PATIENT SAFETY

STAFF ENGAGEMENT AND LEADERSHIP

CLINICAL AND CORPORATE GOVERNANCE

OPERATIONAL PERFORMANCE

PATIENT EXPERIENCE

NHS
Isle of Wight
NHS Trust

Quality Improvement Plan

PAPER C

Forward

The Isle of Wight NHS Trust Board is pleased to present this Quality Improvement Plan as its response to the Care Quality Commissions findings that the Trust was overall "Inadequate" in its delivery of care to patients. The Board has endeavoured to understand the root causes of the failings in care provision and build this plan to systemically address those underlying causes to ensure that its improvement journey is one that leads to sustainable, high quality care.

The Board will focus its agenda on monitoring the delivery of the plan, removing blocks to success and managing risks to delivery. It will seek the support of external scrutiny from the CCG, LA, Patient Council, Healthwatch and others to help ensure the Board's assurance processes are robust. It will seek regular feedback from staff to help understand the impact of the Improvements and to ensure that staff and patients feel that the services they provide are improving.

The Board is committed to ensuring that the improvements required are undertaken well and at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC Inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting staff to improve services and innovate, the Board has set the ambition be rated "Good" by 2020.

Trust Profile

The Isle of Wight NHS Trust is an integrated trust which provides (as a % of total activity) acute (61%), ambulance (5%), community (20%) and mental health (14%) services to a population of approximately 140,000 people living on the Island. Travel to the mainland by ferry takes between 20 and 60 minutes depending on the route.

The Trust was established in April 2012, following the separation of the provider and commissioner functions. The Trust employs around 2,700 staff. The Trust receives £171m per annum to deliver all services.

The main trust services are: St. Mary's Hospital, a 245 bed general hospital and Sevenacres, a 50 bed mental health unit, located on the same site in Newport. Community health and mental health services are provided across three localities with bases at St. Mary's Hospital and clinics and health centres across the island. Woodlands, a mental health rehabilitation unit, is located in Ryde.

In the financial year 2016/17 the Trust undertook the following activity

Currency	Acute	Mental Health	Ambulance	Community
Inpatients	26,414	575	0	0
Outpatients	151,370	6,322	0	10,544
Other Contacts (inc. Community Clinics)	17,434	31,856	0	270,255
A&E	61,002	0	0	0
Patients Transported	0	0	14,820	0

Portfolio of Income

Income source	2016/17 £m
NHS Isle of Wight CCG Total	135.4
NHS England Total	12.8
Isle of Wight Council Total	6.6
Health Education England	3.8
NHS Creative	2.5
Other	10.0
Total	171.1

Partnership and Collaborative Working

The majority of the Trust's services are commissioned by the Isle of Wight CCG. For some services the CCG jointly commissions with the Isle of Wight Council and NHS England. In addition the Trust is part of a Vanguard new care model project with the Local Authority and Primary Care to deliver services in partnership with the voluntary and private sector, as set out in the Island's 'My Life a Full Life' vision for health and social care. This vision sets out the shape of services to be delivered on the Island and within the Trust's overall plans is work to deliver that vision within a Single System plan described below.

