished. 4. Materials Management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services . 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agreed the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. Mar 15 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of Dec 14. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year**. 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % staff aware of EoLC guidance measured by interim staff survey. **Target is quarterly 5% increase from Q3 baseline survey**. 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health econ	Medical Director	1. Jan 15 for baseline staff survey and initial audit 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNA CPR and these are clearly signed and documented in the Healthcare Record. 2. Ensure staff are trained in communicating DNA CPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNA CPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access Diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for outpatient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity, the clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	Dec 14, trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for outpatient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity, achieving targets by Sep 15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Targets as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 4 and 6.. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E and Urgent Care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 13/13 consultants in post by Sept-15. 3. See outcomes for M01 & M02. 4. Minutes of governance/patient safety meetings discussed at UC&LTC. 5. Evidence of embedded learning and pathway improvements. 6. 95% A&E standard to be maintained 7. Re-admissions reduced to national average	Director of Operations	Sep-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct 14 2. Mar 15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps acr	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. 70% of patients assessed within 24 hours of receiving Fax 1 for Social Services assessment 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for Children and Young People. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	Dec 14 and on-going as part of 15/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by an independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results. Target is 10% increase in compliance for locking drugs fridges in 6 monthly audits from baseline in May 14 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug (CD) checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all CD administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by an independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of CDs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 15/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. Target tbc by Nov 14 after diagnostic work. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report or the plan to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD. 4. Audit WHO checklist compliance	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital both as a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) target using Q1 & Q2 data by Nov-14 after diagnostic work completed, Q2 baseline at 45%). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED & Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendations identified have actions identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the findings of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme and increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 2. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 3. All directors and senior managers to be located at QEQMH at least on one day per week by Nov 14. 4. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	Mar-16	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible, identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery, Paediatric cover for A&E and the middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, outp	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to Midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan 15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year.** 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy of any performance. 2. Any areas where data validation is questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec 14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

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KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2.Increase % as a proportion of the above average 6 monthly reporting levels for large acute Trusts. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun15	Quarterly incident reports to the QAB, Quality Board and monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policies and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar 15 2. Mar 15 3. Mar 16 & on-going 4. Dec 15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety and quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme. Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed with improved compliance against national audit programme and published in the Quality Accounts; monitore	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar 15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec 14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	Complete independently run data quality audit by Dec 14.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providing external assurance
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and outpatient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Outpatients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the outpatient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar 15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increased use of Choose & Book or equivalent

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KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of Dec 13.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at present and the size of the Trust generally correlates with the number of complaints received	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec 13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr 15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch

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M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSWs	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure it is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day Surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres. Targets for vacancy rates on ESR (tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at board level, there is an identified lead with the responsibility for services for Children and Young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NLMS/ESR. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of Sep 14, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by Mar 15 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

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M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. CCG Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing with a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	Director of Strategic Development	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) aligned with local refurbishment programmes are in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

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M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance and are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials Management - stock reordered process is being republished. 4. Materials Management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services . 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agreed the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. Mar 15 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of Dec 14. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year**. 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % staff aware of EoLC guidance measured by interim staff survey. **Target is quarterly 5% increase from Q3 baseline survey**. 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health econ	Medical Director	1. Jan 15 for baseline staff survey and initial audit 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNA CPR and these are clearly signed and documented in the Healthcare Record. 2. Ensure staff are trained in communicating DNA CPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNA CPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access Diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for outpatient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity, the clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	Dec 14, trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for outpatient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity, achieving targets by Sep 15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Targets as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 4 and 6.. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E and Urgent Care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 13/13 consultants in post by Sept-15. 3. See outcomes for M01 & M02. 4. Minutes of governance/patient safety meetings discussed at UC&LTC. 5. Evidence of embedded learning and pathway improvements. 6. 95% A&E standard to be maintained 7. Re-admissions reduced to national average	Director of Operations	Sep-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct 14 2. Mar 15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps acr	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. 70% of patients assessed within 24 hours of receiving Fax 1 for Social Services assessment 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for Children and Young People. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	Dec 14 and on-going as part of 15/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by an independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results. Target is 10% increase in compliance for locking drugs fridges in 6 monthly audits from baseline in May 14 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug (CD) checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all CD administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by an independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of CDs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 15/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. Target tbc by Nov 14 after diagnostic work. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report or the plan to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD. 4. Audit WHO checklist compliance	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital both as a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) target using Q1 & Q2 data by Nov-14 after diagnostic work completed, Q2 baseline at 45%). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED & Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendations identified have actions identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the findings of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme and increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 2. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 3. All directors and senior managers to be located at QEQMH at least on one day per week by Nov 14. 4. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	Mar-16	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible, identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery, Paediatric cover for A&E and the middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, outp	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to Midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan 15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year.** 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy of any performance. 2. Any areas where data validation is questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec 14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

