Special Measures Quality Improvement Programme 2016-17 Update

Colchester Hospital University NHS Foundation Trust

11th May 2016

KEY

Delivered
On Track to deliver
Some issues – narrative disclosure
Not on track to deliver
**Background and summary of actions**

Colchester Hospital University NHS Foundation Trust (CHUFT) provides a range of hospital services for the people of Colchester, North East Essex and South Suffolk. The Trust employs over 4,000 members of staff and each year over 400,000 people attend outpatient clinics; around 75,000 patients visit A&E; the Trust treats around 90,000 inpatients and delivers over 4,000 babies each year.

**Keogh review – February 2013**

In February 2013 the Prime Minister asked Professor Sir Bruce Keogh, Medical Director of NHS England, to undertake a review of the quality of care and treatment at 14 Hospital Trusts that had higher than average mortality rates over the previous two years. This group of Trusts included Colchester Hospital University NHS Foundation Trust.

The review of CHUFT referred to “great examples of excellent care being delivered to patients” but it also noted a number of areas where improvements were necessary. Professor Sir Bruce Keogh made a number of recommendations designed to bring about quality improvements. These included:

- The need for better processes to recognise and treat deteriorating patients
- A review of staffing and skill mix
- Improved communication and engagement with staff
- Improved complaints management processes

**CQC cancer services review – November 2013**

In the summer of 2013 a member of Trust staff contacted the Keogh review team with information about alleged waiting list manipulation in respect of cancer services - which the Keogh team passed on to the Care Quality Commission (CQC). The CQC then undertook an inspection of the hospital in August and September of 2013.

The CQC identified “serious concerns” and said staff reported to the CQC that they were “pressured to change data... to make it seem people were being treated in line with national guidelines”. The CQC’s Chief Inspector of Hospitals, Professor Sir Mike Richards, recommended that Monitor place CHUFT into special measures.

The Trust immediately apologised, commissioned an independent review and indicated that “If there is any evidence that any of our staff have inappropriately adjusted and reported cancer figures, the Trust will take the strongest possible action against them.”

Monitor subsequently decided that CHUFT had breached its licence to provide health services and decided to put the Trust into special measures. This meant:

- The Trust had to develop an action plan to rectify the concerns highlighted by the CQC in respect of cancer services
- An Improvement Director would be appointed by Monitor
- A high performing Foundation Trust - the Royal Marsden (an NHS Foundation Trust with a world-leading reputation for cancer services) - would be asked to offer support to CHUFT.

During 2014 the Trust developed and implemented a Cancer Improvement Plan which involved reviewing and redesigning all cancer pathways. These pathways, with the exception of dermatology, were externally assured. In December 2014 the Trust published two independent investigations – the [Troop Taylor Brown report](http://www.colchesterhospital.nhs.uk/The%20Final%20Report%20of%20the%20Independent%20Investigation.pdf) and the [Retrospective Review](http://www.colchesterhospital.nhs.uk/Retrospective%20review%20-%20report.pdf). The broad conclusions of these reports was that there was no evidence of either systematic data manipulation in cancer services or a culture of systematic bullying and harassment within the Trust.
Background and summary of actions

CQC Full Hospital Inspection – May 2014
The Chief Inspector of Hospitals inspected our Trust in May 2014 and published the findings on CQC website in July 2014. The Trust was rated overall as ‘Requires Improvement’ and a number of specific recommendations relating to services provided at both Colchester General Hospital and Essex County Hospital were made. The Trust published its Improvement Plan to address the issues and concerns raised by CQC at the end of August 2014.

