West Hertfordshire Hospitals NHS
NHS Trust

TRUST BOARD MEETING – 28 November 2013

Title of the Paper:	Risk Summit Response Programme Plan
Agenda item:	**TB Item 82/13**
Executive Sponsor: **Author:**	Samantha Jones, Chief Executive Andrew McLaughlin, Programme Director (Interim)
Trust Objective:	Achieving continuous improvement in the quality of patient care we provide and the delivery of service performance across all areas.

Purpose
To update members of the Trust Board on the actions taken and planned to improve the quality of care and treatment across the Trust in response to recent risk summits.

Previously Discussed And Date For Further Review (list relevant committees)
TLEC (further review: 5 December 2013), Risk Summit Response Committee (further review: 16 December 2013) and Trust Board (further review: 30 January 2014).

Benefits To Patients And Patient Safety Implications
Improvements to patient services delivered and reduction in risks to patient safety.

Risk Implications for the Trust (*including any clinical and financial consequences):*	**Mitigating Actions** *(Controls):*
Failing to respond to the issues raised in the risk summits would impact on Trust's reputation and could lead to failures in the delivery of patient services.	Action plans are in place as part of the Trust's Risk Summit Response Programme to address all the issues identified at the risk summits.

Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements
The programme links to all the concerns raised in risk summits. BAF Risks: 2136, 2767 (inc 2766), 2775, 1272, 2719, 2143, 2739, 1512, 2598, 2828 and 2883. CQC Outcomes: 1, 4, 6, 8, 10, 11, 12, 13, 14 and 16.

Legal Implications: (if applicable)

Financial Implications: (if applicable)

Communications Plan: (if applicable)

Recommendations
Members of the Trust Board are asked to note the actions taken to date and those planned as part of our Risk Summit Response Programme.

West Hertfordshire Hospitals NHS Trust

A Programme to Improve the Quality of Care and Treatment

RISK SUMMIT RESPONSE PROGRAMME PLAN

29 October 2013

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Risk Summit Response Programme

1. Introduction

Risk Summit Response Programme

The Risk Summit Response is a comprehensive programme of improvements underway to address risks identified since December 2012 to the delivery of the Trust's objective of *"Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas".*

The programme is intended to coordinate and manage delivery of actions to mitigate and ideally remove the risks highlighted at the Risk Summits held in December 2012 and May 2013 along with the additional risks highlighted by the Chief Executive on 3 July 2013 which led to the most recent Risk Summit held on 5 July 2013. The programme has been created specifically to ensure that the Trust has a single, prioritised plan to focus on the delivery of all key improvements identified at recent risk summits within a given timeframe (which must be as short as possible) with clarity as to the owners for these improvement actions.

The programme consists of six work-streams: Governance; Leadership; Patient Experience; Workforce & Safety; Operational Effectiveness; and Clinical Effectiveness (each of which includes a number of separate projects detailed in Section 4) and is using a framework designed to incorporate all relevant best practice for project management in a health care setting to ensure the improvements are delivered effectively.

Key principles for Improving West Hertfordshire Hospitals

The Risk Summit Response Programme has been designed to embed the following principles:

1) **Patient and public participation** – public representatives play a key role in the improvement programme and are working in partnership with clinicians and directors on the Risk Summit Response Committee. In developing the improvement projects we have listened to the views of the patients and also considered independent feedback from other stakeholders including local GPs and other partners involved in this work. These themes have been reflected in the project aims.

2) **Listening to the views of staff** – staff are supported to provide frank and honest opinions about the quality of care provided to hospital patients and what could be done to improve the way we serve our patients their families and their friends. This daily process has been given the name "Onion" at West Hertfordshire because there is often a need to peel back many layers to find out "*What we can do **today** that will make a difference to our patients **tomorrow***".

3) **Openness and transparency** – all possible information and intelligence relating to the quality of the care provided to our patients has been and will continue to be made available to our partners and stakeholders including our local clinical commissioning group (Herts Valleys CCG), Healthwatch, Patients' Panel, Staff side, the Care Quality Commission (CQC), the General Medical Council (GMC), Health Education East of England (HEEoE), the NHS Trust Development Authority (NTDA) and NHS England.

4) **Cooperation between organisations** – this programme has been built around strong cooperation between all of the different organisations that make up the local health system, placing the interests of patients first at all times.

2. Background

Context

The West Hertfordshire Hospitals NHS Trust (the Trust) was formed in 2000 following the merger of the Watford and Mount Vernon NHS Trust and the St Albans and Hemel Hempstead NHS Trust. The Trust provides acute healthcare services across 3 sites to population of around 550,000 people. The Royal College of Surgeons recommends that the catchment population size for an acute general hospital providing both elective and emergency medical and surgical care should be between 450,000 and 500,000 people. However, whilst it meets this population criterion, operating across 3 sites will not be financially sustainable in the long term and the Trust also has a £67m estates backlog to restore the 3 sites to category B level excluding any additional spend to reconfigure space or update IT.

In 2012/13 the Trust saw approximately 6,000 deliveries, 125,000 A&E attendances, 44,000 emergency admissions along with 41,000 elective admissions and 419,000 outpatient attendances. Watford General Hospital has almost 600 beds and 9 theatres and is the core location for inpatient emergency care, specialist emergency facilities, elective care for higher risk patients and offers a full range of outpatient and diagnostic services. Hemel Hempstead Hospital has a 24/7 urgent care centre, local healthcare facilities such as diagnostic services, MRI and cold pathology and, following a recent £7M refurbishment, sees over 105,000 outpatients per year. St Albans City Hospital has a Minor Injuries Unit open daily from 9am to 8pm, the Trust's elective care centre (with 42 beds and 6 theatres, providing low-risk inpatient care and day-case surgery) and also a wide range of outpatient and diagnostic services seeing over 88,000 outpatients per year.

West Hertfordshire

Overall in West Hertfordshire the population of around 550,000 is in comparatively better health than the rest of the country, in what is a relatively affluent area, although it does have some deprived areas in Watford, Hemel Hempstead and Borehamwood. Over the next 20 years, the overall population is set to increase by 19%, an increase of over 104,000 people. The increasing population is being driven by births within the region, rather than migration, therefore the demand for maternity services will continue to increase with the expectation that deliveries will rise to over 7,000 in the next 5 to 10 years. There will be 96,500 more people over the age of 65, an increase of 53%, which is equivalent of a new town almost the same size as St Albans. The number of children and young people is also growing and an increase of 18% of 0-14 year olds is nearly 39,000 more children. This will increase demand for both paediatrics and paediatric A&E attendances. The predicted demographic change is expected to see the fastest growth in the age groups that are known to be the highest users of healthcare services.

Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer, heart disease and stroke have fallen across West Hertfordshire and are better than the England average; however, as people live longer they require more care, putting pressure on service provision. That said, the Trust did note that both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) ratios were increasing for the year to September 2012 (but have fallen in the year to December) and a detailed and regular analysis of mortality data has been one of the outcomes of the Risk Summit Response Programme.

Market Share

Patients have lots of choice with seven NHS hospitals and six private hospitals are within one hour's driving distance and the Trust faces major competition from East and North Hertfordshire NHS Trust, which includes The Lister Hospital, Mount Vernon Cancer Centre and the QEII, Welwyn Garden City. Overall, the Trust accounts for 32% of Herts Valleys Clinical Commissioning Group (CCG) spend as host commissioner.

The Trust's largest non-elective market share is in acute emergency medicine, at just over 90%, and the highest market share for elective day case rates is paediatrics. With the transfer out of A&E and maternity services from Barnet and Chase Farm, the Trust is likely to experience increased demand, which it will need to match with increased capacity. Currently A&E market share is at 30% and obstetrics has the highest non-elective market share of 44%.
The Trust's largest elective outpatient market is orthopaedics followed by GUM; however this is only a very small part of the Trust's activity. General surgery, midwifery episodes and dermatology follow closely. The largest elective in-patients market share is gynaecology at 71%.

