Medway NHS Foundation Trust
Care Quality Commission Quality Report - MUST and SHOULD do's

1. <u>Data</u> **Lead Interim Director – Tim Bolot**	Urgently address its poor data quality issues.	<u>What we have done already</u> • We have re-established the Data Quality Committee Chaired by the Deputy Director of Finance • We continue to work with East Kent Hospitals University NHS Foundation Trust as part of the 'buddy' arrangement to assess our capacity and capability for IT and information/Intelligence • Commissioned PwC to review performance data relating to the ED 4 hour standard, 18 week RTT and 62 Day Cancer RTT <u>What we need to do next</u> • Develop an IM and T strategy • Design and assessment of the current information function • Work with University Hospital Birmingham (UHB) as part of phase 1 of the diagnostic assessment to identify quick wins and potential future collaborations • Review progress to date in implementing a new Patient Administration System, working with UHB to identify partnership collaborations • Implement recommendations from the PwC review of performance data • Map performance and quality data flows and associated data owners to ensure compliance with data standards • Develop a data dictionary for all divisional and Board of Directors performance and quality data • Implement recommendations from the UHB diagnostic assessment • Ensure the Integrated Audit Committee review progress in meeting these actions <u>Where we need help</u> • Support via the UHB diagnostic assessment and sharing of best practice
2. <u>Governance and risk management</u> **Lead Director – Steve Hams**	Urgently review and standardise risk management and governance both at a local level and trust wide to ensure there are robust processes from board to ward.	<u>What we have done already</u> • Established a weekly Trust Management Committee, made up of the divisional triumvirate and executive team • Divisional Management Boards have commenced • Developed a revised structure for the corporate governance team as part of the wider Quality Directorate led by the Medical Director and Chief Nurse • Reviewed the actions in the Quality Governance Assurance Framework action plan and revisited priority areas <u>What we need to do next</u> • Work with the Good Governance Institute as part of the phase 1 UHB diagnostic and assessment to map existing governance structures and implement recommendations • Clearly articulate the 'rules of engagement' and autonomy structure for the new divisions, providing clarity on structure, form and purpose • Support the new divisional team, in particular the Divisional Directors in a development programme • Advertise for the position of the Deputy Director of Governance, Risk and Patient Safety • Complete the remaining actions in the Quality Governance Assurance Framework • Ensure the Integrated Audit Committee and Quality Assurance Committee review progress in meeting these actions <u>Where we need help</u> • Leadership development for divisional triumvirate teams • Coaching for the Divisional Directors • Buddying support from an organisation with exceptional governance systems

3. <u>Governance and risk management</u> **Lead Director – Steve Hams**	Ensure all staff are aware of their roles and responsibilities to report incidents and that they have access to Datix. Feedback mechanisms and review processes need to be sufficiently robust to ensure that all staff groups are learning from incidents	<u>What we have done already</u> • Trust Induction – All staff informed of their responsibility on how to report incidents and how information is used. Managers made aware of their responsibility to investigate incidents and feedback to reporter • Risk Manager attending meetings with Ward Managers reviewing incidents and facilitating data input • Providing trends in reporting for departments/wards for nursing • Datix available on intranet for all staff to complete, no log-in required • Reports provided for Governance meetings with regards to themes and trends i.e. adverse staffing levels, falls • Daily Dashboard re: data quality incidents, reviewing categories and handlers. • Grand Round completed in June 2014 by Medical Director promoting Datix reporting and feedback • Updated documentation for guidance on how to complete a Datix incident form • Additional support during office hours from Corporate Governance team on how to report incidents via 1-2-1 <u>What we need to do next</u> • Link Datix reporting to the proposed new governance structure supported by the UHB diagnostic/assessment • Further promotion of the system (newsletter, global emails) with specific support for junior doctors • Upgrade of system 12.3 required with automatic feedback to reporters • All staff to have email addresses to receive automatic feedback from Datix • Promote Champion Users of Datix within Divisions to support staff • Regular classroom-based training for staff reporting and handling incidents • Divisions to take ownership of Datix system re: running own reports and approving incidents, with monthly visibility through the governance structure • Flow chart for handling Datix incidents to be produced and promoted • Divisions to ensure staff have Datix reporting training as part of their local induction • Establish a monthly review of the Datix reporting architecture to ensure the process is being adhered too and failed compliance is escalated rapidly • Develop a monthly 'Risk Wise' newsletter as part of the 'Safe to Care' brand sharing incidents and learning • The Quality Assurance Committee will review progress in meeting these actions
