Appendix A

Update to the Action Plan to address Warning Notices Issued by Care Quality Commission and Monitor Enforcement Actions

1.1 Introduction

In response to the CQC warning notices received by the Trust in December 2013 and the Monitor enforcement undertakings, the Trust Board met to develop an Action Plan to return the organisation to compliance with CQC standards. The high level Action Plan and Detailed Milestone Plan have been presented to the Oversight and Assurance Group held on 3 February 2014.

The Trust has established a programme management function to co-ordinate, oversee and report on progress in achieving the Action Plan. A highlight report is produced by the programme management office lead on a weekly basis and discussed in detail at the Quality Programme Board.

Following the CQC inspection in February 2014 and reflecting on the progress made to date, the Trust has taken the opportunity to review and refresh the Action Plan. This document outlines the following:-

- Actions that are completed;
- A summary of actions that are ongoing with an outline of future plans; and
- New actions that the Trust Board considers necessary to drive and embed quality within the organisation.

The Trust recognises the importance of embedding qualitative changes into business as usual and demonstrating to key stakeholders that the actions are having the anticipated impact on quality. A template evidence document is attached at appendix 1 that outlines the actions taken by the Trust, the evidence base that demonstrates that the action has been implemented, the expected outcome and the ongoing mechanism for monitoring the impact.

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2.1 Completed Actions

Through the weekly reporting and scrutiny at the Quality Programme Board, the Trust is satisfied that the following actions have been completed and that, where appropriate, a mechanism is in place to monitor the impact of the action on an ongoing basis.

Ref	Action	Response	Ongoing monitoring of the impact
1.9	Continue to engage with Sodexo to improve the food service.	Sodexo have introduced a new menu based on patient feedback. The menu makes it clear that the full choice (halal, kosher, vegetarian) is available to all.	Fortnightly monitoring of the take up of the new menu by Sodexo. Monthly reports to QPB. Performance against ward dashboards.
2.2	Make changes to nurse leadership roles in appropriate areas.	Changes have been made to matrons in some areas.	Ward quality rounds and safety thermometers will be used to monitor the effectiveness of nurse leaders.
3.1	Recruit a Hotel Services Director to drive improvement.	A Hotel Services Director has been appointed and commenced on 6 January 2014. His remit focuses on facilities, including cleaning, catering and portering.	None required.
3.2	Commission a review of cleanliness from an appropriate organisation and implement recommendations made.	A review of cleanliness was commissioned from Green and Kassab. The Trust has received the recommendations and has developed a plan to respond to areas of weakness (see ongoing action 3.3)	None required. QPB will monitor the cleaning plan included under action 3.3 to implement the recommendations.
3.6	Improve education of Hibiscrub.	Representatives from Hibiscrub visited the Trust to provide training to staff where required. Leaflets on how to use Hibiscrub have also been printed for use by staff on wards. Ward walks have confirmed a sound understanding by staff that Hibiscrub should be used undiluted and that each patient has their own bottle marked with their name.	Ward matron's audit tool.
5.3	Review the need and availability of hoists	Hoist requirements have been reviewed throughout the Trust.	An annual review of the working condition and availability of hoists will take place, led by Health and Safety.
6.3	Develop safe staffing metrics.	Safe staffing metrics have been agreed by the Executive Board. At a minimum, one registered nurse to 8 patients (day) and 10 patients (night) is required.	Monitored through the retrospective and prospective staffing levels report (see 6.2 above).
6.7	Conclude an agreement with a big 4 firm to enable a short term increase in senior management capacity to underpin the delivery of action plans and other organisational priorities.	The Trust has secured additional capacity to support senior management until 31 March 2014. This includes a PMO lead responsible for monitoring the delivery of the CQC Action Plan and reporting to the CEO and Quality Programme Board.	Not required.

