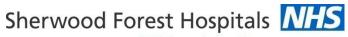


### **Quality Improvement Plan – Subcommittee report to Board of Directors**

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 cdiff 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	



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	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)	Υ	
	Establish data quality audit process		
	against the local access policy		
	standards and CCG and trust		
	defined patient pathways		
Maternity	9.1.3 Escalation processes to	Y	
	identify deteriorating patients in		
	place and used as required.		
Maternity	9.1.5 Work with a partner in	Y	
	maternity to support the		
	development of a patient		
	experience programme		
Maternity	9.1.6 Develop an action plan in	Υ	
	response to 2015 Women's		
	Experience of Maternity Care		
	Survey.		
Maternity	9.3.4 Address the issues raised by	Υ	
	McKenzie Report	T T	

### **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.			