4. <u>Governance and risk management</u> **Lead Director – Steve Hams**	Ensure that there is a robust system in place for reviewing risk assessments to ensure they are reflective of the clinical condition of women who are using the maternity service.	<u>What we have done already</u> • VTE Assessment tool drafted to record re-assessment of patient if in-patient for more than 24 hours. • Reviewed current policy <u>What we need to do next</u> • Amend policy to reflect reassessment after 24 hours • Disseminate revised policy and discuss with all staff • Audit compliance (3 months) • Sign off and review at Monthly Divisional Governance Meeting • The Quality Assurance Committee will review progress in meeting these actions
5. <u>Governance and risk management</u> **Lead Director – Steve Hams**	Review the Clinical Risk Management Strategy to ensure it accurately reflects the recent changes which have been made to how clinical risk is managed within the maternity department.	<u>What we have done already</u> • Risk Management Strategy has been reviewed and gaps identified <u>What we need to do next</u> • Amend strategy and policy to reflect changes identified • Sign off at Monthly Divisional Governance Meeting – Aug 2014 • Disseminate to staff via Intranet, ward briefings and Friday News– end Aug 2014

6. <u>Governance and risk management</u> **Lead Director – Alan Lambourne**	Ensure that local policies and protocols are reviewed to ensure they are consistent with national, best practice guidance throughout the hospital.	<u>What we have done already</u> • The Procedural Documents Review Group (PGRG) has been re-established under the Chairmanship of the Interim Director of Corporate Affairs and will now report to Trust Management Team. • The Trust's Policy on Policies has been reviewed and updated and in future, this Group will undertake policy reviews. • Any minor alterations will be approved by the PDRG and Trust Management Committee will approve any substantial changes. All changes revised documents will be communicated throughout the Trust. <u>What we need to do next</u> • Need to prioritise all outstanding policies and categorising other non-policies currently identified on the list that require governance monitoring. This will enable the implementation of an ongoing programme of review to eliminate the backlog of out of date documentation • Confirm rolling monthly meeting dates to progress and monitor the review • The Trust Management Committee will review progress in meeting these actions
7. <u>Mortality</u> **Lead Director – Phil Barnes**	Continue to actively monitor its HSMR trends, including ensuring that consistent, robust, minuted mortality and morbidity meetings are being undertaken in all departments.	<u>What we have done already</u> • Monthly reporting to Board of Directors of crude mortality and HSMR with a diagnosis specific breakdown <u>What we need to do next</u> • Develop a template for morbidity and mortality meetings to be used consistently across the organisation – to be informed by divisional and departmental data • Map existing Morbidity and Mortality meetings • Develop common standards for mortality and morbidity meetings to include attendance actions and thematic lessons. • The Quality Assurance Committee will review progress in meeting these actions <u>Where we need help</u> • Support from UHB in identifying best practice
8. <u>Mortality</u> **Lead Director – Phil Barnes**	Ensure a standard approach to mortality and morbidity activity and encourage independent review and provide appropriate audit trail.	Linked to MUST do action 7
9. <u>ED</u> **Lead Director – Mark Morgan**	Ensure that the Vanguard unit is not used as overnight accommodation for patients.	<u>What we have done already</u> • Staff have been instructed to close the Vanguard unit at 20.00hrs, when there is no longer any rostered staffing to cover this area • The Vanguard unit is only to be opened at night on the instruction of the on call Director. This is documented on the A&E shift report • The Board of Directors have approved the business case for the A&E reconfiguration <u>What we need to do next</u> • Ensure that the process is robust and adhered to by auditing documentation and the escalation process • Ensure the vanguard unit is only used for triage and usage after 22.00hrs is considered an incident which is escalated, reported on Datix to identify patient safety/experience 'red flags' and an investigation completed • Complete the reconfiguration of the A&E and remove the Vanguard Unit <u>Where we need help</u> • Funding for the phase 1 A&E development