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Ref	Action	Response	Ongoing monitoring of the impact
7.1	External review of maternity cluster of incidents.	The review by Professor Draycott has been completed and fed back to the Trust. An initial action plan was implemented to address the recommendations. Further action plans to provide better management support have been developed with the set up of Division D.	Implementation of the obstetrics and gynaecology action plan and the successful set up of Division D. Review of SI tracker by Healthcare Governance Committee.
7.4	External review of falls.	The Trust invited Professor Adam Darowski, a consultant physician and experienced falls expert from John Radcliffe Hospital to review the falls data at the Trust. Having met with the Trust and reviewed the data, Professor Darowski recommended that FallSafe is implemented at the Trust and that regular audits take place. This mechanism is now in place.	The safety thermometer for each ward includes measurement of falls with harm. Ongoing audits of falls through implementation of the FallSafe programme. Falls will also be measured by the Falls Steering Group.
10.1	Establish and disseminate a single policy on the sharing of patient information with relatives. Policy to be based on good practice and shared learning from other organisations.	The Trust has provided clarity to staff on how to share information with relatives. A mythbusting e-mail has been sent to lead nurses and ward managers to highlight how to share information and what can be shared.	None required.
10.4	Remove first aid kits from wards.	Wards and other non-clinical areas have completed a risk assessment to determine if a first aid kit is required. Those areas that require first aid items have been provided with replenished kits.	The Health and Safety team will perform an annual audit and review of the risk assessments and first aid kits in all areas.
10.7	Review the usage of current red mark scorecards on the wards and provide clarity on what is being measured and why.	A standardised model has been developed. Safety crosses are being used for falls and pressure ulcers only. This has been communicated to staff and the safety crosses are displayed on the ward quality boards.	Ward quality rounds – includes requirement to check that the quality boards are up to date.

2.2 Ongoing Actions

The Trust is continuing to implement a number of other agreed actions. In some instances, the detailed work to develop and implement plans has identified that a different target date for implementation is required.

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
1. Respecting and involving people who use services						
1.1	A technology enabled programme to continuously monitor patient satisfaction, with the intention of capturing feedback and using it to play it back to medical and nursing staff to identify their training needs and foster a greater understanding of the patient's needs.	DoN	February	February	Agreed a series of questions aligned to the Picker inpatient survey. Volunteers trained and arrangements in place to free up staff. First feedback collected.	Monthly reports to the Quality Programme Board. Inclusion of key metrics into the ward dashboard.
1.2	Build a customer care programme for all patient facing staff incorporating a set of basic "Always" themes.	DCEO	January	March Rollout (March – December)	Met with and understood programme from Frimley Park. Trainers have observed Frimley's training programme.	Customising the programme to fit with HWP. Roll out of initial training to managers followed by workshops with other staff. Evaluation process to be introduced.
1.3	Implement changes to a number of ward layouts to improve bed flexibility for patients whilst achieving single gender accommodation.	DoN	January	March	Switchable male/female toilet signs ordered and installed in ward areas with a focus on those where bays/beds are regularly switched between genders.	Assessment of the requirement for male / female signs for shower and wash rooms. Ordering and installation of any additional signs required. Monitor through ward quality rounds.
1.4	Implement a rolling programme for nurse leaders to ensure a sound knowledge of care standards that can be cascaded to others.	DoN	January	March	Task & Finish group established. Draft standards developed and sent to nursing staff for consultation.	Finalise and circulate agreed standards. Establish an ongoing mechanism to monitor compliance.
1.5	Set some common standards to enhance patient experience.	DoN	January	March	Rolling programme of 'did you knows' or mythbusters established to circulate to staff via the regular newsletter.	Drafting of content for newsletters and e-mail cascade.

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Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
1.6	Raise staff engagement through ~~joining~~ membership of the next "listening into action" programme	DCEO	January	January (2015)	Programme has commenced. Pulse survey issued and results used as Trust baseline. Sponsor group in place and lead appointed.	Invitations to every fifth member of staff on payroll to a 'Big Conversation'. Series of 'Small Conversations' to take place at ward level. Agreement of 3 areas of immediate focus by the sponsor group. Regular pulse surveys to track improvements.
1.7	~~Ensure that "Always" events are engrained in staff through a programme of communication with staff~~	DCEO	January	-	Reviewed Salford example of six always events. Focus group held to discuss HWP events.	Incorporated into action 1.2
1.8	Complete a programme of improving discharge planning. (**Safe discharges)**	COO	February	March	Policy drafted and circulated for comment. KPIs established. Mandatory discharge checklist developed and communicated to all staff.	Agreement of policy with internal and external stakeholders.
1.10a	Complete a rapid desktop review of MHPS cases	MD	January	March	NHS England report received which highlighted that some elements of the Trust policies were not fit for purpose. As a result of the finding, NHS England did not progress to undertake the desktop review of cases.	Recommendations of NHS England to be implemented (including update to policies, case manager / investigator training and appointment to Deputy MD position).