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KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2.Increase % as a proportion of the above average 6 monthly reporting levels for large acute Trusts. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun15	Quarterly incident reports to the QAB, Quality Board and monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policies and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar 15 2. Mar 15 3. Mar 16 & on-going 4. Dec 15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety and quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme. Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed with improved compliance against national audit programme and published in the Quality Accounts; monitore	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar 15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec 14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	Complete independently run data quality audit by Dec 14.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providing external assurance
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and outpatient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Outpatients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the outpatient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar 15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increased use of Choose & Book or equivalent

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KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of Dec 13.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at present and the size of the Trust generally correlates with the number of complaints received	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec 13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr 15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch

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M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSWs	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure it is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day Surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres. Targets for vacancy rates on ESR (tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at board level, there is an identified lead with the responsibility for services for Children and Young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NLMS/ESR. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of Sep 14, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by Mar 15 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

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M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. CCG Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing with a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	Director of Strategic Development	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) aligned with local refurbishment programmes are in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

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M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance and are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials Management - stock reordered process is being republished. 4. Materials Management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services . 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agreed the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. Mar 15 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of Dec 14. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year**. 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % staff aware of EoLC guidance measured by interim staff survey. **Target is quarterly 5% increase from Q3 baseline survey**. 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health econ	Medical Director	1. Jan 15 for baseline staff survey and initial audit 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNA CPR and these are clearly signed and documented in the Healthcare Record. 2. Ensure staff are trained in communicating DNA CPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNA CPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access Diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for outpatient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity, the clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	Dec 14, trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for outpatient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity, achieving targets by Sep 15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Targets as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 4 and 6.. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E and Urgent Care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 13/13 consultants in post by Sept-15. 3. See outcomes for M01 & M02. 4. Minutes of governance/patient safety meetings discussed at UC&LTC. 5. Evidence of embedded learning and pathway improvements. 6. 95% A&E standard to be maintained 7. Re-admissions reduced to national average	Director of Operations	Sep-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct 14 2. Mar 15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps acr	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. 70% of patients assessed within 24 hours of receiving Fax 1 for Social Services assessment 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for Children and Young People. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	Dec 14 and on-going as part of 15/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by an independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results. Target is 10% increase in compliance for locking drugs fridges in 6 monthly audits from baseline in May 14 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug (CD) checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all CD administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by an independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of CDs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 15/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. Target tbc by Nov 14 after diagnostic work. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report or the plan to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD. 4. Audit WHO checklist compliance	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital both as a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) target using Q1 & Q2 data by Nov-14 after diagnostic work completed, Q2 baseline at 45%). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED & Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendations identified have actions identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the findings of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme and increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 2. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 3. All directors and senior managers to be located at QEQMH at least on one day per week by Nov 14. 4. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	Mar-16	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible, identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery, Paediatric cover for A&E and the middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, outp	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to Midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan 15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year.** 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy of any performance. 2. Any areas where data validation is questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec 14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

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KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2.Increase % as a proportion of the above average 6 monthly reporting levels for large acute Trusts. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun15	Quarterly incident reports to the QAB, Quality Board and monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policies and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar 15 2. Mar 15 3. Mar 16 & on-going 4. Dec 15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety and quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme. Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed with improved compliance against national audit programme and published in the Quality Accounts; monitore	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar 15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec 14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	Complete independently run data quality audit by Dec 14.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providing external assurance
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and outpatient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Outpatients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the outpatient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar 15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increased use of Choose & Book or equivalent

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KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of Dec 13.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at present and the size of the Trust generally correlates with the number of complaints received	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec 13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr 15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch

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M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSWs	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure it is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day Surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres. Targets for vacancy rates on ESR (tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at board level, there is an identified lead with the responsibility for services for Children and Young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NLMS/ESR. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of Sep 14, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by Mar 15 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

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M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. CCG Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing with a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	Director of Strategic Development	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) aligned with local refurbishment programmes are in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