10. <u>ED</u> **Lead Director – Mark Morgan**	Update its major incident policy in the A&E department and ensure that staff are trained appropriately.	<u>What we have done already</u> • Current major incident plan is available on Intranet which was validated by NHS England in February 2014 via previous Clinical Executive Group • Existing Major Incident cupboard has had anything superfluous to a major incident removed • Input to redesign the major incident cupboard in Emergency Village • Publicised operating procedures and ensured locum and agency staff are aware of their role in the event of a major incident <u>What we need to do next</u> • All staff will be reminded that current major incident policy is available on the intranet • A&E Nursing and Medical Substantive Staff need to have all training provided as per Needs Analysis which has been already established • Medical Locums to have more awareness of Trust major incident plan through the recognised local induction • Next major incident practice planned for 18th September 2014 • The Emergency Planning Committee will review progress in meeting these actions <u>Where we need help</u> • Continuing support from Kent and Medway Local Health Resilience Partnership and Kent Resilience Forum
11. <u>ED</u> **Lead Director – Mark Morgan**	Address its escalation policy within the A&E department to avoid the need to 'stack' patients; this should include formal agreement with specialities regarding expected professional standards.	<u>What we have done already</u> • Associate Director of Operations is working across the Trust with specialties to agree professional standards • Internal Professional Standards from Cambridge University Hospital NHS Foundation Trust have been shared • 'Hospital Ambulance Liaison Officer (HALO) extended to July 2014 with weekly reviews • Re-engaged with the Emergency Care Intensive Support Team (ECIST) to support developments in the emergency and urgent pathway • ECIST have led a workshop of the Trust Management Committee • A&E rebuild agreed by the Board of Directors and works to commence imminently <u>What we need to do next</u> • Implement the Emergency Flow Project and critically review the blocks to delivering the Internal Professional Standards • Enhanced interim Acute Medical Admissions Unit provisions approved from 1st August • Embed internal professional standards • Develop an accountability framework so that speciality teams deliver to agreed standards and timescales • Review the ambulance divert policy with South East Coast Ambulance Service and the regional escalation policy <u>Where we need help</u> • System support for reviewing the escalation policy, processes and early warning systems (CCG and Area Team) • Operational partnering support with UHB • Continued support from ECIST

12. ED **Lead Director – Mark Morgan**	Ensure that the initial assessments of all patients (including children) are in line with national standards.	What we have done already. • College of Emergency Medicine standards have been emailed to all senior clinical staff in A&E and documentation in place to ensure that the information is recorded accurately at initial assessment (documentation and process was in place at the time of the inspection) • Clinical teams have reviewed the initial assessment process and identified changes in documentation to ensure compliance with best practice standards • Streaming as an initial point of assessment has commenced which includes adults and children • Revised the initial assessment documentation for children so that a wider range of prompts (including safeguarding) are more prominent and reviewed What we need to do next • Ensure compliance with standards through audit and regular feedback to clinical teams • Review compliance with the children's documentation, jointly with the Children's Team • Gather patient feedback (via the Friends and Family Test) on the initial streaming process • The Divisional Management Board will review progress in meeting these actions
13. ED **Lead Director – Steve Hams**	Ensure that there are a sufficient number of nurses with paediatric expertise in the A&E department.	What we have done already • An establishment review of the A&E to include paediatric cover to determine the gap to provide the service • Recruitment campaign for the specific skills set developed and implemented • Recruited individuals into the posts currently 5.21 WTE • Established a rotation with paediatrics to retain and learn new skills • Increased child safeguarding input into A&E with secondment support from the Child Safeguarding Team What we need to do next • Interview 2 x band 5's in early July • Undertake a strategic review of a 24/7 paediatric service in A&E
14. ED **Lead Director – Mark Morgan**	Review the completeness of records including detaining patients, medicine administration record in accident and emergency department and patients' weight on admission on surgical wards for high risk patients.	Linked to MUST do action 13