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Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
1.10b	Secure support for a medical governance review.	MD	January	July	Agreed that KPMG will undertake a review of medical governance.	Finalise scope of the review. Provision of documentation requested. Review recommendations and develop an action plan for implementation.
1.11	Develop proxy indicators for measuring cultural change	DCEO	January	March	Agreed to use LiA pulse survey responses to track and measure staff attitude across the organisation. The patient experience tracker will be used to measure the impact upon patients.	Reporting mechanism to be agreed.
2. Care and welfare of people who use services						
2.1	Develop and implement a plan to drive higher standards on wards 4, 7, 8, to incorporate KPI's to demonstrate improvement.	DoN	February	February	KPIs have been developed for each of the wards.	KPIs to be reported to the Quality Programme Board on a monthly basis.
2.3	Implementation of the ward dashboard to highlight issues	CIO	January	March	Initial indicators have been developed and a format agreed.	IM&T to liaise with key staff to identify data requirements, format and timescales. Monthly dashboards to be produced and reported to the Quality Programme Board and divisional governance meetings.
2.4	Increase the number of staff trained to deliver intentional rounding and patient observations.	DoN	March	May	Standard Operating Procedure developed and communicated. Ward walks have taken place to assess level of compliance. 4 individuals certified to train HCAs.	Training plan to be developed. Ongoing compliance monitoring.

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2.5	Complete and evaluate pilot programme on open visiting and relatives assisting in providing appropriate care (e.g. meal times)	DoN	February	March	Pilot completed. Feedback analysed. Decision to roll out open visiting to all areas. Guidance materials developed.	Communication of the decision to launch open visiting to all staff. Circulation of guidance. Launch event.
3. Cleanliness and infection control						
3.3	Implement recommendations from the cleanliness review.	DoHS	July	July	Recommendations reviewed and milestone plan developed to implement change.	Implementation of the milestone plan. Ongoing compliance checks of cleanliness. Reporting of cleanliness in zones for the OPR.
3.4	Complete a deep clean of the Trust	DoHS	January	April	Deep clean of all ward areas completed.	Development of specification and costing of a substantive deep clean team. Recruitment of deep clean team.
3.5	Replace equipment that is identified as a significant barrier to achieving a clean and infection free hospital. (Free standing equipment)	DoEF	January	March	Free standing equipment reviewed and new items ordered. New equipment rolled out to wards.	Installation of new drug cabinets. Ongoing delivery of items with longer lead times. Review of non-condemned equipment held in storage to assess whether it can be repaired. Implementation of a policy and process for equipment inspections to take place on wards on a periodic basis.
4. Safety and suitability of premises						

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Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
4.1	5 year prioritised plan to address £37m of estate issues identified in a 6 facet survey has been agreed with DoH. (Timeline as agreed with DoH)	DoEF	Various	Various	Immediate priorities addressed in advance of the CQC inspection. Capital business cases and plans have been refreshed to reflect completed works. 5 year capital plan consistent with OBC provided to FPH. 13/14 plan updated to reflect increase in capacity (eg. A&E) but expenditure on budget.	Drafting of 14/15 plan for April Board. Implementation of the capital plans.
4.2	Plan to address short term issues, such as toilet and shower facilities in ward 18 are being implemented. (Including storage issues)	DoEF	January	February	Ward action plans developed and prioritised. Short term issues such as ward 18 toilet and shower facilities addressed. 5 storage units now in place.	Longer term plan to be developed to cleanse the Planet FM system and use this for ongoing planned and reactive maintenance.
4.3	**Infection control** signage being installed	DoEF	January	February	Infection control signs with hand gel installed throughout the Trust. Domestic staff given responsibility for checking and replenishing hand gel.	Ongoing monitoring mechanism that hand gel is replenished to be established.
4.4	Trust signage plan to be completed **(Non-infection control)**	DoEF	July	July	Signage company engaged to undertake rolling audit of areas. Lead appointed to establish agreed names for areas in the Trust.	Small governance group to sign off plans and quality check proofs of signs. Installation of new signs.
4.5	Implementation of an adequate lockable security solution to secure site.	DoEF	March	March	Six requisitions placed for lockable security solutions. Installation plan agreed and has commenced.	Communication of clear policy on expectations re lockable areas. Compliance checking that appropriate areas are locked in accordance with the policy.
5. Safety availability and suitability of equipment						
5.1	Accelerate and re- prioritise the equipment replacement programme to ensure that everything is fit for purpose –	DoEF	January	March	Survey of macerators by Vernacare. 20 new items required. 9 new macerators installed. All macerators	EBME service to be reviewed. EBME equipment condition to be validated