The Patients' Perspective

The last patient surveys were conducted in 2012 for Inpatients and 2011 for Outpatients. Between the 2011 and 2012 Inpatient surveys, the Trust improved significantly on five of 73 questions, and was significantly worse on only one. However, in comparison to other Trusts, West Hertfordshire was significantly worse on twenty-four of 86 questions and significantly better on only one. The Trust improved significantly in 23 of 62 comparable questions between the 2009 and 2011 Outpatient Surveys, and was significantly worse in none. However, the Trust was only significantly better than average on four questions, but significantly worse than average on seventeen of the 74 questions asked in 2012. In 2011 6% of outpatients said they would not recommend the outpatient department to family or friends, compared to an average of just 3%.

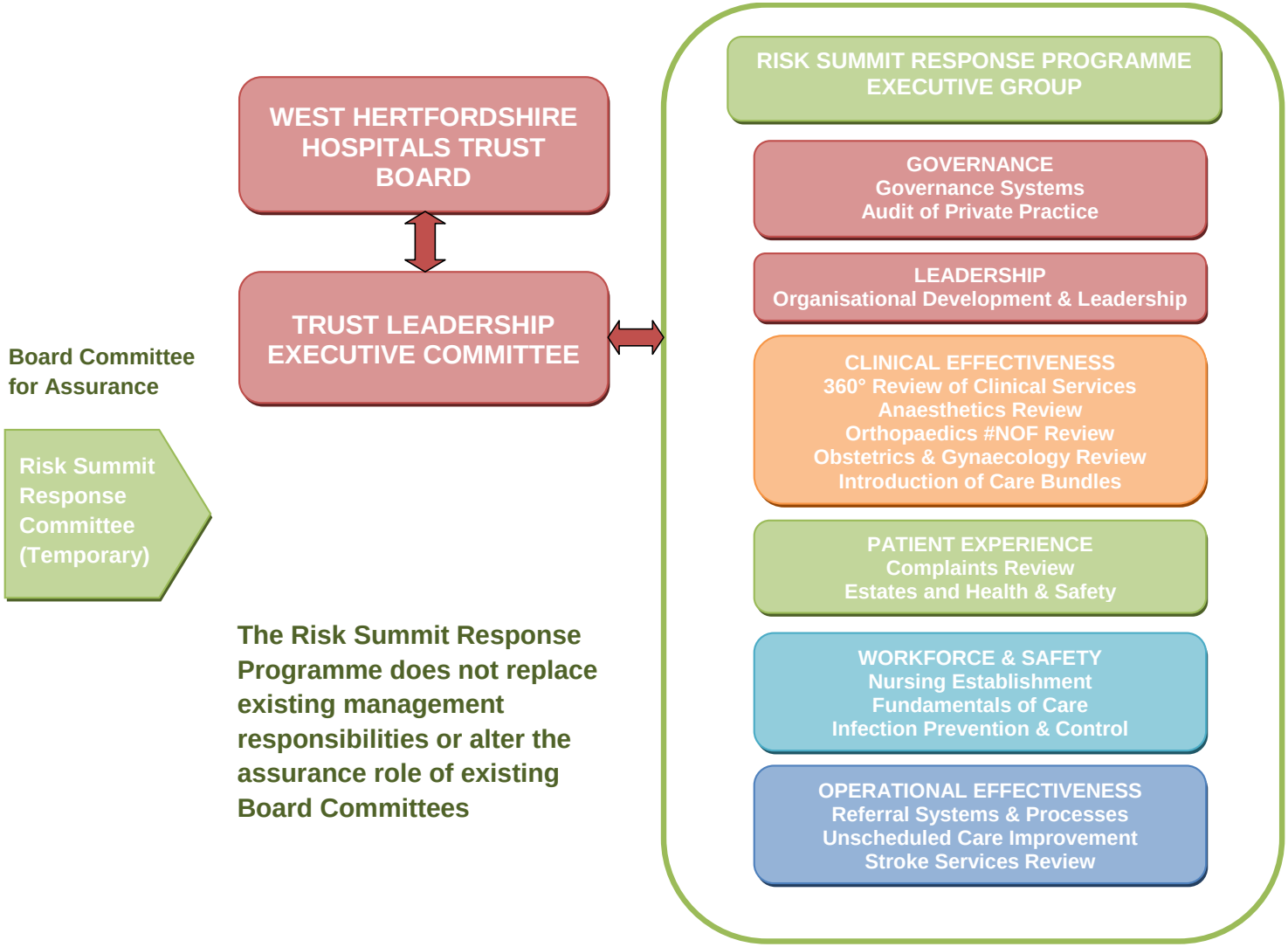
In April 2013 the Trust introduced the NHS Friends and Family test. The benchmark results were +50 (possible range -100 to +100) and significant work has been done to engage with staff since then. The Trust's results have improved steadily to reach a combined "net promoter" score for A&E and inpatients of +75 in July 2013 (results published 29 August) which is seven points higher than June (68) and eleven points above the national average (64).

3. Programme Aims

Theme	Expected End State
Governance	1. We can clearly explain our governance processes for assuring the quality of care. 2. Leadership roles and responsibilities are clearly defined for our quality processes. 3. We can all describe the quality governance process and how we would raise any concern we may have.
Leadership	4. We can demonstrate we have an organisational development plan intended to create an open and honest culture where the patient always comes first. 5. We have a single, prioritised action plan to focus on all key improvement areas across the Trust within a given timeframe and owners for these improvements.
Patient Experience	6. We can evidence how we engage with patients, their families and carers to seek views about their experience. 7. We are aware of the key themes emerging from consulting patients on their experience and the actions taken to address those themes. 8. The Board is aware of compliance and safety issues identified concerning the condition of the estate and actions taken to address them. 9. The Board has adequate assurance that the organisation is delivering safe care.
Workforce & Safety	10. We can clearly demonstrate that we are all engaged in developing our strategy. 11. We can demonstrate that we support all staff with adequate training and development (including safeguarding and other mandatory training).

Workforce & Safety (continued)	**12. We can demonstrate that we monitor and review patient safety indicators and take action to improve patient safety whenever required.** **13. We can describe our workforce strategy and demonstrate effective workforce planning (including skill mix and succession planning).** **14. The Board has adequate assurance that the organisation has the necessary workforce deployed to deliver safe, effective care.**
Operational Effectiveness	**15. We can demonstrate effective governance arrangements for monitoring operational performance data at a senior level.** **16. The Board can evidence how it is using performance information to drive improvements in quality.** **17. The Board is aware of issues identified concerning the management of patients and actions taken to address them.**
Clinical Effectiveness	**18. We can demonstrate a reducing mortality rate (HSMR/SHMI).** **19. We can demonstrate increased monitoring, understanding and ownership of mortality performance at all levels of the organisation.** **20. We can explain what we have done to develop and strengthen clinical engagement and leadership.** **21. We can demonstrate effective governance arrangements for monitoring clinical performance data at a senior level.** **22. The Board has adequate assurance that the organisation is delivering effective clinical care.**

4. Governance Structure



The Risk Summit Response Programme does not replace existing management responsibilities or alter the assurance role of existing Board Committees

5. Assurance Framework

Key Principles

The assurance framework to support the Risk Summit Response Programme incorporates the Office of Government Commerce recommendations and lessons learned from the 2012 Olympic legacy by using the "3 Lines of Defence" assurance model. In this model, operational managers provide the first level of assurance that changes are underway, the programme team provide the second line by providing objective internal scrutiny and internal audit / review provide a third and final means of assurance. This integrated assurance model is summarised in the diagram below.