Section 31 Notices
“Section 31” notices are warning notices telling an organisation that they are not complying with a condition of their registration. At the end of 2014 CQC imposed two “Section 31” notices on the Trust, following an inspection of the A&E department and Emergency Assessment Unit (EAU) in November and December. Following two unannounced inspections in July 2015, CQC imposed a third “Section 31” notice in relation to induction of staff in clinical areas. The Trust responded robustly in undertaking new practices to ensure patient safety and this “Section 31” notice was lifted on 6th October 2015. During an inspection in September 2015, CQC reviewed evidence and found the Trust's processes were safe and appropriate. They noted that improvements had been made - which removed the risk of harm to patients - and the “Section 31” relating to the A&E department was also lifted on 29th October 2015 - the hard work continues on the remaining “Section 31” for EAU. This was excellent news and the staff and team who worked so hard to get all three “Section 31” notices lifted were to be congratulated.

Following an unannounced visit by CQC in April 2016 a further two “Section 31” notices were issued. One of the Section 31 notices was issued to the Emergency Department (ED) to ensure that patients attending ED are streamed to appropriate patient pathways. In addition there will be a sufficient number and suitably qualified skilled and experienced nurses to support the streaming of patients into these pathways. The second Section 31 notice was issued to the Surgical Theatre department to ensure the Trust operates effective audit and monitoring system that provides accurate assurance that the safer surgery checklist is being consistently carried out in accordance with the recommendations of the World Health Organisation Safer Surgery Checklist (2016), and the NHS Central Alert System (CAS) reference NPSA/2009/PSA002/U1 (Issue date 26 January 2009). The Trust provides weekly evidence and updates to CQC on compliance.

NHS England (NHSE) Assurance Visit
The Improvement Plan was recast in January 2015 – following the CQC visit in November 2014 – and, as part of an assurance of the Trust improvement journey, NHS England visited the trust on 28th April 2015. Their one-day visit was supplemented by a suite of documents and evidence provided beforehand. Overall the message was one of good progress - whilst recognising that there was still significant work to do. The issues and actions identified were incorporated into the Improvement Plan. The one area where the Trust received an “inadequate” rating was on Sepsis. The Director of Medicine lead work to add momentum to the Trust’s change programme. NHSE’s report can be found at http://www.colchesterhospital.nhs.uk/nhs_england_site_visit_april_2015.pdf

Risk Summit – August 2015
A Risk summit was held with Colchester Hospital’s regulators, commissioners and partners to take stock of the hospital’s improvement progress and any concerns. It was agreed to focus on 10 priority areas - known as work streams. Related actions were transferred from the existing Improvement plan and additional actions were added - taking into account points raised from the July 2015 CQC report. These were consolidated into a focused four-month plan which concluded at the end of January 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services Effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are Services caring?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services responsive?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Inadequate</td>
</tr>
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</table>
Going Forward
The CQC visited the Trust again in September 2015 and the resulting report was published on 19th January 2016. The Quality Improvement Plan was subsequently developed and submitted to CQC on 23rd February. This new plan incorporates all on-going actions from the Trust’s previous plans (split into six work-streams – Assessment & Monitoring of Risk; Governance & Leadership; Deteriorating Patient & End of Life Care; Patient Care, Experience & Effectiveness; Staffing; Medical Equipment) along with – having worked closely with partner agencies - requirements from the local Clinical Commissioning Group and Health Education East of England. This plan forms the basis of the Quality Improvement Programme going forward and will continue to be monitored on a regular basis. Staff are to be commended on their continuing positive attitude to improvement and change and - together with improved leadership, more robust governance and increased staff engagement – the Trust will be able to drive the improvements necessary to bring about consistent and sustainable high quality care.

The latest published report from CQC can be found on the CQC website: http://www.cqc.org.uk/location/RDEE4
CHUFT - Improvement Plan and Progress

Who is responsible?