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
	e.g. all macerators to be under 5 years old.				over five years old are being replaced.	and reported back to medical electronics on a periodic basis.
5.2	Review the working condition of equipment (e.g. resuscitators).	DoEF	January	January	Ward action plans include a list of equipment required. Monthly audits of equipment take place to ensure that items are in working condition. EBME have reviewed all resusitaires and confirmed that they are in working order.	Ongoing monitoring of equipment through monthly audits, ward quality rounds and Planet FM.
6. Staffing						
6.1	Secure additional support to ensure that persistent workforce performance issues are resolved (eg. General Surgery)	MD	January	December	Fiona Reed and Associates appointed to address inter-personal issues within general surgery.	Meetings to take place with general surgeons.
6.2	Complete implementation of ward staffing system to ensure that safe staffing levels can be monitored at Senior Management level.	DoN	January	March	Daily report produced as a forward look and circulated to senior nurses daily. Weekly report identifying shifts that fell below expected levels produced and ADs asked to explain the actions for red shifts. Forward looking report produced to consider staffing over a 7 week period.	Upward reporting mechanism to be finalised – to be included within the ward compliance reports and discussed at Healthcare Governance Committee and Board.
6.4	Deliver programme to enable “real-time” understanding of staffing levels to include cleansing of ESR data	DoN	July	August	Plan for implementation developed and agreed.	Implementation of integrated nursing and medical rostering and interface with NHS Professionals. Development of a real time report on staffing levels.
6.5	Ensure that all “non uk” health professionals receive adequate acclimatisation support during induction	DCEO	January	March	Lead for overseas nurse induction identified. Feedback from current cohort of	Plan for updated induction procedure to be agreed and implemented.

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
					overseas nurses collated.	
6.6	Organisational development review to include leadership development	CEO	June	June	See 1.2 – Customer care programme See 1.4 – Nurse leadership programme See 1.6 – Listening into Action See 1.7 – Always and Never events See 1.11 – Cultural indicators See 2.2 – Changes to nurse leadership roles See 6.1 – Addressing persistent workforce issues including general surgery See 7.1 and 7.2 – Review of maternity incidents and services	Ongoing actions to implement organisationalchanges.
7. Assessing and monitoring the quality of service provision						
7.2	External review of Maternity Services	MD	January	March	Royal College review commissioned and completed. Awaiting receipt of report and recommendations.	Develop actions in response to the findings.
7.3	Review of safeguarding with support to receive assurance	DoN	January	March	Training requirements assessed for children and adults. Training implemented for adults. Datix module for safeguarding reports implemented.	Training on childrens safeguarding. Quarterly reporting (first report to April Board).
7.5	Complete implementation of a ward dashboard to drive continuous improvement and reporting up through the Trust	CIO	January	March	Indicators agreed. Key stakeholders engaged on data requirements and timescales. First draft dashboards produced and feedback obtained.	Process review by IM&T. Monthly reporting.

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Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
7.6	Complete implementation of ward quality rounds (with matron assessments peer reviewed against independent perspectives)	DoN	February	March	Guidance has been circulated to matrons, lead nurses and the Executive Team. Discussions held on revising the ward quality round questions to ensure that some of the CQC actions can be monitored through this mechanism.	Revised ward quality round questions to be finalised and included within the electronic survey. Summary report to Executive Team and Board to be developed (incorporate into action 11.21)
7.7	Ensure that approaches that have yielded improvement on wards 1, 3, 5, 17 and 18 are shared to enable a broad based change across the Trust.	DoN	January	June	Presentations to matrons meetings on what makes a good ward.	Shared learning to be incorporated into the Action Learning Sets. Future matrons meetings to include consideration of themes of Datix incidents, compliance reports and ward dashboards to facilitate awareness and shared learning.
8. Records						
8.1	Programme to review clinical records prior to automation	CIO	July	July	Patient records review complete and catalogue of documents developed. Recommendations developed.	Agree recommendations based on a cost-benefit analysis of storage vs scanning.
8.2	Retrieval and storage of records via funded EDM project	CIO	July	October	OJEU tender published. Work ongoing to establish scanning volumes.	Scanning volumes to be finalised. ITT to be published. Contractor to be appointed.
8.3	Review of nursing documentation complete	DoN	January	March	Policy, guidance and standard documentation developed and approved.	To be included as part of the ward quality round checklist to ensure that it is embedded within the organisation.
8.4	Reinforce and police the need for correct documentation	DoN	January	March	Ward walks have taken place to confirm that standard documentation is in use.	To be included as part of the ward quality round checklist to ensure that it is embedded within the organisation.
9. Governance						
9.1	Agree terms of reference with Monitor	DoCA	January	January	Terms of reference drafted and submitted to Monitor. Verbal agreement that Monitor is satisfied with the content.	Formal agreement from Monitor.

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Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
9.2	Commission a governance review	DoCA	January	February	Desktop review of governance undertaken with key themes identified. Structural map re-designed and issued to Executive Board for comment. Standard operating procedure drafted. Good Governance Institute approached to review arrangements.	Agreement of structural map. Finalise Standard operating procedure. Formal agreement with the Good Governance Institute.
9.3	Review findings of governance review and develop an action plan	DoCA	February	July	-	Implement recommendations arising from the Good Governance Institute review.
10. Other						
10.2	Review staff training for individuals with learning disabilities	DoN	January	May	Identification of individuals who require training. Core principles developed and circulated to nurses.	Training plan to be developed and implemented.
10.3	Develop a system for marking equipment as "clean and ready for use"	DoN	January	March	Guidance issued on items that should be marked with an “I am clean” sticker.	Monitoring to take place through ward quality rounds.
10.5	Implement 8-8 working hours for staff on the reception desk	COO	January	February	Arrangements have been in place at Wexham Park since mid January.	Substantive posts to be appointed.
10.6	Review the policy on injectable medicines to determine whether one or two nurses are required. Update the policy as required.	DoN	January	February	Policy reviewed and considered appropriate. Reminder issued on medicines management to all staff.	Scheduled regular review of the policy.
10.8	Re-issue Datix passwords to ward managers, lead nurses and clinical leads	DoCA	January	February	Quick guide to Datix developed and distributed to staff. Ward walks have confirmed that appropriate staff have access to Datix, including the reporting features.	Further staff training to take place. Ongoing monitoring. Potential item to include in the ward quality rounds.

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Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
10.9	Implement a system to identify and disseminate newly produced professional clinical guidelines (other than NICE)	MD	February	March	Terms of Reference mirroring NICE guidance dissemination prepared and circulated for comment.	Finalise and communicate the policy and mechanism to capture non NICE guidance.
10.10	Establish an assurance process to ensure that intentional ward rounding and care plans are in place.	DoN	January	-	Standard Operating Procedure developed and communicated. Ward walks have taken place to assess level of compliance.	Incorporated into action 2.4.

2.3 New Actions

The Trust's Executive Team has taken stock of the current challenges that it feels the organisation is facing, together with the informal feedback provided by the CQC in February 2014. This has led to the development of the following additional actions which will continue to be monitored by the programme management office lead and reported to the Quality Programme Board.

Ref	Action	Reason for the action	Intended outcome	Responsible	Completion date
11.1	Agree a review of sickness absence by internal audit.	CQC inspection queried the accuracy of the reported sickness absence figures.	Assurance that that the reporting of sickness absence is appropriate.	DCEO	March
11.2	Ensure that the boarding pass is used for all handovers to agency staff and that appropriate induction takes place.	Concerns over inadequate handovers with agency staff as noted in CQC 3.	Agency staff are familiar with basic ward facilities (such as the location of the crash trolley) and with the standard documentation used in the Trust.	DoN	March
11.3	Commission external resource to investigate bullying and harassment claims at the Trust and develop a programme of training to target bullying behaviour and to support managers to have difficult conversations/hold people to account.	Allegations of bullying and harassment from various sources together with feedback that the Trust is not holding people to account (staff survey and CQC feedback).	People are held to account without feeling that they are being bullied.	DCEO	April
11.4	Provide support to wards that require additional help to improve quality. This will include providing ongoing training to all lead nurses and matrons together with clarified job descriptions.	Trust and CQC concerns about Snowdrop, wards 2, 20 and 17. Other wards to be identified on an ongoing basis through the ward quality metrics (compliance, staffing and dashboards).	Improvements to quality demonstrated through the ward dashboards.	DoN	July
11.5	Review and deliver medical device training.	Some senior nurses do not have up to date medical device training which is compromising their ability to train more junior members of staff.	Improved training and records for medical devices.	DoN	June
11.6	Implement recommendations of the NHS England review of MHPS policies.	The NHS England report has identified that the MHPS policies within the Trust are inadequate. The policies require revision and approval by the LNC. Training for staff to enable them to manage MHPS cases is also required.	LNC approved policies and well-trained and supported staff able to manage case reviews.	MD	July