15. Operational flow **Lead Director – Mark Morgan**	Address the concerns regarding patient flow through the hospital, including improving discharge processes.	What we have done already • Focus on length of stay analysis • Engagement of all Divisions and Specialities to enhance discharge planning, including Estimated Date of Discharge, and early facilitated discharge • Review of services supporting Bed Management practice • Emergency Flow PID created and programme approach being applied • Enhanced interim AMU provisions approved from 1st August What we need to do next • Marginal rate reinvestment of CCG funds into admission avoidance schemes via the system resilience group • Integrated Discharge Team to be at full capacity by August 2014 • Agree metrics for improvement across the 'whole system' pathway • Active engagement with local partners as part of the Better Care Fund • Work with partners to develop reasonable admission alternatives and shared ownership of discharge with incentives for all agencies to ensure patients are correctly placed • The Trust Management Committee and Quality Assurance Committee will review progress in meeting these actions

		Where we need help • Shared knowledge of practice from UHB and shared with Medway Executive Programme Board • Enhanced system performance
16. Operational flow **Lead Director – Mark Morgan**	Commence robust audit theatre utilisation to ensure clear allocation of elective and emergency lists.	What we have done already • Draft 6-4-2 theatre planning process policy. • Implement a weekly 'look back and learn' of cancelled elective activity, utilisation of elective theatres • Implement measurements within Surgical Assessment Unit (SAU) to ensure that patients are seen within specific time frames to ensure emergency pathway flow. • What we need to do next • Implementation of 6-4-2 theatre planning process policy to ensure there is sufficient capacity to manage the elective flows and that elective lists are booked to the maximum utilisation • Ensure that the patients' are in the correct specialty bed. Right patient right bed to improve delivery of care and reduction in length of stay • Review the measurements for SAU to ensure that they are robust. • Identify and implement a task and finish group to clearly define the utilisation of CEPOD, how urgent cases are allocated and who medically /clinically leads CEPOD 24/7 • Design an electronic record which clearly capture historical data around clinical waits, cancellation and plan of care (i.e. by 14.30 each day realistically plan the list for the next 16 hours - potentially creating an urgent elective list for the next day) by consultant and specialty • Review performance at the Divisional Management Board Where we need help • UHB Clinical operations support
17. Operational flow **Lead Director – Mark Morgan**	Improve the quality of cancellation of operations reporting	What we have done already • No patients' to be cancelled on the day of surgery without the final approval of the Associate Director of Operations or Director of Operations who will consider patient safety and operational performance What we need to do next • Cancelled operations policy to be revised and implemented. • Review all theatre cancellations from previous day, and galvanise lessons learnt from cancelled operations to ensure pre-assessment requirements and the concerns in compiling elective lists are addressed. • Implement outcomes from the TIAA Audit report received in June 2014. • Review performance at the Divisional Management Board
18. Operational flow **Lead Director – Mark Morgan**	Review outpatient department booking templates to ensure allocated time for clinic appointments are appropriate.	What we have done already • Templates were reviewed in the last year as part of the Outpatient Improvement Project by directorates as part of consultant job planning and changes made on Patient Administration System system when notified to the Patient Service Centre • Some clinical pathways were reviewed as part of the same project and amended in conjunction with CCGs and patient representatives • Patient letters were also reviewed and streamlined for updating once Oasis system was implemented • 2nd text reminder of appointments was implemented to help reduce the number of DNAs • Choose & Book directory of services was reviewed and all appointment slots, with the exception of 2 week wait slots, were made available via Choose & Book What we need to do next • Establish on-going Outpatient Improvement group to include senior trust staff as regular attendees • Changes made at consultant job planning to be reflected in clinic templates and notified to Patient Service Centre to make changes • Further of review of patient allocation to time slots by divisions as part of consultant job planning

		• Review of speciality processes in relation to clinic templates, cancellations, amendments and covering rather than cancelling clinics to prevent overbooking of other sessions • Work with specialities to achieve median new to follow up ratios, freeing up clinic capacity
19. <u>Operational flow</u> **Lead Director – Mark Morgan**	Review the effectiveness of medical notes library.	<u>What we have done already</u> • Health Records Work Group monitors and reacts to any health records related issues / complaints • Regular case note tracking audits undertaken • Information sharing with neighbouring trusts health records teams • Previous audit and amnesty of records held outside library to be returned and not stockpiled in offices • Refresher training offered for staff non-compliance with health records policy and processes <u>What we need to do next</u> • Review health records messages given at junior doctors induction • Review of available reports relating to health records • Re-visit the review on the effectiveness of the Health Records Work Group • Ownership of issues by all divisions and proactive management of records being held outside the library • Further audit and amnesty for records to be returned to the library • Change of culture – records are 'on loan' from the library for an agreed loan period • Action to be taken by line managers where non-compliance with health records policy and processes and consideration of removal of PAS access for persistent offenders