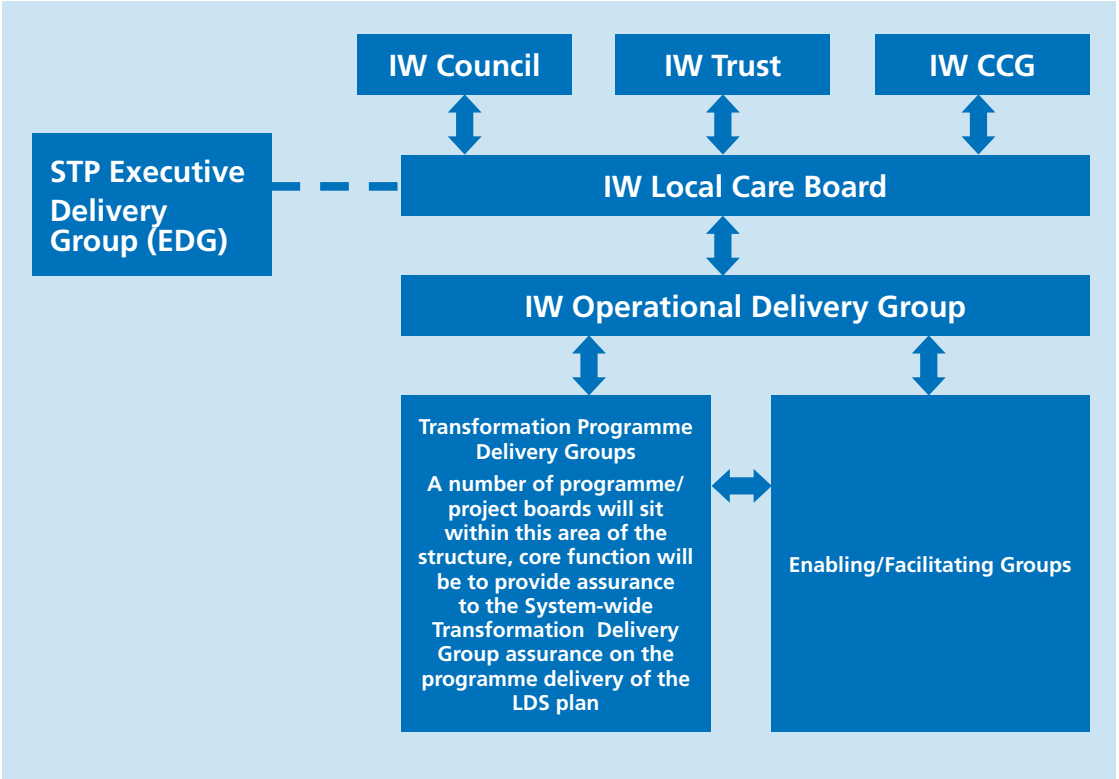
The Trust works as part of a whole system under the umbrella of the Hampshire and Isle of Wight System Transformation Plan (STP) working with other NHS Trusts and Local Authorities in that geography to provide networked and collaborative services at scale for the benefit of patients.

The Island has a Single System plan as part of the wider STP plans with a system leader to over see the delivery of that plan through a Local Care Board comprising the CCG, LA and Trust. The plan includes a System Improvement Plan and the Trust's QIP will seek to work in concert with that plan to ensure that where relevant, it is integrated with the system plans and to avoid duplication.

The Trust's work within its own wider Integrated Improvement Plan and Quality Improvement Plan will report actions, where relevant, into the Governance structures established for the Single System Plan and the wider STP.

The plan seeks to deliver the improvements the Trust requires internally and the ones where the Trust cannot improve alone and works in partnership with the local and wider system. Both are equally important and will be the focus for the Board.

Partnership Governance



Working with Partners

The Trust's services are not delivered in isolation and it is important that where they interface with partner organisations, or provide joint services, that the Trust maximises the value that can be added for patients through ensuring seamless pathways of care. To that end the Trust will seek to work closely with all partners to support its improvement journey. Examples would be the development of Integrated Community teams and the Acute Service Redesign Project.

Quality Summit

The Trust attended a Quality Summit on May 2 2017 held by NHSI involving partner organisations, patient representatives, commissioners and Regulators. The purpose of the summit was to work with all present to determine what support could be offered to the Trust.

An example of some the commitments made at the summit are within the table and the Trust will ensure that it pro-actively seeks to secure these commitments into practical deliverables that improve the quality of care for patients.

On-going Dialogue

A first draft of this plan has been shared with the IOW CCG and LA. In the discussion other areas of joint work were discussed, some specific to clinical pathways and greater involvement of primary care and others much broader to include recruitment of staff to the Island. The Trust will continue this dialogue to ensure the willingness and enthusiasm of partner organisations to support the Trust is harnessed and focused on improvements to services for patients.

Summit Commitments

Commitment	Organisation/Group
Clinical Advice and Leadership to support the Board with Mental Health Services	Mental Health Alliance
Shared approach to supporting some services with clinical staff job planned to work some sessions on the Island	Solent Acute Alliance
Support to Palliative and end of life care through moving to an integrated service	IOW Hospice
Redesign Community Mental Health Services	IOW CCG
Acute Mental Health service redesign	STP
Refresh the impetus and plans in My Life a Full Life	IOW Local Authority
Focus on patient outcome measures	Healthwatch and Oversight and Scrutiny
Support the development of a quality improvement culture	NHSI Chief Nurse and Chief Medical Officers
Develop improved patient feedback mechanisms and systems for co-production with patient groups	The Trust Patient Council