- The Trust’s actions to address the improvements required have been agreed by the Trust Board and are monitored monthly by the Executive Team.
- An Improvement Board with representation from Trust Directors, North East Essex Clinical Commissioning Group, Healthwatch Essex and Essex County Council has been established to provide assurance to the Trust Board of Directors, patient and the public that progress is being made against the plan.
- The Quality & Patient Safety Committee monitors progress monthly before it is presented to each Board meeting.
- The Trust’s Chief Executive, Frank Sims is ultimately responsible for implementing actions in the Quality Improvement.
- The Improvement Director assigned to Colchester Hospitals NHS Foundation Trust is Sue Lewis - who will be acting on behalf of Monitor and in concert with the relevant Regional Team of Monitor to ensure delivery of the improvements and oversee the implementation of the action plan overleaf. Should you require any further information on this role please contact specialmeasures@monitor.gov.uk
- If you have any questions about how the Trust is doing, contact Ann Alderton via ann.alderton@colchesterhospital.nhs.uk

How the Trust will communicate our progress to you

- The Trust will update this progress report every month while they are in special measures.
- There will be regular updates on NHS Choices and subsequent longer-term actions may be included as part of a continuous process of improvement.
- The Trust will develop a patient forum to ensure that improvements they make best meet the needs of their patients.

Chair / Chief Executive Approval (on behalf of the Board):

<table>
<thead>
<tr>
<th>Chair Name: Alan Rose</th>
<th>Signature:</th>
<th>Date: 11.05.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Name: Frank Sims</td>
<td>Signature:</td>
<td>Date: 11.05.16</td>
</tr>
</tbody>
</table>
The Quality Improvement Plan commenced February 2016 and incorporated all on-going actions from the Trust’s previous plans. In line with the five CQC domains – Safe, Caring, Effective, Responsive and Well-Led – the status of the initial 209¹ actions was as follows:-

<table>
<thead>
<tr>
<th></th>
<th>SAFE</th>
<th>CARING</th>
<th>EFFECTIVE</th>
<th>RESPONSIVE</th>
<th>WELL-LED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Actions:</td>
<td>115</td>
<td>57</td>
<td>29</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Completed and Evidenced:</td>
<td>16</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On Track for Delivery:</td>
<td>87</td>
<td>48</td>
<td>22</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>At Risk:</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Overdue:</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

¹ As the plan evolves actions may be added/amended/removed. These changes will be tracked via the “QIP Change Log” and will be reported to the Quality Oversight Group on a monthly basis.
In line with the five CQC domains – Safe, Caring, Effective, Responsive and Well-Led - progress on the 220¹ current actions is as follows:-

**SAFE**

- Total Actions: 128
- Completed and Evidenced: 33
- On Track for Delivery: 85
- At Risk: 6
- Overdue: 4

**CARING**

- Total Actions: 56
- Completed and Evidenced: 14
- On Track for Delivery: 42
- At Risk: 0
- Overdue: 0

**EFFECTIVE**

- Total Actions: 28
- Completed and Evidenced: 6
- On Track for Delivery: 20
- At Risk: 0
- Overdue: 2

**RESPONSIVE**

- Total Actions: 2
- Completed and Evidenced: 1
- On Track for Delivery: 1
- At Risk: 0
- Overdue: 0

**WELL-LED**

- Total Actions: 6
- Completed and Evidenced: 2
- On Track for Delivery: 4
- At Risk: 0
- Overdue: 0

¹ As the plan evolves actions may be added/amended/removed. These changes will be tracked via the “QIP Change Log” and will be reported to the Quality Oversight Group on a monthly basis.
Summary Position of Quality Improvement Plan – April 2016

In line with the five CQC domains – Safe, Caring, Effective, Responsive and Well-Led - progress on the 231 current actions is as follows:-

SAFE

- Total Actions: 136
- Completed and Evidenced: 57
- On Track for Delivery: 65
- At Risk: 3
- Overdue: 11

CARING

- Total Actions: 62
- Completed and Evidenced: 23
- On Track for Delivery: 38
- At Risk: 0
- Overdue: 1

EFFECTIVE

- Total Actions: 25
- Completed and Evidenced: 12
- On Track for Delivery: 10
- At Risk: 0
- Overdue: 3

RESPONSIVE

- Total Actions: 2
- Completed and Evidenced: 1
- On Track for Delivery: 1
- At Risk: 0
- Overdue: 0