Assurance Model

Benefits Realisation

The ultimate aim of the assurance model is to ensure that the benefits expected from the Programme are fully realised and translate to tangible improvements in the quality of care and treatment experienced by our patients. The arrangements are summarised below:

Identify Benefits Needed

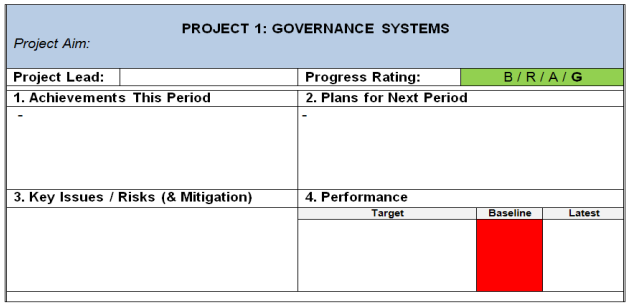
Approach:

- Outline anticipated benefits in Project Initiation Document.
- Finalise RSR Programme Plan.
- Agree Baseline Metrics against which improvements will be measured.

Monitor Progress

Approach:

- Receive Monthly Project Updates



PROJECT 1: GOVERNANCE SYSTEMS			
Project Aim:			
Project Lead:		Progress Rating:	B / R / A / G
1. Achievements This Period		2. Plans for Next Period	
-		-	
3. Key Issues / Risks (& Mitigation)		4. Performance	
		Target / Baseline / Latest	

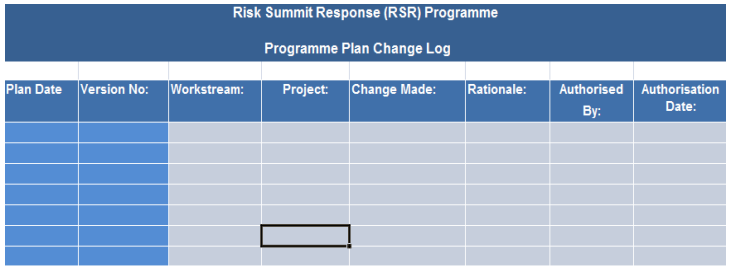
- Use 'BRAG' rating to assess progress:

Blue	Action completed & embedded
Green	Action complete on planned date
Amber	Action may not complete on time
Red	Action will not complete on time

Review / Remove Obstacles

Approach:

- Keep a log of all changes to plan

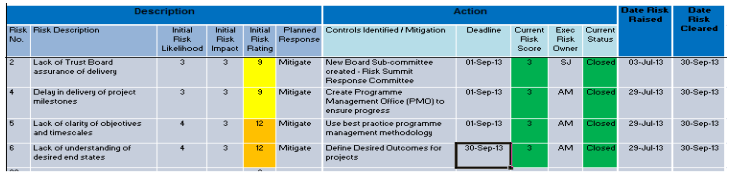


Risk Summit Response (RSR) Programme

Programme Plan Change Log

Plan Date	Version No:	Workstream:	Project:	Change Made:	Rationale:	Authorised By:	Authorisation Date:

- Manage risks & issues.



Description					Action				Date Risk Raised	Date Risk Cleared
Risk No.	Risk Description	Initial Risk Likelihood	Initial Risk Impact	Initial Risk Rating	Planned Response	Controls Identified / Mitigation	Deadline	Current Risk Score	Exec Risk Owner	Current Status		
2	Lack of Trust Board assurance of delivery	3	3	9	Mitigate	New Board Sub-committee created - Risk Summit Response Committee	01-Sep-13	3	SJ	Closed	03-Jul-13	30-Sep-13
4	Delay in delivery of project milestones	3	3	9	Mitigate	Create Programme Management Office (PMO) to ensure progress	01-Sep-13	3	AM	Closed	29-Jul-13	30-Sep-13
5	Lack of clarity of objectives and timescales	4	3	12	Mitigate	Use best practice programme management methodology	01-Sep-13	3	AM	Closed	29-Jul-13	30-Sep-13
6	Lack of understanding of desired end states	4	3	12	Mitigate	Define Desired Outcomes for projects	30-Sep-13	3	AM	Closed	29-Jul-13	30-Sep-13

Confirm Achievement of Benefits

Approach:

- Assess improvement against baseline metrics.
- Create a template to assess benefits from perspectives of patients, staff and the organisation.
- Confirm lessons learned by Trust and consider applicability for the wider NHS.

Financial Assurance

This Programme complements existing governance structures and does not authorise spending or allocate funding to quality improvement initiatives. Financial approval and assurance is provided via existing means with a Business Case required to justify any additional investment (ie measured against existing commitments/priorities).

6. Programme Baselines

Theme	Project	Risk Summit	Title	Metric	Target	Baseline	Latest
Governance	1	May 2013	Governance Systems	Improvement in score on the Good Governance Institute Self Assessment Maturity Index	>4	<3	Report due in December
	2	May 2013	Private Practice	% of consultant job plans that have received detailed review by Apr 14	100%	0%	In Progress
Leadership	3	May 2013	Organisational Development & Lead	Staff survey results	Further Improvement	3.70	In Progress
Patient Experience	4	May 2013	Complaints Review	% of complaints responded to within 20 working days	>80%	33% (April)	96% (YTD)
				Combined net promoter % from family & friends test	Further Improvement	67% (April)	74% (September)
	5	July 2013	Estates and Health & Safety	Reduction in anticipated number of HSE improvement / prosecution notices	0	8 – 10 (Predicted)	0 (YTD)
Workforce & Safety	6	July 2013	Nursing Establishment	% of permanent nursing vacancies across all WHHT services	< 5%	17.5% (April)	17.4% (October)
				Number of 'whole-time equivalent' nurses recruited to WHHT since April 13.	Not Applicable	Not Applicable	81.1
	7	July 2013	Fundamental Nursing Care	Pressure Ulcers per 1000 bed days	Under Review	6.24 (July)	4.79 (September)
				Falls per 1000 bed days	Under Review	1.81 (July)	1.19 (September)
				UTI per 1000 bed days	Under Review	6.04 (July)	3.39 (September)
	8	May 2013	Infection Prevention & Control	Number of hospital acquired MRSA infections	Reduction to 0 for 2013/14	1	1 (YTD)
				Number of hospital acquired Clostridium Difficile infections	<24 for year	44	17 (YTD)
				Time taken to isolate patients in a single room (Data under review)	<2 hours	83%	80%

Theme	Project	Risk Summit	Title	Metric	Target	Baseline	Latest

Operational Effectiveness	9	July 2013	Referral Systems & Processes	% of admitted, planned patients < 18 week wait	>90%	88.4% (April)	90.0% (YTD)
				% of non-admitted, planned patients < 18 week wait	>95%	95.5%	96.2% (YTD)
				% of admitted & non-admitted planned patients with pathways completed on system	>92%	95.0%	92.1% (YTD)
				No of specialties breaching admitted pathway/month	0	3 (April)	3 (September)
				No of specialties breaching non-admitted pathways	0	6 (April)	8 (September)
				No of specialties breaching incomplete standard	0	0 (April)	3 (September)
	10	May 2013	Unscheduled Care Improvement	% of A&E patients seen & treated < 4 hours at WHHT	>95%	94.7% (April)	95.7% (YTD)
				% of A&E patients seen & treated < 4 hours at WGH	>95%	91.9% (April)	93.5% (YTD)
				% of Ambulance to A&E 'turnaround' times that are within 15 minutes of ambulance arrival	>85%	31% (April)	44.4% (YTD)
	11	May 2013	Stroke Service Project	% of stroke patients admitted to Stroke Unit within 4 hours of arrival	>90%	59.5% (April)	62.7% (September)
				% of patients who have had a stroke who spend at least 90% of their time on the Stroke Unit	>80%	70.2% (April)	78.3% (September)
				% of people at high risk of Stroke who experience a TIA assessed/treated within 24 hours	>60%	60.0% (April)	73.7% (September)
Clinical Effectiveness	12	July 2013	360° Reviews of Clinical Services	Detailed, routine review of all conditions that are outlying for RAMI / HSMR / SHMI	11 reviews complete	No review process	On Track
	13	Dec 2012	Anaesthetics Review	Deanery endorsement that action plan complete and WHHT provides good training experience	No Deanery concerns	Significant concerns	No concerns confirmed
	14	July 2013	#NOF Audit - Patient Safety Mitigation	% Patients receiving #NOF surgery within 48 hours of admission	100%	85.7% (January)	93.0% (YTD)
				Mortality rate for patients admitted to Watford with #NOF below national rate. (Quarterly RAMI)	<100	117.6 (2012)	Next report awaited
	15	Dec 2012	Obstetrics & Gynaecology Review	% having caesarean section below national rate	≤24%	29% (2012/13)	26.6% (September)