Quality Regulation and Monitoring

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC's role is to monitor and inspect services and to provide a rating of the quality of service provision against clear, published quality criteria. The CQC rate services using the following themes:

- ✔ Safety
- ✔ Effectiveness
- ✔ Responsiveness
- ✔ Caring
- ✔ Well

Services are rated as:

- ✔ Outstanding
- ✔ Good
- ✔ Requires Improvement
- ✔ Inadequate

And in addition the organisation receives an overall rating within the same categories

Immediate Findings

The CQC found immediate quality failings that Placed patients at risk of harm and issued a Section 31 Enforcement Notice for some aspects of the mental health services and a Regulation 17 letter covering a range of concerns across all services.

The Isle of Wight NHS Trust was inspected by the CQC between 22 – 24 November 2016 and a further additional inspection of mental health services was undertaken 18-19 January 2017.

The inspection was to follow up on areas identified as requiring improvement during a previous CQC inspection in June 2014 or if the CQC had not inspected the service previously

The (CQC) reviewed the following core services in:

- **Acute Services:** Accident and emergency, medical care (including older people's care) and end of life care.
- **Community Services:** Community health services for children, young people and their families, community adult services and community inpatient services.
- **Mental Health Services:** Acute inpatient mental health, psychiatric intensive care unit, rehabilitation wards, community mental health, community learning disability services, community children and adolescent mental health services, older adults wards, and substance misuse services.
- **Ambulance services:** Urgent emergency ambulance, emergency operation centre, patient transport services.

The CQC also inspected and assessed the 'well led' domain, which covers the overall leadership and management of the trust.

Trust Overall Rating

The full CQC report was published on 12 April 2017 and all services inspected were rated. The Trust's overall rating was Inadequate and the Trust was placed in Special Measures by NHSI, the Regulator of provider health services, also on 12th April 2017.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Care Quality Commission

C - 7

CQC Report Findings

The CQC inspection was extensive and comprehensive. The reports are lengthy and detailed. All full reports can be accessed through the links below:

(insert all links)

Within the reports there are 133 number of "must dos" and 93 number of "should dos". These requirements are far ranging and include some, straight forward "fixes" but in the main are each significant pieces of improvement work.

To address the shortcoming identified within the report the Trust has worked on identifying key themes and causes as set out in the chart.

The Trust Board Response:

The Trust Board accepted the reports without reservation and acknowledged their failing in their oversight of services. The Board apologised to patients and their carers and resolved to deliver the improvements required.

This Board consider that the successful implementation of this Quality Improvement Plan should ensure that when the CQC next inspect the Trust's services, the overall rating for the Trust will have moved to at least Requires Improvement by no later than March 2018 and will progress to Good by June 20/20

Key Issue	Root Cause
Board not sighted on many of the issues	Poor Governance Structures
Lack of visible leadership and disconnect between the Executive team and front line	Poor Leadership and Staff Engagement
Poor Leadership and Staff Engagement	Poor Leadership and Staff Engagement
Lack of performance management culture and holding to account	Poor Organisational Development
Little attention to organisational culture and staff development	As above
Inability to drive improvements to conclusion	Lack of consistency in plans, rapid changes to plans and limited project management
Paucity of meaningful information from data collection	Lack of Information and trend analysis
Lack of clarity of purpose	Lack of clarity of purpose

Developing a Culture of Continuous Improvement

In December 2016 NHS Improvement published Developing People, Improving Care.