20. <u>Equipment</u> **Lead Director – Jason Seez**	Ensure that all equipment is in date and is checked consistently.	<u>What we have done already</u> • We have established the Better Care Together inspections (following experience of the maternity CQC visit) which reviews compliance against the essential standards for quality and safety • We have established with support from Senior Sisters and Charge Nurses a 'Safe to Care' daily checklist, which ensures all essential equipment is checked daily • Better Care Together folders of evidence are provided in all clinical areas and discussed with staff at team meetings • All equipment managed through the Equipment Library is checked and cleaned prior to deployment <u>What we need to do next</u> • Launch the Safe to Care programme • Ensure accountability for completion is driven through the new divisional leadership teams, including appropriate performance management • Re-launch the well organised ward bundle of the Productive Wards Programme to ensure there are safe systems and process in place for stock rotation • Complete a full review of resuscitation trolleys with a consistent approach applied across the organisation (i.e. resuscitation trolley and contents)
21. <u>Equipment</u> **Lead Director – Jason Seez**	Ensure that all wards have appropriate equipment to meet peoples care needs.	<u>What we have done already</u> • A hoist audit and inventory has been completed across the hospital to identify gaps in availability • We have an annual process of clinical equipment planning led by the Medical Devices and Equipment Management Group (MD and EMG) – priorities for 14/15 have been identified and are awaiting capital approval (£1.9m) • Ensured all of our clinical areas have equipment inventories • Linking with the implementation of e-rostering all areas will have an up to date list of equipment competencies for clinical staff <u>What we need to do next</u> • The management, maintenance and delivery of hoists will become part of the Equipment Library service, this will centralise activity and ensure rapid response to equipment deficits and failures • Revise the clinical induction process so that all clinical staff are appropriately trained prior to commencing

		ward based activity • Implementation progress of these actions will be monitored via the MD and EMG
22. <u>Equipment</u> **Lead Director – Jason Seez**	Review processes and effectiveness of equipment library.	<u>What we have done already</u> • Identified gaps in service delivery i.e. syringe drivers for palliative care patients <u>What we need to do next</u> • Undertake a customer service questionnaire • Review Equipment Library scope, purpose and function • Publish performance data on call to delivery time for equipment • Establish a task and finish group to review access to palliative care equipment i.e. syringe drivers
23. <u>Health and safety</u> **Lead Director – Jason Seez**	Ensure that all fire exits are accessible at all times.	<u>What we have done already</u> • Reminded clinical areas to keep fire exits clear • Identified additional storage space for larger pieces of equipment • Better care Together inspections • Director and Governor visits to clinical areas <u>What we need to do next</u> • Review fire compartmentalisation • Review fire exits and signs • Review fire marshals and fire activation process • Ensure all fire doors have intumescent strips correctly applied • Ensure compliance with fire safety mandatory training • Commission an external review of risk assessments for fire safety • The Health and Safety Committee will review progress in meeting these actions •
24. <u>Safeguarding</u> **Lead Director – Steve Hams**	Ensure that mental capacity assessments (MCA) are undertaken where appropriate and staff are adequately trained in MCA and Deprivation of Liberty.	<u>What we have done already</u> • We have recruited a substantive Adult Safeguarding Lead and increased capacity with an additional WTE to support education and training of adult safe guarding/DoLs and MCA • Restated the MCA/DoL role of the Clinical Site Managers, Matrons and General managers • Integrated MCA/DoLs training in the adult safeguarding training • Reviewed syllabus for induction training to ensure that MCA/DoLs is included • Identified additional actions as part of point 26 <u>What we need to do next</u> • Commission external training support for MCA and DoLs • Review DoL revised guidance and establish new organisational policy • Audit compliance against the standards • Work with local advocacy services to develop internal capacity and capability