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M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance and are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials Management - stock reordered process is being republished. 4. Materials Management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services . 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agreed the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. Mar 15 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of Dec 14. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year**. 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % staff aware of EoLC guidance measured by interim staff survey. **Target is quarterly 5% increase from Q3 baseline survey**. 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health econ	Medical Director	1. Jan 15 for baseline staff survey and initial audit 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNA CPR and these are clearly signed and documented in the Healthcare Record. 2. Ensure staff are trained in communicating DNA CPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNA CPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access Diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for outpatient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity, the clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	Dec 14, trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for outpatient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity, achieving targets by Sep 15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Targets as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 4 and 6.. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E and Urgent Care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 13/13 consultants in post by Sept-15. 3. See outcomes for M01 & M02. 4. Minutes of governance/patient safety meetings discussed at UC&LTC. 5. Evidence of embedded learning and pathway improvements. 6. 95% A&E standard to be maintained 7. Re-admissions reduced to national average	Director of Operations	Sep-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct 14 2. Mar 15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps acr	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. 70% of patients assessed within 24 hours of receiving Fax 1 for Social Services assessment 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for Children and Young People. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	Dec 14 and on-going as part of 15/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by an independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results. Target is 10% increase in compliance for locking drugs fridges in 6 monthly audits from baseline in May 14 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug (CD) checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all CD administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by an independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of CDs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 15/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. Target tbc by Nov 14 after diagnostic work. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report or the plan to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD. 4. Audit WHO checklist compliance	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital both as a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) target using Q1 & Q2 data by Nov-14 after diagnostic work completed, Q2 baseline at 45%). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED & Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendations identified have actions identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the findings of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme and increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 2. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 3. All directors and senior managers to be located at QEQMH at least on one day per week by Nov 14. 4. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	Mar-16	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible, identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery, Paediatric cover for A&E and the middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, outp	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to Midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan 15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year.** 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy of any performance. 2. Any areas where data validation is questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec 14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

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KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2.Increase % as a proportion of the above average 6 monthly reporting levels for large acute Trusts. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun15	Quarterly incident reports to the QAB, Quality Board and monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policies and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar 15 2. Mar 15 3. Mar 16 & on-going 4. Dec 15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety and quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme. Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed with improved compliance against national audit programme and published in the Quality Accounts; monitore	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar 15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec 14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	Complete independently run data quality audit by Dec 14.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providing external assurance
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and outpatient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Outpatients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the outpatient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar 15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increased use of Choose & Book or equivalent

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KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of Dec 13.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at present and the size of the Trust generally correlates with the number of complaints received	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec 13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr 15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch

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M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSWs	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure it is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day Surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres. Targets for vacancy rates on ESR (tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at board level, there is an identified lead with the responsibility for services for Children and Young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NLMS/ESR. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of Sep 14, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by Mar 15 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

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M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. CCG Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing with a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	Director of Strategic Development	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) aligned with local refurbishment programmes are in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

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M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance and are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials Management - stock reordered process is being republished. 4. Materials Management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services . 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agreed the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. Mar 15 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of Dec 14. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year**. 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % staff aware of EoLC guidance measured by interim staff survey. **Target is quarterly 5% increase from Q3 baseline survey**. 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health econ	Medical Director	1. Jan 15 for baseline staff survey and initial audit 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNA CPR and these are clearly signed and documented in the Healthcare Record. 2. Ensure staff are trained in communicating DNA CPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNA CPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access Diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for outpatient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity, the clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	Dec 14, trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for outpatient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity, achieving targets by Sep 15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Targets as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 4 and 6.. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E and Urgent Care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 13/13 consultants in post by Sept-15. 3. See outcomes for M01 & M02. 4. Minutes of governance/patient safety meetings discussed at UC&LTC. 5. Evidence of embedded learning and pathway improvements. 6. 95% A&E standard to be maintained 7. Re-admissions reduced to national average	Director of Operations	Sep-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct 14 2. Mar 15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps acr	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. 70% of patients assessed within 24 hours of receiving Fax 1 for Social Services assessment 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for Children and Young People. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	Dec 14 and on-going as part of 15/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by an independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results. Target is 10% increase in compliance for locking drugs fridges in 6 monthly audits from baseline in May 14 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug (CD) checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all CD administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by an independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of CDs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 15/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. Target tbc by Nov 14 after diagnostic work. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report or the plan to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD. 4. Audit WHO checklist compliance	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital both as a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) target using Q1 & Q2 data by Nov-14 after diagnostic work completed, Q2 baseline at 45%). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED & Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendations identified have actions identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the findings of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme and increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 2. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 3. All directors and senior managers to be located at QEQMH at least on one day per week by Nov 14. 4. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	Mar-16	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible, identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery, Paediatric cover for A&E and the middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, outp	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to Midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan 15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year.** 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy of any performance. 2. Any areas where data validation is questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec 14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