7. Programme Plan

Governance

Theme / Key issue	Action Agreed and Support Required	Lead	Timescale	BRAG
1. Governance Systems Project	**Programme Aims 1, 2 and 3**			
Create and implement a plan to review and improve the Board's assurance processes, deliver a Board development programme and conduct a review of governance support available to the Trust with a view to facilitating organisational learning (quality and safety).	• Develop Project Initiation Document (PID)/Action Plan/Risk Log	AM	21.8.13	B
	• Complete Good Governance Institute (GGI) Board and governance rapid review	MH/SJ	31.5.13	B
	• Board Assurance			
	- Review Board assurance processes against current NHS best practice	GGI	2.9.13	B
	- Implement improvements to reporting lines and subordinate committee structure	AT	5.9.13	G
	• Board Development			
	- Conduct an internal and external stakeholder review	GGI	26.9.13	B
	- Complete Board Member skills review and a 360° assessment of all Board member	GGI	4.10.13	B
	- Review the Trust Board Audit Committee	GGI	31.10.13	G
	- Conduct an initial Board development programme	GGI	30.11.13	
	- Develop a full Board Development Programme in response to reviews undertaken	MH/SJ	28.11.13	
	• Quality & Safety			
	- Review all governance support available to the Trust	AT	TBC	
	- Ensure that governance support facilitates organisational learning (quality & safety)	AT	TBC	
	• Introduce Board governance systems and processes regarded as good practice	AT	21.11.13	
	• Appoint a permanent chairman as soon as practicable	TDA	TBC	
	• Chief Executive to recruit to executive director posts by 31 December 2013	SJ	31.12.13	
	• Chairman to recruit one non-executive director by 31 December 2013	TDA	31.12.13	
	Expected Project Completion (*Board Development Plan agreed*): 30 November 2013	AT	30.11.13	

2. Private Practice Audit		Programme Aim 1			
Internal audit to complete review of all Private Practice	• Agree Terms of Reference (TORs) for Internal Audit (BDO) of Consultant Job Plans		PB	23.8.13	B

Leadership

	Audit Completed: 25 October 2013		PB	25.10.13	G
3. Organisational Development & Leadership Project		**Programme Aims 4 and 10**			
Create and implement a plan to embed 'values-based' Organisational Development, designed to drive enhanced outcomes for patients through sustainable cultural change.	• Develop PID/Action Plan/Risk Log		AM	28.8.13	B
	• Hold director-led workshops on creating values with staff		LG	Complete	B
	• Create detailed plan for design and implementation phase		LG	Complete	G
	• Organisational Development Plan to September Trust Board		LG	Complete	B
	• Finalise specification and tender for delivery plan		LG	Complete	G
	• Implement robust assessment processes for new staff:				
	- Improve assessment processes for very senior appointments.		LG	28.2.14	
	- Institute assessment centres for appointment of senior leaders at Associate/Deputy Director, DGM and CD levels.		LG	28.2.14	
	- Implement talent management principles for the executive team		LG	31.12.13	
	• Develop a set of values that describe our cultural aspirations.		LG	30.11.13	
	• Translate values into behaviours that describe excellence for staff at different levels		LG	31.12.13	
	• Putting in place positive consequences to drive high performance:				
	- Establish behaviourally based assessment - to ensure the best are appointed		LG	31.1.14	
	- Establish behaviourally based appraisal - to align individual objectives and development to business plans and behaviours to values		LG	31.1.14	
	- Talent Management - to identify, nurture and retain our most talented staff on the basis of current performance and future potential		LG	In progress	
	- Succession planning - to identify those with potential and aspiration to move into key roles now and in the future		LG	Ongoing	
	• Removing the obstacles to enable and ensure front line staff deliver experience led and person centred care, 'walking in patients' shoes':				

	- Teach patient led design – to map and teach ways of working that enable front line staff and their managers to co-design services with their patients and service users	LG	30.4.14	
	- Person-centred system redesign – to embed new ways of working that 'nudge' and support people to behave in person centred ways at scale	LG	28.2.14	

Patient Experience

	- Team enablement - to support leaders of frontline staff through the period of transition and to embed new ways of working	LG	28.2.14	
	- Partnership development – to mature relationships and nurture positive, values based partnerships – most especially with commissioners and the local community	LG	Ongoing	
	• Create bespoke leadership programmes - developed around values, corporate objectives, RSR programme and our own leadership behaviours. Provided to everyone who manages others and designed to accelerate business outcomes, drive redesign and quality	LG	28.2.14	
	• Instil executive coaching - for directors and most senior talented managers	LG	31.12.13	
	• Develop senior leadership teams - starting with development centres then a programme to provide bespoke development of each individual including coaching and mentoring	LG	31.1.14	
	• Assess the suitability of individuals to undertake key roles as part of organisational restructuring and appointment to new posts	LG	28.2.14	
	Expected Completion Date for the Initial Phase of the Project: 31 March 2014	LG	31.3.14	

4. Complaints Review Project	**Programme Aims 6, 7 and 9**			
Develop and implement improved, open approach to complaints that enables learning.	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• *Review current approach to complaints with external advice and support*	JA	Complete	B
	• Clear complaints backlog	JA	31.7.13	B
	• Ensure acknowledgement of all formal/informal complaints within 3 working days	JA	31.7.13	G
	• Ensure all formal complaints responded to within 20 working days	JA	31.7.13	G
	• Ensure all MP enquiry letters responded to within 10 working days	JA	31.7.13	G
	• Ensure all enquires responded to within 20 working days	JA	31.7.13	G
	• Ensure all "for Trust comments" responded to within 15 working days	JA	31.7.13	G

	• Ensure all Divisional action plans provided within 10 days of complaint response	JA	31.10.13	
	• Ensure Divisional action plans are signed off at Divisional Governance Committee	JA	31.10.13	
	• *Develop and implement an improved, open approach that enables organisational learning*	JA	31.10.13	
	• Ensure that organisational learning is shared with other stakeholders	JA	31.10.13	
	• Ensure Local Resolution Meeting dates are offered within 15 working days	JA	31.10.13	
	• Ensure Local Resolution Meetings are held within 40 days of agreement	JA	31.10.13	
	• Ensure accessibility for service users to raise concerns or to provide feedback	JA	31.10.13	
	• Ensure lost property claims are responded to within 20 days	JA	31.10.13	
	• Ensure all Ombudsman cases are responded to in accordance with given timeframes	JA	31.7.13	G
	Expected Project Completion Date: 31 October 2013	JA	31.10.13	
5. Estates and Health & Safety Project	**Programme Aims 8 and 9**			
Address the significant backlog maintenance risks to clinical service delivery and demonstrate that the Trust complies with all statutory policies and procedures.	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• Prepare application for TDA funding	PB	Ongoing	B
	• Ensure that full compliance is delivered across the Trust's estate:	LG	Complete	G
	- Create compliance team	LG	Complete	G
	- Work through all Hospital Technical Memorandum (HTM) requirements and ensure that all required policies and procedures are documented	LG	Complete	G
	- Water pipes in ITU replaced as part of Legionella Plan	LG	Complete	G
	- Asbestos Management Plan completed	LG	Complete	G
	- Ratify all policies and procedures	LG	30.11.13	
	- Work with Estates staff to implement policies	LG	30.11.13	
	- Provide training where required	LG	TBC	
	- Audit compliance with new policies and procedures	LG	31.1.14	
	- Identify any further actions/changes required	LG	Ongoing	
	• Ensure all "critical" and "significant" backlog maintenance risks are addressed:			
	- Replace failing air handling units	LG	31.3.14	
	- Prioritised programme of fire door replacement (including SACH Theatre doors)	LG	28.2.14	
	- Install additional back-up power capacity at WGH in 2014/15	LG	TBC	
	- Extensive internal works in all ward areas, public areas and public toilets	LG	31.3.14	