25. <u>Workforce</u> **Lead Director – Steve Hams**	Ensure departments are sufficiently staffed by competent staff with the right skill mix, including out of hours.	<u>What we have done already</u> • Determined minimum acceptable levels of registered nurse and unregistered workforce • Written and published a policy to support safe staffing on the wards with clear escalation • Twice daily site safety meeting established to review staffing across the organisation and facilitate the movement of staff, management of risk and appropriate decision making • Weekly meeting with Heads of Nursing to review temporary staff usage and Staffing related Datix incidents • Identified current Nursing establishments and gaps between in post vs. budget vs. minimum vs. NICE recommendations • Safer Nursing Care Tool review of staffing across all adult inpatient wards • BirthRate plus review by Marie Washbrook for midwifery staffing • Implementation of eRoster across inpatient areas • Weekly recruitment steering group established • Recruitment open days with one stop shop to reduce process time lag from 4 weeks to 1 day (June, July and September) • Microsite for recruitment to support campaign • Local advertising of open days • Refer a friend scheme developed to encourage staff to join the Trust • Weekly meeting with divisional teams reviewing impact of e-rostering and ensuring appropriate deployment of staff • Working with NHS Professionals to recruit staff and offer induction program and development support to improve competence and reduce agency usage • Reduced recruitment time for the appointment of Consultants <u>What we need to do next</u> • Overseas recruitment to Spain to recruit experienced registered nurses into ward positions as well as hard to recruit to areas such as the Neonatal Intensive Care Unit (NICU) and specialist Chemo therapy givers in early July • Launch media wide recruitment campaign to support active recruitment program. Raise positive profile of the trust as an employer • Hold 2nd Nursing recruitment open day 26th July • Recruit Staff at the RCN Jobs fair in London 4 to 5th September • Present staffing review in line with Safer Nursing Care Tool (SNCT) to the Trust Board in August 2014 • Trust Board needs to agree establishment figures for the wards and sign off establishments accordingly • Develop band specific nursing development program • Develop a medical and therapy workforce assessment/model with support from UHB and other centres of excellence • Review of these actions will be completed by the Workforce Assurance Committee <u>Where we need help</u> • Medical workforce modelling
26. <u>Workforce</u>	Review the current training matrix for mandatory training and improve the recording system so that there is a comprehensive record of compliance with training trust wide.	<u>What we have done already</u> • The training matrix for mandatory training was reviewed in March 2014 and has been aligned with the UK Core Skills Training Framework to include 12 core mandatory training subjects. This was implemented in April 2014 and remains current. This was communicated to all staff and every staff member received a copy of the requirements within the Employee Pocket Book which was attached to their March payslip • We are in the process of implementing a new mandatory training compliance reporting system (WIRED) across the trust that provides a comprehensive record of compliance accessible to all staff. All 12 core mandatory subjects have been loaded onto the system and we are in the process of validating this data

		<u>What we need to do next</u> • Complete WIRED data validation and roll out across the Trust during September 2014 for the core subjects. • Agree and add additional mandatory training subjects onto WIRED by Q1 2015 • Complete e-rostering implementation – all mandatory training will be recorded electronically • Develop a campaign to support recognition of the 12 core mandatory training subjects • Review training delivery methodology • Review of these actions will be completed by the Workforce Assurance Committee
27. <u>Workforce</u> **Lead Director – Manuel Oyarzabal**	Ensure that Consultant surgeons are undertaking ward rounds at weekends.	<u>What we have done already</u> • Adaptions made to the ENT and Urology medical rotas to ensure Consultant led ward rounds at the weekends. <u>What we need to do next</u> • Continue to work towards full provision of seven day services, including support services. Completion of NHSIQ Toolkit to identify where there are gaps for implementation of seven days services are to be implemented. • Introduction of a second SpR on the on call rota to support the current General Surgical rota. • Implementation for all specialties on call Consultants' to undertake ward rounds as per job plans. Ensuring that patients' are highlighted as a concern to the Doctors' by the ward sister to ensure that the patient is seen specifically by the Consultant on call • Reiterate Consultant ward Round compliance at the Divisional Management Board meeting - All Clinical Leads fully understand and engage the requirement for weekend ward rounds, and share at their Speciality Unit meetings. • Audit compliance • The Trust Management Committee and Workforce Assurance Committee will review progress in meeting these actions
28. <u>Workforce</u> **Lead Director – Graeme Sanders**	Review the medical oversight of the medical high dependency unit and lack of regular input from critical care directorate.	<u>What we have done already</u> • New Divisional structure since 1st May, which affords an overarching clinical lead of these areas via the Divisional Director <u>What we need to do next</u> • Part of Medway village will share juniors across ITU and Medical HDU, which will give on-call intensive care cover out of hours • The Trust Management Committee and Quality Assurance Committee will review progress in meeting these actions <u>Where we need help</u> • Recruitment of appropriately skilled and trained physicians
29. <u>Workforce</u> **Lead Director – Prof. Hasib Ahmed**	Review the current arrangement for protected consultant presence on the labour ward including the supervision of trainees performing elective caesarean sections.	<u>What we have done already</u>: • Project group established and scoped two options with initial cost summary presented to the finance team • Selected favoured option, which is appointing three Consultant's and reducing second tier on call delivered through SpR, additional sessions and reduced PA's – a model to be tested initially by the presentation of a Business Case <u>What we need to do next</u> • Agree timeline and content for business case production at next Project Group meeting • Obtain corporate agreement through the Strategic Investment Group to proceed and funding identified

30. Workforce	Review effectiveness of multidisciplinary team working hospital wide.	To be reviewed in the context of SHOULD do action number 31 and a wider divisional review of structures
31. Workforce	Continue to work towards full provision of seven day services, including support services	What we have done already • We are part of the early adopter for 7 day services, our links with NHSIQ remain in place – although director responsibilities have changed What we need to do next • Review current progress with NHSIQ and agree future involvement • Review 7 day services with UHB as part of the diagnostic/assessment phase to identify areas of good practice • Work with system partners to identify and agree quick wins to develop and deliver a 7 day approach to service delivery
32. Workforce **Lead Director – Steve Hams**	Ensure that all agency staff have completed an induction before they start work and ensure an audit trail of inductions is retained by ward areas.	What we have done already • Developed a trust wide temporary staff induction pack What we need to do next • Implement documentation consistently across the organisation • Temporary staff (NHS Professional) interface with e-rostering implementation • Use e-rostering to monitor and record temporary staff induction compliance Where we need help • Allocate are contracted to facilitate and program manage the e-rostering / NHS Professionals interface
33. Workforce **Lead Director – Steve Hams**	Review and improve availability of specialist nurses.	What we have done already • Previous reviews carried out looked at reducing cost base What we need to do next • Review the specialist nursing and midwifery workforce in relation to value add i.e. quality improvement, admission avoidance, rescue and income generation • Identify opportunities to improve Quality of care and service, admission avoidance and income generation • Implement recommendations Where we need help • Specialist input to support the review and identification of quality opportunity
34. Communications **Lead Director – Jason Seez**	Improve communication to staff regarding the use of staff car parking so that the improvement of parking availability for patients is fully implemented.	What we have done already • Proposals to reduce onsite staff car parking and increase patient car parking • shared with the Joint Staff Committee (JSC) on 9 April and followed up with meetings with union representatives • Communications plan and programme developed, comprising letter to all colleagues from Director of Strategy and Infrastructure with Q&As and PowerPoint presentation • Plans and collateral shared and agreed with JSC on 14 May • Communications to colleagues through e-mailed letter from Jason Seez, with before and after car park maps and Q&As and links to PowerPoint containing details of offsite park and ride. This took place on 16 May • Car parking subsequently an item in monthly team brief and featured at the CEO and chairman's open forums • Following colleague feedback and further consultation with JSC, agreed to phase in changes • All colleagues who wrote with feedback received a personal reply from Jason Seez and the Q&As were