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KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2.Increase % as a proportion of the above average 6 monthly reporting levels for large acute Trusts. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun15	Quarterly incident reports to the QAB, Quality Board and monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policies and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar 15 2. Mar 15 3. Mar 16 & on-going 4. Dec 15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety and quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme. Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed with improved compliance against national audit programme and published in the Quality Accounts; monitore	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar 15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec 14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	Complete independently run data quality audit by Dec 14.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providing external assurance
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and outpatient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Outpatients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the outpatient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar 15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increased use of Choose & Book or equivalent

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KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of Dec 13.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at present and the size of the Trust generally correlates with the number of complaints received	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec 13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr 15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch

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M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSWs	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure it is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day Surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres. Targets for vacancy rates on ESR (tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at board level, there is an identified lead with the responsibility for services for Children and Young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NLMS/ESR. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of Sep 14, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by Mar 15 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

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M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. CCG Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing with a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	Director of Strategic Development	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) aligned with local refurbishment programmes are in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

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M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance and are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials Management - stock reordered process is being republished. 4. Materials Management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services . 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agreed the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. Mar 15 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of Dec 14. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year**. 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % staff aware of EoLC guidance measured by interim staff survey. **Target is quarterly 5% increase from Q3 baseline survey**. 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health econ	Medical Director	1. Jan 15 for baseline staff survey and initial audit 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNA CPR and these are clearly signed and documented in the Healthcare Record. 2. Ensure staff are trained in communicating DNA CPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNA CPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access Diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for outpatient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity, the clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	Dec 14, trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for outpatient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity, achieving targets by Sep 15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, Midwives, Paediatric cover for A&E and middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Targets as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 4 and 6.. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E and Urgent Care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 13/13 consultants in post by Sept-15. 3. See outcomes for M01 & M02. 4. Minutes of governance/patient safety meetings discussed at UC&LTC. 5. Evidence of embedded learning and pathway improvements. 6. 95% A&E standard to be maintained 7. Re-admissions reduced to national average	Director of Operations	Sep-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct 14 2. Mar 15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps acr	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. 70% of patients assessed within 24 hours of receiving Fax 1 for Social Services assessment 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for Children and Young People. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	Dec 14 and on-going as part of 15/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by an independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results. Target is 10% increase in compliance for locking drugs fridges in 6 monthly audits from baseline in May 14 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug (CD) checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all CD administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by an independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of CDs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 15/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. Target tbc by Nov 14 after diagnostic work. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report or the plan to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD. 4. Audit WHO checklist compliance	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based on the diagnostic for staff engagement and an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital both as a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) target using Q1 & Q2 data by Nov-14 after diagnostic work completed, Q2 baseline at 45%). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED & Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendations identified have actions identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the findings of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme and increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 2. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 3. All directors and senior managers to be located at QEQMH at least on one day per week by Nov 14. 4. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	Mar-16	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible, identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery, Paediatric cover for A&E and the middle grade doctors in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, outp	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for Physician's Assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to Midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan 15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training. Target maximum respectively of 5%, 5%, 2% and 5% 2. Data on Agency/Overtime/NHSP usage Targets 10%, 10%, 5% and 10% as % of Establishment respectively 3. Overall improvement in % of shifts filled during the night and the day (26 areas with a red average [i.e. average number of shifts filled <80%] in May, 24 in June, 21 in July 2014). Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1. Target as per Balanced Scorecard 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	Improvements in measures begin Nov-14	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training by Oct 14, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. **Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year.** 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy of any performance. 2. Any areas where data validation is questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec 14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

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KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2.Increase % as a proportion of the above average 6 monthly reporting levels for large acute Trusts. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun15	Quarterly incident reports to the QAB, Quality Board and monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policies and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar 15 2. Mar 15 3. Mar 16 & on-going 4. Dec 15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety and quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme. Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed with improved compliance against national audit programme and published in the Quality Accounts; monitore	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar 15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy of any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec 14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	Complete independently run data quality audit by Dec 14.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providing external assurance
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and outpatient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Outpatients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the outpatient booking improvement plan. 2. Improve the communication around waiting times in outpatients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar 15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of outpatient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme Mar 15 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increased use of Choose & Book or equivalent

Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey. **Target is 5% increase from Q3 baseline survey.** 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	Dec 14 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of Dec 13.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at present and the size of the Trust generally correlates with the number of complaints received	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec 13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr 15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch