Quality Improvement Plan – Subcommittee report to Board of Directors

Committee	Date
Quality Committee	21 July 2016

Actions considered for marking "blue" as embedded

Workstream	Action	Evidence reviewed and recommended to Board to mark "blue" (Y/N)	Comments
Personalised Care	4.1.1 Adopt a patient centred approach that involves patients in the planning, delivery and evaluation of Health Care	Y	Inpatient survey to be added
Personalised Care	4.1.2 Refine 150 care plans based on the pilot core assessment and care planning documents.	N	Committee requested to defer to August when meetings to ratify care plans are in progress
Personalised Care	4.1.6 Develop and implement a ward accreditation programme	Y	Summary to be included in Board Leadership walk round
Personalised Care	4.3.4 Review and implement safeguarding children and adult policies	Y	Amend spelling of Policies in 'detail' paragraph
Safety Culture	5.1.1 Establish a Patient Safety Culture Team with clinical lead and project support team to drive the programme of work	Y	
Safety Culture	5.1.2 Establish resource requirements (patient safety champions, clinical lead, full time project manager), programme structure, objectives and timelines	Y	
Safety Culture	5.2.6 Monthly meetings will be held between service leads and coding teams to ensure data quality	Y	
Safety Culture	5.4.7 All patients with a hospital acquired infection (starting with c-diff and MRSA) will have a RCA undertaken within 72 hours of diagnosis. A cause and action report submitted immediately to the Executive Team	Y	
Safety Culture	5.4.8 Achieve 90% compliance with hand hygiene throughout organisation through use of audits and responsive education	Y	
Safety Culture	5.4.12 Develop a systematic method of taking timely and appropriate specimens introduced	Y	Add PSQB into monitoring arrangements
Safety Culture	5.5.9 Put in place temperature checking sheets with both maximum and minimum recordings. Ward managers to	Y	

	ensure this is completed and daily review by matrons		
Timely Access	6.6.5'Establish data quality audit process covering outpatient (RTT & non RTT reporting, Waiting list, Inpatient and ED) Establish data quality audit process against the local access policy standards and CCG and trust defined patient pathways	Y	
Maternity	9.1.3 Escalation processes to identify deteriorating patients in place and used as required.	Y	
Maternity	9.1.5 Work with a partner in maternity to support the development of a patient experience programme	Y	
Maternity	9.1.6 Develop an action plan in response to 2015 Women's Experience of Maternity Care Survey.	Y	
Maternity	9.3.4 Address the issues raised by McKenzie Report	Y	

Comments on review of Red/Amber actions

Has the committee reviewed relevant workstream summaries?	Yes / ■ (Please delete)
Does the committee agree with the assessment of Red and Amber actions identified on those reports?	Yes / ■ (Please delete)
Is the committee satisfied with the executive lead's actions with regards these actions and have additional actions been required by the committee (please note)?	Yes - further clarification provided at Quality Committee regarding red actions and mitigation plans.

Additional comments from committee chair

Evidence was reviewed by the committee. All evidence challenged and agreed.