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Ref	Action	Reason for the action	Intended outcome	Responsible	Completion date
11.7	Drive consistent use of the WHO checklist for all medical staff.	CQC review identified discrepancies between the checklist used in practice and the version published on the intranet.	Consistent and mandated use of the WHO checklist across both medical and surgical divisions.	MD	July
11.8	Set up division D with an appropriate governance structure.	The Trust has set up division D to split out the management of obstetrics and gynaecology from other services.	Division D is set up with a robust structure and clear knowledge and understanding of the expected governance mechanism.	MD	April
11.9	Establish a deep clean schedule and set up a team (internal or outsourced) to routinely cover all areas of the Trust on an annual basis.	A deep clean exercise has been undertaken and needs to form part of the Trust's business as usual.	Maintenance of the cleanliness of the hospitals.	DoHS	March
11.10	Develop RealTime as an operational tool.	The Trust has implemented RealTime but is not yet maximising the capabilities of the system.	RealTime to be used as an effective operational tool.	COO	TBC
11.11	Restructure the booking centre and outpatient process.	The Trust has identified that outpatient appointments are often cancelled at short notice or delayed.	Delivery of a more efficient outpatient service model to be measured using KPIs.	COO	TBC
11.12	Deliver improvements to the radiology service.	The CQC has expressed concern at a perceived radiology backlog that could cause clinical harm. The Trust has identified that a more robust capacity and demand plan is required and that further service improvements can be made.	A more efficient and planned radiology service that is able to cope with the projected demand.	COO	TBC
11.13	Review treatments and procedures to deliver a robust capacity plan informing operational planning for FY15. This will focus upon delivering internal professional standards.	The Trust and CQC have identified that patient flow is not as effective as it should be. Improved patient flow can be informed by a robust capacity plan and delivering to internal professional standards.	A robust capacity plan to facilitate improved patient flow. Clear expectations around internal professional standards (eg. Turnaround time for x-rays, scans, OT assessments etc).	COO	TBC
11.14	Review the elective access pathways and processes to deliver a more effective and efficient service.	The Trust and CQC have identified that patient flow is not as effective as it should be. In particular, there is a need to operate more cohesively across the related services to support the Trust in delivering better patient flow across the elective pathways.	Improved performance in particular to waiting list targets and a reduction in the backlog.	COO	TBC
11.15	Deliver improvements to the follow up appointments process.	The Trust has identified that booking procedures for follow up appointments should be reviewed.	An improved pathway for patients who require a follow up appointment.	COO	TBC
11.16	Perform a review of the emergency pathway, ambulatory care and hospital at night.	The Trust and CQC have identified that patient flow is not as effective as it should be. In particular, the CQC commented that the ambulatory care pathway is outdated.	Four ambulatory care pathways to be implemented with ongoing development of additional ambulatory care pathways and care at night.	COO	TBC

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Ref	Action	Reason for the action	Intended outcome	Responsible	Completion date
11.17	Review of occupational and physical therapy.	Backlogs have been identified in the provision of these services, indicating that they could be planned and operated more effectively.	A recovery plan for the improvement of occupational and physical therapy services.	COO	TBC
11.18	Transition the management of estates jobs back onto Planet FM.	Planet FM has been used ineffectively and has resulted in an influx of additional immediate reactive jobs. Planet FM has been supplemented with wards using spreadsheet based action plans to identify and monitor progress of estates work required.	Use of Planet FM as the sole mechanism for identifying and prioritising estates work and for communicating progress to Ward staff. Maximise the system capabilities to effectively manage property, plant and equipment. To improve ward communications with estates	DoEF	June
11.19	Develop a monthly Estates newsletter.	The Trust has recognised that communication between estates and other staff has not been effective. In particular, there is a need to clearly communicate to the organisation estates performance, upcoming planned works and good news stories especially in terms and capital investments being made to improve the working environment for patients and staff.	Improved communication between estates and other staff within the Trust.	DoEF	June
11.20	Develop a clear reporting timetable for ward quality information to be collated and reported to the Executive Team and Board. This will include the ward dashboard information, ward quality round compliance reports and safe staffing metrics.	The Trust has developed several mechanisms for reporting quality at ward level which need to be collated, summarised and reported to give a clear picture of quality. This will improve the ward-to-Board reporting.	Clear picture of quality at ward level and clarity for Board members on where quality is not meeting expectations.	DoCA	March

Appendix 1: Template evidence document

Action:

Reason for the action

Action taken by the Trust

Evidence

Expected outcome

Ongoing monitoring