WELL-LED

- Total Actions: 6
- Completed and Evidenced: 2
- On Track for Delivery: 4
- At Risk: 0
- Overdue: 0

¹ As the plan evolves actions may be added/amended/removed. These changes will be tracked via the “QIP Change Log” and will be reported to the Quality Oversight Group on a monthly basis.
Summary Position of Quality Improvement Plan – May 2016

In line with the five CQC domains – Safe, Caring, Effective, Responsive and Well-Led - progress on the 231¹ current actions is as follows:-

**SAFE**
- Total Actions: 138
- Completed and Evidenced: 75
- On Track for Delivery: 50
- At Risk: 2
- Overdue: 11

**CARING**
- Total Actions: 67
- Completed and Evidenced: 35
- On Track for Delivery: 24
- At Risk: 0
- Overdue: 8

**EFFECTIVE**
- Total Actions: 27
- Completed and Evidenced: 20
- On Track for Delivery: 5
- At Risk: 0
- Overdue: 2

**RESPONSIVE**
- Total Actions: 2
- Completed and Evidenced: 1
- On Track for Delivery: 1
- At Risk: 0
- Overdue: 0

**WELL-LED**
- Total Actions: 6
- Completed and Evidenced: 2
- On Track for Delivery: 3
- At Risk: 0
- Overdue: 1

¹ As the plan evolves actions may be added/amended/removed. These changes will be tracked via the “QIP Change Log” and will be reported to the Quality Oversight Group on a monthly basis.
## CHUFT – Summary of progress against Quality Improvement Plan