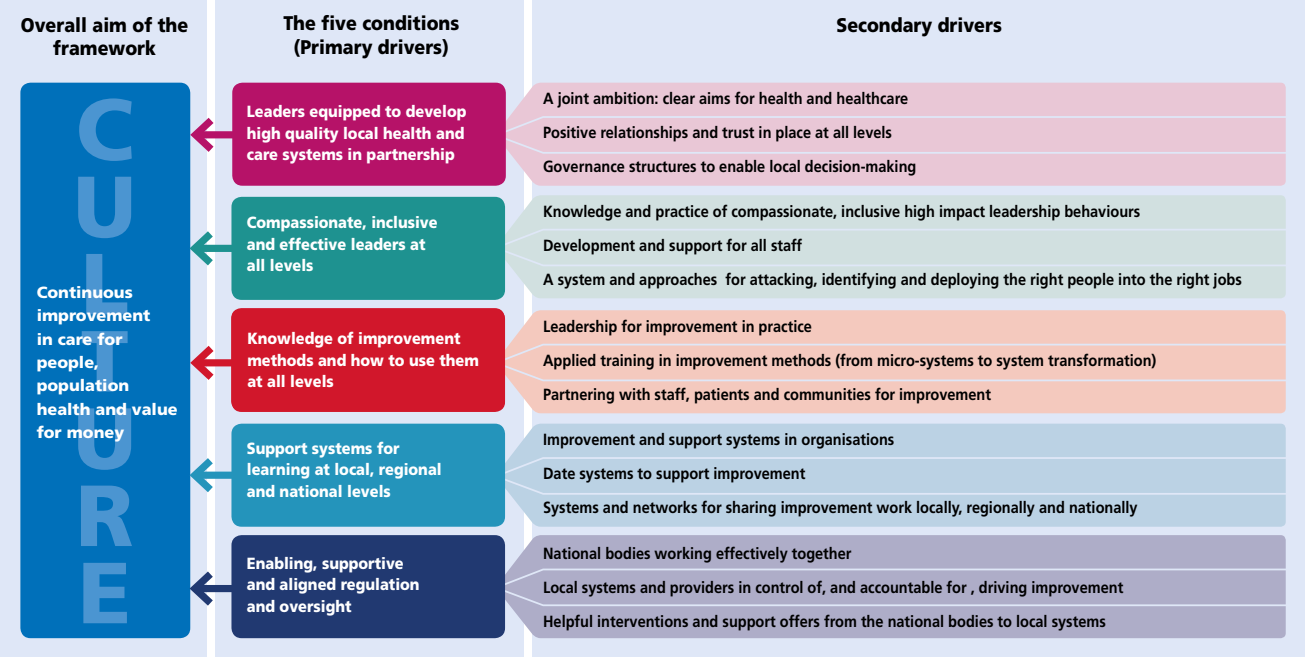
https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf.

The document sets out a framework for developing leaders within NHS organisations and building improvement skills in all staff based on significant evidence that the approach is effective in improving care for patients. The Trust Board is committed to developing and creating a positive, learning culture within the organisation and will seek to use the tools and techniques within the Framework as a bedrock from which to start the journey.

The Board recognises that the culture of the organisation starts from the vision and values that it sets. The Board will undertake its own capacity and capability review with the aim of building its own development programme based on the principles and conditions within the framework to ensure that it is equipped to lead and inspire the whole organisation.

Seeking to build skilled, compassionate, inclusive leaders within the organisation this plan includes significant work to assess the personal development needs of all its leaders, provide tailored support through personal development plans and build new skills by training a large group of staff in Improvement techniques.

This plan describes the actions that will be taken in the first 12 months toward achieving the goal that will take between 1-3 years to achieve and undertake work in the first 3 primary drivers described in the framework as set out below.



Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services

Our Approach to Improvement

The breadth and depth of issues highlighted by the CQC requires a solid understanding of the systemic fault lines within the organisation that led to the manifestation of the failings the CQC found. The Trust had many single issue action plans and no framework to drive the delivery of improvements or to monitor their effectiveness in resolving the problems.

The Trust has now built an Integrated Improvement Framework (IIF) and governance that captures all that activity into a single programme delivery methodology supported by a dedicated programme management team [see fig 1].The IIF is all encompassing and is now the vehicle for receiving and responding to any actions, recommendations or instructions for improvement that come from any external body or from internal investigations.