	- Complete priority fire safety works	LG	31.3.14	
	- Complete feasibility study for installation of 2 additional lifts in PMOK	LG	30.11.13	
	- Remove old oil tanks and replace with tanks suitable for dual fuel	LG	31.12.12	
	- Relocate Maxillofacial/Helen Donald unit	LG	30.6.14	

Workforce & Safety

	- Carry out essential works to the external fabric and roof of the Moynihan Building	LG	31.3.14	
	- Carry out window replacements at WGH	LG	31.1.14	
	- Carry out pressure system repairs/replacement for heating systems	LG	31.1.14	
	- Complete Legionella Plan	LG	31.1.14	
	- Carry our essential lift maintenance and refurbishment	LG	31.12.13	
	- Procure and install new medical gas plant across all three sites	LG	28.2.14	
	- Install a single nurse call system solution across all sites in 2014/15	LG	28.2.14	
	- Provide isolation on steam systems	LG	31.3.14	
	- Carry out essential road and path repairs on all sites	LG	30.11.13	
	- Carry out rolling programme of theatre internal refurbishment	LG	28.2.14	
	- Demolition of redundant buildings to allow for decant facilities to be sited	LG	28.2.14	
	- Produce estates records and drawings in accordance with statutory requirements	LG	31.12.13	
	Key dependency: NHS (E) to support discussion with the TDA to ensure a decision is made quickly on WHHT business case for TDA "distress funds" to fund significant and high risk issues (£12.7M for 12 month spend – ie July 2013-14 and request for £3.5M in 2014-15).	LG	£12.7M Approved 20 Sep 13	G
	Expected 1st Phase Completion Date: 31 March 2014 (2nd Phase: 31 August 2014)	LG	31.3.14	

6. Nursing Establishment Project	**Programme Aims 9, 11, 13 and 14**			
Review establishments and skill mix for nursing and midwifery and implement a phased recruitment campaign.	• Develop PID/Action Plan/ Risk Log	AM	21.8.13	B
	• Review Adult inpatient nursing establishment and skill mix	JA	30.4.13	B
	• Review Paediatric and Maternity establishments and skill mix	JA	31.8.13	B
	• Establish funding for revised establishments	JA	30.6.13	G

	• Develop and implement a phased recruitment campaign:	JA	Ongoing	G
	- Recruitment streamlined to ensure good quality candidates start as soon as possible	JA	Ongoing	G
	- Ensure Students from local universities are recruited	JA	Complete	G
	- Review apprenticeships	JA	Ongoing	G
	- Maximise impact of recruitment advertising	JA	30.4.13	G
	- Track recruitment and pending starters	JA	Complete	G
	- Offer part-time additional contracted hours	JA	Ongoing	G
	- Attract Return-to-Practice Nurses to the Trust	JA	Complete	G
	- Attend nursing conferences for recruitment	JA	31.10.13	G
	- Increase resourcing in recruitment to facilitate increased workload	JA	31.10.13	G
	- Run recruitment campaigns in Ireland and Scotland	JA	Ongoing	G
	- Increase staff retention rates	JA	31.10.13	G
	- Overseas recruitment for trained nurses	JA	31.10.13	G
	- Recruit 2 x band 6 Practice Development / Support Nurses on 6-month secondment to support newly appointed staff	JA	In progress	
	• Develop a 3-month induction and training programme for HCAs	JA	26.9.13	G
	• Review Recommendations Approved by September Trust Board	JA	31.8.13	G
	• Repeat establishment reviews repeated on a regular basis (Annual unless change in service or clinical area dictates more regular review)	JA	31.1.14	
	• Introduce monthly Quality Scorecard measures to include workforce KPI	JA	28.2.14	
	• Supervisory Band 7's to be held to account for delivery on KPI's including workforce quality	JA	31.8.13	A
	• Chief Nurse to be provided with weekly/monthly updates on recruitment activity and vacancy factors that is shared at Divisional level with Sisters, Matrons & HON's	JA	31.3.14	
	Expected Project Completion Date (with staff vacancies less than 5%): 31 March 2014	JA	31.3.14	
7. Fundamental Nursing Care Project	**Programme Aims 9, 11, 12 and 14**			
Introduce Nursing Care Indicators/Patient Experience Metrics to	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• Implement the Test Your Care Nursing Care Indicators/Patient Experience Metrics as developed at Birmingham Heartlands NHS Trust			

all wards including medication storage and custody, infection control & privacy and dignity, patient observations, pain management, tissue viability, nutrition assessment, falls assessment and continence assessment.	- Conduct 3-month trial on Cleves, Stroke, AAU Level 3 Blue wards with peer assessment of nursing processes in the following areas:	JA	30.11.13	G
	1. Medication storage and Custody	JA	30.11.13	G
	2. Infection Control and Privacy and Dignity	JA	30.11.13	G
	3. Patient Observations	JA	30.11.13	G
	4. Pain Management	JA	30.11.13	G
	5. Tissue Viability	JA	30.11.13	G
	6. Nutritional Assessment	JA	30.11.13	G
	7. Falls Assessment	JA	30.11.13	G
	8. Continence Assessment	JA	30.11.13	G
	9. Patient Experience	JA	30.11.13	G
	- Commence Roll-out of the “Test Your Care” system to all other wards	JA	31.12.13	
	• Complete actions recommended as part of the 'Nursing Route Map'			
	- Revise nursing & midwifery strategy	JA	30.11.13	
	- Review roles and responsibilities of band 7 sisters and matrons	JA	31.12.13	
	- Roll out the 'Productive Ward' programme to the Acute Admissions Unit	JA	31.11.13	
	- Review senior nursing support for Hemel Hempstead Hospital	JA	31.7.13	G
	- Undertake detailed review of specialist nurse and enhanced practitioner workforce	JA	31.1.14	
	- Review corporate practice development team resources	JA	30.11.13	
	- Review current programme for preceptorship to ensure that nurses are appropriately supported	JA	31.12.13	
	• Develop the role of supervisory ward leaders			
	- Commence development programme for all ward managers/charge nurses	JA	30.11.13	
	- Ensure sufficient nurses to enable all inpatient ward managers to be supervisory	JA	28.2.14	
	• Ongoing Nursing Outcomes Assessment Framework			
	- Agree outcome measures/baselines to assess impact of the Test Your Care pilot	JA	31.12.13	
	- Review current nursing care quality measures and targets and agree outcome measures for each domains above that will form the basis of a regular Trust report	JA	31.12.13	
	- Ensure regular reports of nursing care quality through Divisions and TLEC to Board	JA	31.1.14	
	Expected Project Completion Date: 31 March 2014	JA	31.3.14	