<table>
<thead>
<tr>
<th>CQC Domain</th>
<th>Agreed timescale for implementation</th>
<th>Progress</th>
<th>Comments / Current main concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe</strong></td>
<td>March 2016 to end of December 2016</td>
<td>Good progress has been made on the 138 actions - with 75 having been completed. The 18 completed in April/May are mentioned below:</td>
<td></td>
</tr>
<tr>
<td><strong>CQC rating</strong> = Inadequate</td>
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<tr>
<td>Complete = 75</td>
<td></td>
<td>There are 65 actions “On Track” in this domain. Of the remaining actions there are 3 actions “At Risk” and 11 actions “Overdue” – listed below:</td>
<td></td>
</tr>
<tr>
<td>On Track = 50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At Risk = 2</td>
<td></td>
<td><strong>At risk:</strong></td>
<td></td>
</tr>
<tr>
<td>Overdue = 11</td>
<td></td>
<td><strong>Medical Equipment</strong></td>
<td></td>
</tr>
<tr>
<td>Actions = 138</td>
<td></td>
<td><strong>ME03.3</strong> Ensure that &gt;85% of Doctors and other staff that use medical equipment are trained and assessed as competent to use equipment which is required for the provision of patient care. <strong>Update:</strong> The competency for Doctors will be subject to a self assessment process based on the Training Needs Analysis and equipment risk categories defined within the updated Training Procedure. The self assessment draft is pending subject to sign off of the new Training Procedure. JA to confirm assessment with senior medic representative.</td>
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<tr>
<td><strong>Governance &amp; Leadership</strong></td>
<td></td>
<td><strong>ME03.4</strong> Ensure that &gt;85% of nursing staff are trained and assessed as competent to use equipment which is required for the provision of patient care. Review of core skills and mandatory training competencies requirements for nurses, doctors and therapists to inform revised training and skills matrix and training program. <strong>Update:</strong> Nursing staff /ODP competency is reported on a 3 monthly basis with results indicating a slight rise in compliance to 82%. Latest data is currently unavailable for medical staff.</td>
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<tr>
<td><strong>Deteriorating Patient &amp; End of Life Care</strong></td>
<td></td>
<td><strong>Overdue:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DPE02.8</strong> Training for HCA’s in observing deteriorating patient and escalating to a Registered Nurse or Doctors across the medical division so that our unregistered work force have the right skills to work competently in this area.</td>
<td></td>
<td><strong>Assessment &amp; Monitoring of Risk</strong></td>
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</tr>
<tr>
<td><strong>AM01.2</strong> Ensure there is a robust incident and accident reporting system, including reporting of lessons learnt to all groups of staff.</td>
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<td><strong>AM01.4</strong> Ensure that Serious Incidents relating to deterioration levels of harm or near misses are reported in urgent and emergency care.</td>
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<tr>
<td><strong>AM01.5</strong> Lessons learnt and actions identified from incidents are shared amongst the urgent and emergency care teams.</td>
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<td><strong>AM01.9.4.1</strong> Agree new format for risk register.</td>
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</tr>
<tr>
<td><strong>Patient Care, Experience &amp; Effectiveness</strong></td>
<td></td>
<td><strong>AM01.9.4.2</strong> Design systems trailing around migration of risk to new format for relevant staff.</td>
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<tr>
<td><strong>PCE04.1</strong> Clear escalation policy/process including pressures within the Emergency Department.</td>
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<td><strong>Update:</strong> This action is currently being reviewed to determine appropriate timescales and plans for risk migration have been identified to occur between May and June 2016.</td>
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<tr>
<td><strong>Governance &amp; Leadership</strong></td>
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<td><strong>GL02.3</strong> Review the process for the creation of temporary records in outpatients.</td>
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<tr>
<td><strong>GL01.3</strong> There is a nurse staffing escalation and contingency process in place that is documented and accessible to staff.</td>
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<td><strong>Update:</strong> The upgrade on the portal has been delayed until May/June.(date to be confirmed) Upgrade will enable the Trust to restrict the creation of ‘temp’ notes to Health Records only.</td>
<td></td>
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</tbody>
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| **Safe**                        | January 2016 to end of December 2016 | **ME01.5** Centralise Maintenance Contract Management within EBME function. Advertised (9/12/15) closing date 31/12/15 and recruit. **ME01.7** Implement Standard Work Instructions for use of Equip Database and maintenance of data. **ME01.9.3** Issue Service Level Agreements to all Divisions, clearly detailing range of services provided by EBME, service response times and responsibility matrix detailing roles of Eqpt users and EBME function. **ME01.9.9.2** Develop Communications plan to improve awareness of Equipment user responsibilities and how to access EBME services. **ME01.9.9.3** Develop improved Procurement guidance for medical and nursing staff to ensure that all new equipment is procured or leased in accordance with Policy and Procedure. **ME01.9.9.4** Develop and implement EBME staff training program to improve competencies and widen scope of in-house service capability. **ME01.9.9.6** Ensure broken and redundant equipment is removed from all clinical areas in a timely manner. **ME03.6** The process for decontamination of endoscopy scopes needs to be urgently reviewed and plans to ensure that the decontamination and testing are in line with best practice and JAG accreditation. | Deteriorating Patient & End of Life Care  