		updated to reflect their feedback and address their concerns • Collateral and updated Q&As are available on the intranet • Car parking onsite has noticeably improved with 255 of the 300 available offsite park and ride spaces taken up <u>What we need to do next</u> • Continue to monitor progress with the JSC to identify and agree if more staff car parking spaces need to be released, and what other actions could be taken to ease congestion at the hospital • Maintain dialogue with colleagues through open forums and JSC, while communicating through other channels as enhancements to both patient and colleague onsite car parking take place through summer and autumn 2014 • Capture ongoing feedback with Q&As updated to reflect issues raised • Continue to promote the park and ride facility until all available spaces are taken up by colleagues • Use the Inspire Medway platform to involve colleagues and get their ideas on possible future initiatives • Ensure that colleagues understand the future direction of travel in terms of onsite parking and possible increases in tariffs, for them and patients and visitors • The key message is that need to improve patient experience with minimum of inconvenience to colleagues <u>Where we need help</u> • From third parties such as the Council and Arriva in finding additional solutions where possible
35. <u>Communications</u> **Lead Director – Jason Seez**	Improve support and communication with staff at all levels.	<u>What we have done already</u> • Managed day to day communications issues and needs with interim support • Introduced chairman and CEO forums • Embedded the monthly 'Team Briefing' process throughout the organisation • Supported the nurse recruitment campaign • Supported the Transforming Medway programme – three stakeholder events and related communications • Improved our digital presence • Currently developing plans to handle outcomes of the CQC report <u>What we need to do next</u> • Agree a list of communications priorities and develop associated action plans • Identify how we can utilise support from UHB Identify gaps that still exist following any agreements reached with UHB • Recruit candidates with the capability to meet the organisation's communications objectives
36. <u>End of Life</u> **Lead Director – Steve Hams**	Improve the end of life care out of hours for all patient groups.	<u>What we have done already</u> • Out of hours EOL/ palliative care advice is available via the Wisdom Hospice on call Doctor or Palliative Clinical Nurse Specialist (CNS) on call via telephone (5pm - 8am) . <u>What we need to do next</u> • Plan is to have on site (MFT) HPCT CNS support at weekends, providing a seven day (not 24 hrs.) 'face to face' EOL/palliative care service in conjunction with the out of hours advice as provided by the Hospice Dr and CNS based at the Wisdom hospice. • Review commissioning arrangements for end of life care • Review governance arrangements and performance delivery of the end of life commissioning specification • Review divisional oversight of end of life care • Lead Nurse at Hospice currently working with the Head of Nursing for Cancer Services to re-structure the HPCT CNS team and to recruit (funded by MCH) x 2, 22.5 WTE Band 7s to work rolling weekends on MFT

		site. Where we need help • Service review led by the Clinical Commissioning Group • Agree governance and performance architecture
37. Clinical practice **Lead Director – Steve Hams**	Ensure that the staff who are responsible for taking blood samples from new born babies undertake revised training in the completion of blood sample labels to reduce the number of incidents whereby blood samples are rejected by the laboratory due to missing or incorrect information.	What we have done already • Revised procedure implemented at the end of 2013. • Neonatal Governance Lead and Senior Sister on Delivery Suite have revised staff training. • Printed labels have been changed to only include NHS and PAS numbers (unit numbers no longer used). What we need to do next • Completed.
38. Clinical practice **Lead Director – Steve Hams**	Review the storage of medicines in theatres and the accident and emergency department.	What we have done already • In both areas wooden Controlled Drugs (CD) cupboards were identified as non-compliant with 1973 regulations. Replacement metal CD cupboards have been ordered and the security risk has been added to the risk register. • An assessment of A and E medication storage has been undertaken by pharmacy on 23.06.14. • Additional metal cupboards have been installed in the A&E for safe medication storage • Counter Fraud team accessed via the Local Involvement Network have supported a review of CD storage and use in A&E following concerns relating to compliance What we need to do next • A program of medication storage audits to be planned and undertaken on all areas within the Trust that store medication. • Actions will be reviewed by the Medicines Management Committee
39. Patient experience **Lead Director – Steve Hams**	Ensure that a formalised process is introduced for seeking feedback from patients and/or their parents/carers who use children's services to help improve the overall quality of the service.	What we have done already • In process of assessing effectiveness of existing feedback mechanisms (baby and parent experience – (neonates), service leavers' survey (special needs nursery) What we need to do next • Review results of above to inform next step (below) • Instigate project to identify potential to implement Friends and Family Test across Children's Services • Publish data at ward/unit level Where we need help • National examples of good practice of engaging children, young people and parents/carers in service feedback and quality improvement