8. Infection Prevention & Control Project	Programme Aims 9, 11, 12 and 14			
Complete review of all systems/processes related to Infection Prevention & Control.	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• Deliver all actions agreed as part of Trust's Infection Control Action Plan:			
	- Complete root cause analysis (RCAs) for patients who acquire infection in hospital led by Divisions, with the involvement of the consultant that cared for that patient	JA	31.8.13	B
	- Introduce drug chart stickers for patients on IV antibiotics to highlight review date	JA	31.7.13	B
	- Introduce better processes for isolating patients within 2 hours	JA	31.8.13	G
	- Develop robust IC action plan (including links to Code of Practice)	JA	31.8.13	B
	- Review compliance against Hygiene Code	JA	31.8.13	G
	- Develop system to capture and monitor IC data and provide compliance assurance	JA	31.7.13	G
	- Ensure all wards areas well maintained & environment/equipment appropriately managed to prevent infection	JA	Ongoing	G
	- Assure quality of environmental cleanliness and shared patient equipment	JA	30.4.13	G
	- Develop Root Cause Analysis (RCA) process to support leadership by clinical areas and formulation of robust action plans for all cases of C-diff	JA	Ongoing	B
	- Revise C-diff policy	JA	31.7.13	G
	- Decrease use of PPI in Care of the Elderly	JA	Ongoing	G
	- Ensure antibiotics used appropriately	JA	Ongoing	G
	- Review & disseminate antimicrobial prescribing guidelines to reflect best practice	JA	31.7.13	G
	- Introduce anti-microbial prescribing training	JA	Complete (not fully embedded)	G
	- Provide training for junior doctors on completion of death certificates			
	- Consultant gastroenterologist to review all C-diff deaths			
	- Develop policy review and update programme to ensure evidence based			
	- Introduce education and training to support effective hand hygiene			
	- Introduce promotional Campaigns/Communication			
	- Introduce mandatory infection control update training			
	- Introduce e-learning training on infection control			
	- Ensure prevention of sharps injuries (compliance with EU Directive)			
	- Develop and implement recruitment plan to support findings of workforce review			
	- Develop role models for infection prevention best practice			
	- Monitor staffing as contributory factor to C-diff			
	- Reinforce matrons' role in assuring Infection Control quality			

	- Ensure Infection Control in job descriptions			
	- Reinforce role of medical staff in good Infection Control			
	- Ensure clinical engagement in RCA process			
	- Provide Infection Control training for Trust Board			

Operational Effectiveness

	- Promote vaccinations programme as part of winter planning	JA	Complete	G
	- Divisions to submit their own local plans for Infection Prevention & Control	JA	Complete	G
	- 20 voice-activated machines to remind people about hand hygiene put in at WGH	JA	21.10.13	G
	- High impact measure peer review audit to be completed across all ward areas	JA	31.10.13	G
	- Ward cleaning requirements & schedules in place to meet 2007 standards	LG	1.12.13	
	- Appoint Director of Infection Prevention & Control and fill vacant posts in IC	JA	28.2.14	G
	- Achieve supervisory status for ward sisters	JA	31.12.13	G
	Expected Project Completion Date: 31 March 2014	JA	31.3.14	

9. Referral Systems & Processes Project (inc RTT)	**Programme Aims 15, 16, 17 and 22**			
Agree and implement an action plan to improve referral systems and processes.	• Develop PID/Action Plan/Risk Log	AM	28.8.13	B
	• Clear all 'backlog' issues:			
	- Review all patients on 'suspended' list and ensure pathways clarified	BB	Complete	G
	- Review all cardiac and respiratory patients and ensure clinical review	BB	Complete	G
	• Deliver immediate actions agreed to improve processes and performance:			
	- IMAS review completed and written diagnostic report received	BB	Complete	G
	- Complete capacity and demand modelling exercise for T&O, ENT, pain and ophthalmology	BB	Complete	G
	- Convene capacity and demand workshop for all other specialties	BB	Complete	G
	- Review and refine 'PTL' process	BB	31.10.13	
	- Re-write access policy to ensure it is in line with current best practice	BB	31.10.13	
	- Develop next phase project plan, based on IMAS review recommendations	BB	31.10.13	
	• Further actions required:			

	- Complete capacity and demand modelling exercise for all other specialties	BB	31.10.13	
	- Produce recovery plans for all failing specialties	BB	30.11.13	
	- Complete external 'second tier' review of outcomes for 'backlog' patients	BB	30.11.13	
	- Match capacity to demand in a sustainable manner	BB	TBC	
	- Clear 18-week+ patients to recover performance across all specialties	BB	TBC	
	Expected Completion Date for the initial Phase of the Project: 30 November 2013	BB	30.11.13	
10. Unscheduled Care Improvement Project	**Programme Aims 15, 16, 17 and 22**			
Agree and implement an action plan to improve urgent care across the health system.	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• Patient Flow:			
	- Ensure that every patient in every bed is reviewed by a senior decision making doctor (preferably a consultant) every day	BB	Underway	G
	- Ensure that every patient has an EDD (expected date of discharge) and CDD (physiological/functional criteria for discharge) as part of their medical care plan	BB	Underway	G
	- Ensure that discharge activities are prioritised against other routine work. The aim is to discharge most patients before midday to create space for new admissions	BB	Underway	G
	- Ensure that wards take responsibility for having an up to date list of any outlying specialty patient (including in AAU) and that wards work in liaison with the bed management team to proactively manage ward capacity to enable specialty patients to be cared for in the appropriate location	BB	Underway	G
	- Ensure that all patients categorised as needing specialist in-put are managed by the appropriate specialist team whilst in the AAU. The specialist teams should attend the AAU each morning and, ideally, at a set time to receive verbal handover	BB	Underway	G
	- Agree and implement a dashboard of performance measures to show the impact of changes made	BB	Underway	G
	- Ensure that the catheter laboratory and CDU not used routinely as surge capacity	BB	Underway	G
	• Emergency Department:			
	- Ensure that the CDU is ring-fenced for observation	BB	Ongoing	G
	- Improve planning for merging of majors and minors queues	BB	Complete	G
	- Conduct a team job review to ensure that consultant deployment matches demand	BB	15.10.13	A
	- Consider recruitment and deployment of ANPs at night when cover is thin	BB	Complete	G
	- Improve flow of patients between ED and GP out-of-hours services	BB	30.11.13	

	- Establish a set of internal professional standards	BB	15.10.13	A
	• Acute Medical Take:			
	- Review current model to ensure continuity of care, with on-take consultants covering more than one day, to reduce in-hospital mortality and readmissions	BB	1.12.13	
	- Establish a clear direction of travel to reform the take, including intermediate steps, such as strengthening the take now by changing the rota	BB	1.12.13	
	- Establish a standard that all new arrivals have a medical assessment commenced within 30 minutes of arrival on the ward, and senior review within 4-hours. No patient admitted before 9pm should go overnight without at least a rapid consultant assessment, even if he/she has not been clerked	BB	Underway	G
	- Establish rolling ward rounds, where patients are seen shortly after arrival rather than waiting to be seen as part of a round	BB	Underway	G
	- Ensure services operate from dedicated spaces without overlaps between assessment, in-patient, day case and ambulatory services	BB	Underway	G
	• Care of Older People:			
	- Ensure every patient has a consultant approved expected date of discharge (EDD)	BB	Complete	G
	- Daily board rounds, by senior clinical decision maker (preferably a consultant) are undertaken to ensure that EDDs current and discharge occur once goals are met	BB	Complete	G
	- Ensure frail elderly patients are systematically identified and provide specialist geriatrician cover for AAU and ED to ensure comprehensive geriatric assessment (CGA) is started as early as possible on the patient's pathway	BB	Underway	G
	- Ensure that good practice for care of people with dementia is in place on all wards	BB	31.3.14	
	- Develop a strategy to ensure that all frail older people are identified, managed assertively through consultant-led geriatric MDTs and discharged early to avoid them de-compensating in hospital	BB	31.3.14	
	• Patient Pathways:			
	- Ensure that the potential for ambulatory care is maximised	BB	Complete	G
	- Ensure services operate from dedicated spaces without overlaps between assessment, in-patient, day case and ambulatory services	BB	Underway	G
	- Define the difference between ambulatory and short stay patients, and ensure that patients are seen in the right environment under the care of the right clinical team	BB	Underway	G
	• Ambulance Response Times:			