**DPE02.9.5** Review of outreach capacity to ensure it is able to meet patient demand at any time of day, or day of the week. **Update:** Review is currently underway.  
**DPE02.9.6** Metrics to determine outcomes of outreach service to be implemented and monitored to inform a revised business case submission if required.  
**Update:** Metrics are currently being reviewed via the weekly QIP meeting chaired by the CEO.  
**DPE03.3** Improve robustness of mortality review by ensuring peer review of deaths and use of standardised template set a trajectory to review 100% all deaths. Ensure mortality figures are within expected range and where higher numbers occur identify reasons for such and actions to address any issues.  
**Update:** Work plan agreed and evidence provided. Themes identified and evidence provided. Mortality meetings happening in divisions, evidence provided. Business case for MARS tool has been completed and to go to ET for approval 21.04.16. Medical Director to request at weekly Improvement Meeting if the target of 100% can be changed.  
**Patient Care, Experience & Effectiveness**  
**PCE02.9** Patient assessments regarding their risk of falling are carried out within 24 hours of admission. Risk of falling assessments to be audited on a weekly basis and priority actions to take place in areas of non-compliance.  
**Update:** The audit for patient assessments is currently underway.  
**PCE03.6** Provide training for staff in correct Partial booking process |
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<tbody>
<tr>
<td><strong>Caring</strong></td>
<td>March 2016 to end of December 2016</td>
<td>Good progress has been made on the 67 actions with 35 having been completed. The 12 actions completed in April/May are mentioned below:</td>
<td></td>
</tr>
<tr>
<td><strong>CQC rating = Requires improvement</strong></td>
<td></td>
<td><strong>Governance &amp; Leadership</strong></td>
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<tr>
<td></td>
<td><strong>GL07.1.1</strong> review out turn of 7/4/16 &quot;In Your Shoes&quot; and cascade across trust.**</td>
<td><strong>Deteriorating Patient &amp; End of Life Care</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>GL07.3.1</strong> Cascade complaints procedure across the Trust.**</td>
<td><strong>DPE01.7</strong> Ensure that divisions embed the strategy to front line staff and patients. **</td>
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<tr>
<td></td>
<td><strong>GL07.4</strong> Compliance and tracking of complaints management at Divisional level to be reported through central governance framework (Patient Experience Group) as a vehicle to share learning and evidence best practice.</td>
<td><strong>DPE01.9.4</strong> Ensure that staff use the dedicated ICR LDL so that patients can receive appropriate care at the end of their life care. Rollout the Treatment Resuscitation and End of Life (TREC) tool to identify ceiling of care and the Supportive Palliative Indicator Care Tool (SPICT) to identify patients in last year of life. **</td>
<td></td>
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<tr>
<td></td>
<td><strong>DPE01.9.9.1</strong> Ensure outcomes of fast track process are monitored on a monthly basis and presented to internal and system wide End Of Life(Eol) meetings **</td>
<td><strong>DPE01.9.9.3</strong> Assess effectiveness by increased use of My Care choices record and monthly audit of use of ICR-LDL. **</td>
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<tr>
<td></td>
<td><strong>DPE01.9.9.7</strong> Develop programme to use patient/family and user group feedback to co-design services for EOL care. Use walkabouts to gain patient views and staff input across inpatient journey **</td>
<td><strong>DPE02.1</strong> Review Trust handover arrangements between day and night nursing staff to ensure they are robust and to identify patients who are at high risk and whose care is being handed over between shifts. **</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DPE02.5</strong> Ensure compliance with guidance through clinical audit and address any areas of non compliance as a priority action. **</td>
<td><strong>DPE02.9.7</strong> Patients will have an initial pain score assessment and subsequent timely assessments as condition requires. Adequate analgesia will be prescribed and given to the patient in a timely manner. Audits of assessment and subsequent actions will take place on a quarterly basis. Areas of non compliance will have targeted actions. **</td>
<td></td>
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<tr>
<td></td>
<td><strong>DPE02.9.7</strong> Review the nursing, medical and leadership establishments within end of life care and if required develop robust business cases for additional staffing. **</td>
<td><strong>DPE01.6</strong> Ensure that ward based end of life champions have been competency assessed and that ward based staff know from whom to seek support at ward level when none of the palliative care team are available. **</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DPE01.9.3</strong> E-learning training to be completed by at least 85% of key identified clinical staff band 2 and above and medical staff. **</td>
<td><strong>Update:</strong> These champions have been named. Each ward has 1 minimum. **</td>
<td></td>
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<tr>
<td></td>
<td><strong>DPE01.9.6</strong> Review the nursing, medical and leadership establishments within end of life care and if required develop robust business cases for additional staffing. **</td>
<td><strong>Update:</strong> Strategic Outline BC completed and due to be reviewed at Investment Committee w/c 09/05/16 **</td>
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<tr>
<td></td>
<td><strong>DPE02.5</strong> Ensure compliance with guidance through clinical audit and address any areas of non compliance as a priority action. **</td>
<td><strong>Update:</strong> Discussion is taking place between key stakeholders on how to move this action forward. **</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DPE02.9.7</strong> Patients will have an initial pain score assessment and subsequent timely assessments as condition requires. Adequate analgesia will be prescribed and given to the patient in a timely manner. Audits of assessment and subsequent actions will take place on a quarterly basis. Areas of non compliance will have targeted actions. **</td>
<td><strong>Update:</strong> decided focus on ED initially for auditing pain assessment and treatment and then roll out to surgical and oncology wards</td>
<td></td>
</tr>
</tbody>
</table>