	- Work with the Ambulance Trust to implement a dual response that meets patient needs and required performance standards for handover times	BB	Ongoing	G
	• Further actions planned:			
	- Audit actions to date to ensure changes are embedded in normal practice	BB	1.11.13	
	- Improve partnership working with social care and community teams so that they are represented at board rounds and work closely with the clinical navigation service	BB	1.11.13	
	- Establish the management of capacity and flow as a corporate function	BB	25.12.13	
	- Confirm if early supported discharge for stroke patients could be in place for winter	BB	25.12.13	
	- Develop a multi disciplinary workforce strategy for the AAU	BB	25.12.13	
	- Build a dedicated ambulatory facility for general medical adult and COE streams	BB	25.12.13	
	- Develop a separate SAU/ acute surgical take	BB	25.12.13	
	Expected Project Completion Date: 25 December 2013	BB	25.12.13	
11. Stroke Service Project	**Programme Aims 15, 16, 17 and 22**			
Implement in full the action plan agreed following the December quality review.	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• Ensure at least 90% of stroke patients are admitted to the Stroke Unit within 4 hours of arrival in hospital:			
	- Increase stroke nurse specialist workforce from 1.4 to 2.0 WTE, to ensure cover is in place 8am – 8pm, 5-days a week	BB	Complete	B
	- Ensure that there is one ring-fenced bed available on the stoke unit at all times, with daily reporting of achievement of access to unit within 4 hours	BB	Complete	G
	- Increase stroke awareness and early identification through education and training for staff in A&E and AAU (including all new junior doctors in A&E)	BB	Ongoing	G
	- Undertake RCAs for all patients for whom the standard has not been achieved and learn from outcomes to ensure correct pathway	BB	Ongoing	B
	- Increase nursing establishment in the Stroke Unit to enable the Trust to provide a 24/7 specialist service for stroke patients including thrombolysis	BB	21.10.13	G
	• Ensure at least 90% of stroke patients spend at least 80% of their time in hospital on the Stroke Unit:			

	- Ward Manager to manage all discharge plans and progress timely discharge of patients with all documentation complete if IMC or on-going social care required	BB	Underway	G
	- Review provision of beds for stroke patients across the whole system including a review of the stroke rehabilitation pathway	BB	Underway	G

Clinical Effectiveness

	• Ensure at least 60% of people with high risk of Stoke who experience a TIA are treated within 24 hours:			
	- Complete RCA of each breach with feedback to GPs and GP stroke lead	BB	Complete	B
	- Implement a stroke referral hotline for GPs for all TIAs (not just high risk patients) with a weekend and Bank Holiday service provided by Luton & Dunstable	BB	Complete	B
	- Review consultant workforce needed to provide a 5-day/week consultant-led service and recruit an additional joint Care of the Elderly/Stroke Consultant (No applicants for joint post)	BB	In progress	A
	• Further actions planned:			
	- Complete capacity and demand exercise to establish required stroke bed base	BB	31.12.13	
	- Review current pathways and evaluate resources required to support an Early Supportive Discharge (ESD) service in Hertfordshire	BB	31.3.14	
	- Consider centralising stroke service at Watford General Hospital (WGH) by re-locating the 16 stroke rehabilitation beds from Hemel Hempstead	BB	31.3.14	
	- Consider increasing consultant establishment to allow for the provision of a 7-day consultant delivered service	BB	31.3.14	
	- Identify a location for one-stop TIA clinics with flexible access to Doppler service.	BB	31.3.14	
	Expected 1st Phase Project Completion Date: 30 September 2013	BB	30.9.13	A

12. 360° Reviews of Clinical Services & Data Project	**Programme Aims 18, 19, 20 21, and 22**			
Produce detailed analysis of mortality data for Anaesthetics, Stroke, Orthopaedics #NOF and Obstetrics & Gynaecology.	• Develop PID/Action Plan/Risk Log	AM	21.8.13	B
	• Establish methodology and collect and collate data	PJ	Complete	B
	• Conduct initial analysis of RAMI / SHMI mortality data and clinical outcomes	PJ	Complete	B
	• Cross reference internal and external sources of data/information for Level 1 priority services and specialities	PJ	Complete	B

	• Conduct initial review of clinical services with CCG	PJ	Complete	G
	• Conduct service reviews and establish service intelligence 'buckets' of relevant data sources and information to give clarity of business as usual.	PJ	Complete	B
	• Support development of data quality early warning system and escalation processes/procedures for internal safety awareness and assurance.	PJ	31.10.13	B
	• Establish 360 Review Panels incorporating stakeholder representation.	PJ	24.10.13	B
	• Complete all service-level desktop reviews and self-assessments (New action)	PJ	31.10.13	
	• Complete detailed reviews of specific services and defined clinical audits (New action)	PJ	30.11.13	
	Expected Extended Project Completion Date: 30 November 2013	PJ	30.11.13	
13. Anaesthetics Review	**Programme Aims 18, 19, 20 21, and 22**			
Ensure HEEoE concerns about the training and supervision of junior doctors are addressed.	• Develop PID/Action Plan	AM	28.8.13	B
	• All actions outlined in the action plan agreed by the London Deanery, Health Education East of England and WHHT delivered. Key areas covered by this plan are as follows:			
	- Curriculum Requirements	MvdW	Complete	G
	- Out-of-hours supervision in obstetric anaesthesia	MvdW	Complete	G
	- On-call supervision arrangements for all anaesthetics training grades	MvdW	Complete	G
	- Improved incident & concern reporting arrangements	MvdW	Complete	G
	- Trainee availability to attend training	MvdW	Complete	G
	- Concerns regarding undermining addressed	MvdW	Complete	G
	• Serious Incidents to be formally reported, investigated and reflected upon	MvdW	Complete	G
	• Establish monthly mortality & morbidity meetings	MvdW	Complete	G
	• Anaesthetics private practice arrangements confirmed and clearly audited (linking with private practice for obstetrics)	MvdW	Ongoing	G
	• Compliance with clinical guidelines to be routinely audited and reported to clinical governance sessions. (First priority to demonstrate compliance with anaesthesia guidelines for Fractured Neck of Femur patients, linking with the #NOF action group).	MvdW	1.12.12	
	• Trainees to be involved in clinical governance sessions and routinely reporting incidents/concerns.	MvdW	Ongoing	G
	• Review job plans for all anaesthetics consultants	MvdW	Complete	G
	• Confirm consultant staffing levels are correct	MvdW	In progress	

	• Arrange an 'Anaesthetics Review Team' (ART) visit and deliver further action plan in response to all recommendations made	MvdW	1.11.13	G
	Expected Project Completion Date: 31 December 2013	MvdW	31.12.13	
14. #NOF Audit - Patient Safety Mitigation Plan	**Programme Aims 18, 19, 20 21, and 22**			
Implement patient safety mitigation plan in response to #NOF audit outcomes.	• Develop PID/Action Plan	AM	29.7.13	B
	• Complete all immediate actions planned in response to areas of specific clinical concern:			
	- Trust documentation guidelines reissued	MvdW	Complete	G
	- All patients to have orthopaedic, anaesthetic and medical registrar review within 12 hours of admission	MvdW	Complete	G
	- A&E staff and orthopaedics staff to be issued with national analgesic guidelines	MvdW	Complete	G
	- Reduce use of general anaesthesia by ensuring consultant presence	MvdW	Complete	G
	- All patient to remain in recovery ward for 4 hours, unless consultant anaesthetist agrees with early transfer	MvdW	Complete	G
	- National guidelines for post-operative review by consultant within 24 hours to be followed	MvdW	Complete	G
	- All trainees to have direct consultant supervision during #NOF procedures (both anaesthetics & orthopaedics)	MvdW	Complete	G
	• Complete retrospective audit of 2012-13	MvdW	Complete	G
	• Establish #NOF action group	MvdW	Complete	G
	• Maintain review of compliance with best practice, with rolling 3-month audit reported to #NOF action group	MvdW	Ongoing	G
	• Review accuracy of coding of patient deaths with #NOF coded as the primary cause	MvdW	In progress	G
	• Review of orthopaedic consultant staffing levels and job-plans	MvdW	1.12.13	
	Expected Project Completed: 31 December 2013	MvdW	31.12.13	
15. Obstetrics & Gynaecology Review	**Programme Aims 18, 19, 20 21, and 22**			
Agree and implement a plan in response to the external review commissioned from the Royal College of Obstetrics and	• TORs for RCOG Review produced (to include gynae oncology pathway)	MvdW	28.8.13	B
	• Action plan in place to deliver reduction in C-section rate and actions on target	MvdW	Ongoing	G
	• Private practice guidelines issued to consultants and monitoring underway.	MvdW	Complete	G
	• Expected RCOG Review Date: 10/11 October 2013	MvdW	Complete	G
	• Action Plan compiled in response to external review	MvdW	TBC	