There are 38 actions “On Track” in this domain. There are no actions “At Risk” and there is 1 action “Overdue”:

**Update:** These champions have been named. Each ward has 1 minimum.

**Overdue:**

**Deteriorating Patient and End of Life Care**

**DPE01.6** Ensure that ward based end of life champions have been competency assessed and that ward based staff know from whom to seek support at ward level when none of the palliative care team are available.

**Update:** These champions have been named. Each ward has 1 minimum.

**DPE01.9.3** E-learning training to be completed by at least 85% of key identified clinical staff band 2 and above and medical staff.

**Update:** Monitored and discussed at weekly QIP meeting. Package developed for non-clinical staff training. Children’s package has commenced roll out. Divisions asked to identify groups of staff that are non-compliant how and when will they take actions to ensure compliance.

**DPE01.9.6** Review the nursing, medical and leadership establishments within end of life care and if required develop robust business cases for additional staffing.

**Update:** Strategic Outline BC completed and due to be reviewed at Investment Committee w/c 09/05/16

**DPE02.5** Ensure compliance with guidance through clinical audit and address any areas of non compliance as a priority action.

**Update:** Discussion is taking place between key stakeholders on how to move this action forward.

**DPE02.9.7** Patients will have an initial pain score assessment and subsequent timely assessments as condition requires. Adequate analgesia will be prescribed and given to the patient in a timely manner. Audits of assessment and subsequent actions will take place on a quarterly basis. Areas of non compliance will have targeted actions.

**Update:** decided focus on ED initially for auditing pain assessment and treatment and then roll out to surgical and oncology wards.
# CHUFT – Summary of progress against Quality Improvement Plan

<table>
<thead>
<tr>
<th>CQC Domain</th>
<th>Agreed timescale for implementation</th>
<th>Progress</th>
<th>Comments / Current main concerns</th>
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</table>
| **Caring**                        | March 2016 to end of December 2016  | **DPE02.1.1** Review Trust handover arrangements between day and night medical staff to ensure they are robust and to identify patients who are at high risk and whose care is being handed over between shifts.  
**DPE02.2** Review compliance with the process and escalate any areas of non compliance for priority action.  
**DPE02.7** Ensure compliance with Trust wide NEWS/Sepsis audit schedule and continue to include review of NEWS in the Trust wide Peer Review Programme. Areas of non compliance will have targeted priority actions ensure compliance. | **DPE01.9.9.8** Audit compliance with preferred place of death to meet patients preferences as part of the My Care Choices audit.  
**Update:** audit of ICR LDL has commenced and will be completed by the audit team.  
**Patient Care Experience and Effectiveness**  
**PCE01.1** Review staff communication with patient and relatives to ensure that patients are treated with dignity and respect to maintain patient privacy during clinical handover.  
**Update:** The new interim COO is currently reviewing operational processes.  
**PCE01.5** Review the policy for patient movement out of hours by completing a policy review.  
**Update:** The new interim COO is currently reviewing policies. |