Gynaecology (RCOG).				
	Expected Project Completion Date: To be confirmed when RCOG Review is received	MvdW	TBC	

16. Care Bundle Implementation Project	**Programme Aims 18, 19, 20 21, and 22**			
Implement care bundles across common respiratory conditions such as pneumonia and sepsis.	• *Develop PID/Action Plan*	AM	29.7.13	B
	• *Care bundle for hospital acquired pneumonia agreed and put into action.*	MvdW	Complete	G
	• *Care bundle for community acquired pneumonia agreed and put into action.*	MvdW	Complete	G
	• *Care bundle for sepsis agreed and put into action.*	MvdW	Underway	G
	Project Completed: 9 September 2013	MvdW	9.9.13	G

Glossary

AAU – Acute Admission Unit
ANP – Advanced Nurse Practitioner
ART – Anaesthetics Review Team
BDO – Internal Audit
CCG – Clinical Commissioning Group
CD – Clinical Director
CDD – Clinical Discharge Date
CDU – Clinical Decision Unit
CQC – Care Quality Commission
DGM – Divisional General Manager
ED – Emergency Department
EDD – Expected Date of Discharge
ESD - Early Supportive Discharge
GGI – Good Governance Institute
GMC – General Medical Council
GUM – Genito-Urinary Medicine
HCAs – Health Care Assistants
HEEoE – Health Education East of England
HON – Head of Nursing
HSMR – Hospital Standardised Mortality Ratio
HTM – Hospital Technical Memorandum
IC – Infection Control
IMAS – (NHS) Interim Management and Support
ITU – Intensive Therapy Unit
KPI – Key Performance Indicator
MDT – Multi-Disciplinary Team
#NOF – Fractured Neck of Femur
PID – Project Initiation Document
PMO – Project Management Office
PPIs – Proton-pump Inhibitors (a group of drugs)
RAMI – Risk-Adjusted Mortality Index
RCA – Root Cause Analysis
RSR – Risk Summit Response
SAU – Surgical Acute Unit
SHMI – Summary Hospital-level Mortality Indicator
TDA – (NHS) Trust Development Authority
TIA – Transient Ischaemic Attack (mini stoke)
TORs – Terms of Reference
WTE – Whole Time Equivalent

Italics used for actions from original risk summits

8. Programme Risk Log

Description						Action						
No	Description	Initial Likelihood	Initial Impact	Initial Rating	Planned Response	Controls Identified / Mitigation	Deadline	Current Score	Exec Owner	Current Status	Raised	Cleared
3	Lack of Executive capacity to deliver	3	3	9	Mitigate	Consider use of interim staff	Ongoing	6	SJ	Open	03 Jul 13	
7	Loss of TDA/CQC/CCG support for Trust	3	5	15	Mitigate	Deliver programme effectively and at pace	01 Aug 13	6	SJ	Open	03 Jul 13	
8	Inadequate support from staff, patients, carers and families	3	3	9	Mitigate	Produce good Communications Plan	01 Sep 13	9	AT	Open	29 Jul 13	
9	Loss of staff morale due to pace of change	4	3	12	Mitigate	Celebrate success and improvement	01 Sep 13	9	SJ	Open	29 Jul 13	
10	Loss of key staff at short notice	3	3	9	Mitigate	Consider use of interim staff capacity	Ongoing	9	AM	Open	29 Jul 13	
11	Lack of staff “buy-in” to Programme aims	3	3	9	Mitigate	Involve people to promote ownership	01 Sep 13	6	AM	Open	18 Aug 13	
12	Lack of staff skill in project management	3	3	9	Mitigate	Offer training sessions for project leads	01 Nov 13	9	AM	Open	02 Sep 13	
13	Reputation risk from adverse media stories if communications not managed proactively	3	3	9	Mitigate	Proactive media handling and ensure Communications Plan is kept “live”	Ongoing	9	AT	Open	09 Sep 13	
14	Poor quality of underlying data	4	4	16	Mitigate	Improve quality of patient records/coding	Ongoing	16	PJ	Open	17 Sep 13	
1	Lack of coordination and control of projects	4	4	16	Mitigate	Interim Programme Director Appointed	Complete	3	SJ	Closed	03 Jul 13	30 Sep 13
2	Lack of Trust Board assurance of delivery	3	3	9	Mitigate	New Board Sub-committee created	Complete	3	SJ	Closed	03 Jul 13	30 Sep 13
4	Delay in delivery of project milestones	3	3	9	Mitigate	Create PMO to ensure progress	Complete	3	AM	Closed	29 Jul 13	30 Sep 13
5	Lack of clarity of objectives/timescales	4	3	12	Mitigate	Good programme management	Complete	3	AM	Closed	29 Jul 13	30 Sep 13
6	Lack of understanding of desired end states	4	3	12	Mitigate	Define Desired Project Outcomes	Complete	3	AM	Closed	29 Jul 13	30 Sep 13

9. Project Issues Log

Description				Action						
No	Issue Description	Initial Rating	Project Number	Controls Identified / Mitigation	Deadline	Current Rating	Issue Owner	Current Status	Raised	Cleared
1	Significant project costs agreed in principle only at this stage.	3	1	Split programme into phases (design / delivery) and focus existing staff input.		3	LG	Open	07 Oct 13	
2	New complaints processes not yet followed in 100% of cases.	2	4	Continue audit and education of staff.		2	JA	Open	07 Oct 13	
3	Funding only recently confirmed so cash not yet received.	4	5	Mitigation: use of Trust capital initially in close liaison with TDA.		1	LG	Open	29 Sep 13	
4	Funding for additional paediatric nursing and midwifery posts has yet to be confirmed.	3	6	Need for 1 -2 more posts has been identified and service pathways are being reviewed to confirm.		1	JA	Open	07 Oct 13	
5	Supervisory nurse leaders not recruited for all wards.	3	7	Recruitment campaign underway (see Project 6).		3	JA	Open	29 Sep 13	
6	Ward cleaning requirements & schedules still to be agreed.	4	8	Director of Strategy & Infrastructure leading to resolve this issue.		4	LG	Open	07 Oct 13	
7	Vacancies in infection prevention and control team (small team so significant impact on team).	3	8	Recruitment underway. Appointment made to ‘AD for Infection Prevention and Control’ starting in Jan 2014.		3	JA	Open	07 Oct 13	
8	Lack of robust RTT processes will delay other improvements.	4	9	The Referral Systems & Processes Project acts as mitigation.		4	BB	Open	07 Oct 13	
9	Consultant cover insufficient for enhanced thrombolysis cover.	4	11	Complete Business Case for additional consultants.		4	BB	Open	07 Oct 13	
10	Data quality issues identified affecting data accuracy credibility.	3	12	Identify actions to improve data quality from patients’ notes and coding.		3	PJ	Open	07 Oct 13	
11	Funding required additional consultant anaesthetists.	2	13	Business Case will be developed to show funding plan.		2	MvdW	Open	07 Oct 13	
13	Availability of staff to deliver consultant-led care.	2	15	Review consultant staffing levels after RCOG visit and audit of job plans.		2	MvdW	Open	07 Oct 13	
14	Ensure use of care bundles become routine.	2	16	Rolling audit of their use throughout RSR programme.		2	MvdW	Open	07 Oct 13	