**CQC rating** = Requires improvement  
**Complete** = 35  
**On Track** = 24  
**At Risk** = 0  
**Overdue** = 8  
**Actions** = 67
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<tbody>
<tr>
<td><strong>Effective</strong></td>
<td>March 2016 to end of December 2016</td>
<td>Good progress has been made on the 27 actions with 20 having been completed. The 8 actions completed in April/May are mentioned below:</td>
<td>There are 10 actions “On Track” in this domain. Of the remaining actions there are no actions “At Risk” and 3 actions “Overdue” – listed below:</td>
</tr>
<tr>
<td><strong>Governance and Leadership</strong></td>
<td></td>
<td>GL02.1 Ensure that patients' records are appropriately stored in accordance with legislation at all times. GL02.4 On-going surveillance of use of complete patient records and record storage and safety as business as usual GL02.5 Complete review of nursing documentation as part of Task and Finish group GL03.4 Structure agreed, changes are being implemented and staff have slotted into post and remaining open posts are being appointed to.</td>
<td><strong>Overdue:</strong> Patient Care, Experience and Effectiveness PCE05.8 The demand and capacity for the Surgical Assessment Unit (SAU) and its corresponding opening hours to be reviewed. The operational policy for SAU to be reviewed and updated in line with current practice. <strong>Update:</strong> The operational policy is currently being reviewed. There has been a capacity problem with medical patients occupying SAU preventing this from progressing. A risk assessment has been undertaken and is an integral part of decision making.</td>
</tr>
<tr>
<td><strong>Patient Care, Experience and Effectiveness</strong></td>
<td></td>
<td>PCE02.2 Ensure on-going sustainability of performance at a minimum of 95% for all eligible patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td></td>
<td>S04.3 Ensuring all appraisals do not become just a paper exercise but are meaningful and valuable to staff. S04.4 A recovery plan to be formulated and agreed with the divisions to ensure that their staff appraisals are completed in a more timely fashion.</td>
<td><strong>Staffing</strong> S04.5 Ward / Department Managers will ensure appraisals are completed for all staff they line manager. Appraisals are evidenced on ESR (excluding those on maternity leave and long term sick or who are absent from the work place) to achieve agreed target. <strong>Update:</strong> There has been a continued increase in appraisal compliance which currently stands at 76.13%. To enable greater clarity around who requires an appraisal the monthly reports now included detailed data. In addition to the programmed monthly appraisal training an additional 3 sessions have been facilitated in the past two months to enable more staff to appraise. The requirement for 80% compliance for 18.4.16 was not met.</td>
</tr>
</tbody>
</table>

No external support/assurance
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<tr>
<td><strong>Responsive</strong></td>
<td>March 2016 to end of December 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC rating = Inadequate</td>
<td>Complete = 1</td>
<td>Good progress has been made on the two actions. One action has been completed:</td>
<td>There is one action “On Track” in this domain. There are no “At Risk” or “Overdue” actions.</td>
</tr>
<tr>
<td></td>
<td>On Track = 1</td>
<td><strong>Governance &amp; Leadership</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>At Risk = 0</td>
<td>GL06.1 Open forums for staff have been revisited to be aware of recent observations and on-going challenges. Staff are invited and positively encouraged to attend open forums which are attended by a member of the Executive Team as well.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overdue = 0</td>
<td><em>No external support/assurance</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actions = 2</td>
<td></td>
<td></td>
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</tbody>
</table>

**Actions:**

- GL06.1 Open forums for staff have been revisited to be aware of recent observations and on-going challenges. Staff are invited and positively encouraged to attend open forums which are attended by a member of the Executive Team as well.
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<td><strong>Well-Led</strong></td>
<td>March 2016 to end of December 2016</td>
<td>Good progress has been made on the six actions. Two actions have been completed.</td>
<td>There are four actions “On Track” in this domain. There are no “At Risk” or “Overdue” actions.</td>
</tr>
<tr>
<td><strong>CQC rating</strong> = Inadequate</td>
<td></td>
<td><strong>Staffing</strong>&lt;br&gt;&lt;br&gt;<strong>S04.3</strong> Ensuring all appraisals do not become just a paper exercise but are meaningful and valuable to staff.&lt;br&gt;<strong>S04.4</strong> A recovery plan to be formulated and agreed with the divisions to ensure that their staff appraisals are completed in a more timely fashion.</td>
<td></td>
</tr>
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</table>

| Complete = 2<br>On Track = 3<br>At Risk = 0<br>Overdue = 1<br>Actions = 6 |

*No external support/assurance*