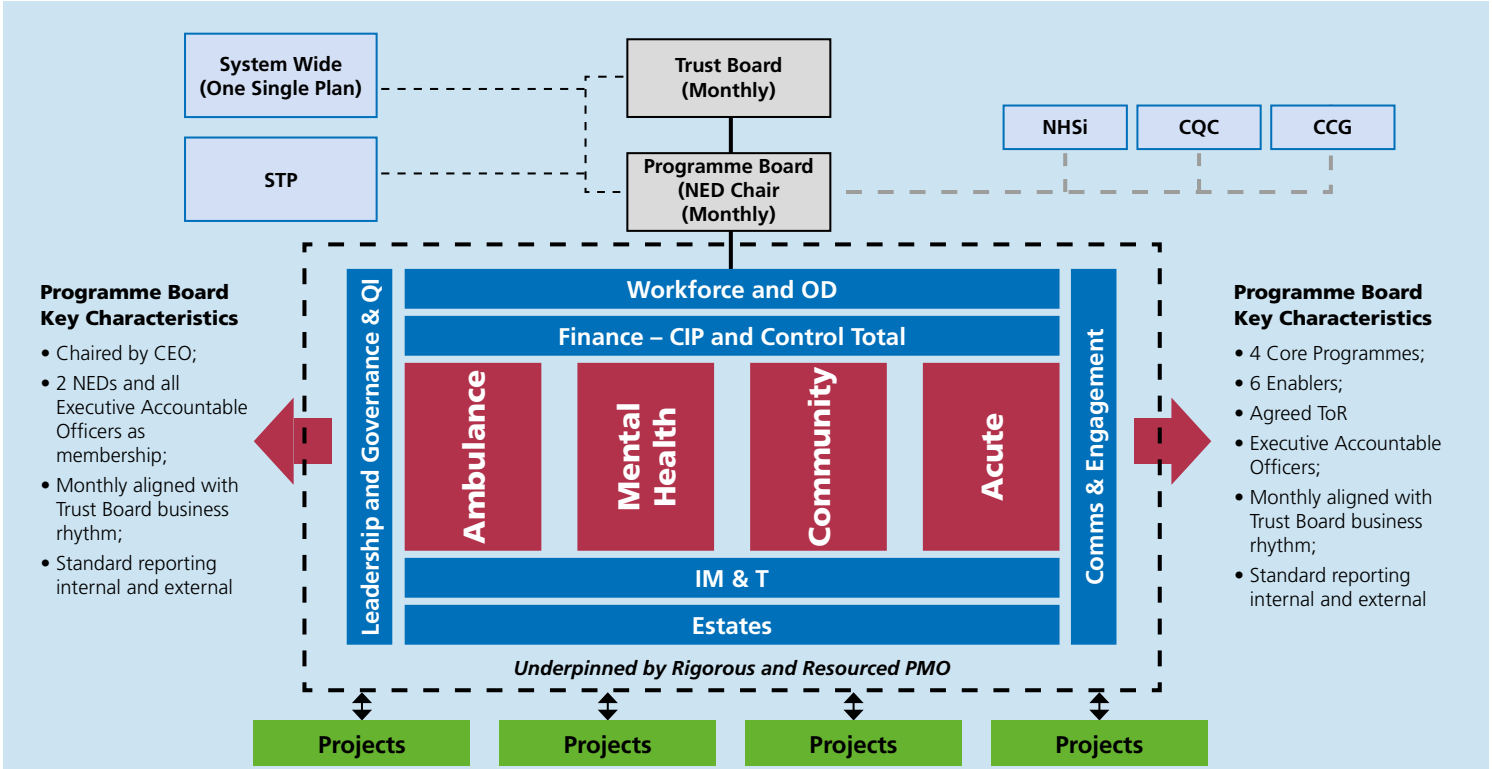


Fig 1 - The Integrated Improvement Framework

The Integrated Improvement Framework

The Integrated Improvement Framework comprises 4 specific service plans to drive improvements in those areas and 6 cross cutting plans that will improve care across all services. Each programme within the IIF has an overall goal to achieve and the plans within the programme show how delivery of that goal will be achieved. As example:

Community Service Programme:

To develop an infrastructure alongside partner colleagues that delivers more care, safely delivered, closer to home for the people of the Isle of Wight.

Finance Programme:

To establish and effectively implement systems and/or processes for effective financial decision making, management, governance and control to achieve Financial Recovery and Financial Sustainability whilst improving Quality

Estates Programme:

To ensure the Trust has a fit for purpose Estates and Facilities function with a clear Strategy and programme of work supporting the improvement in Estate for high quality and safe clinical service provision.

Actions within each programme are attributed to a source that includes CQC requirements, NHSI undertakings, Single System Delivery Plan etc. This ensures that we focus our efforts on the actions that will have the greatest impact for all and avoid duplication. As example, addressing the IT records issues in community services will address the concerns raised by the CQC and will also support the move to Integrated Community Services that is the requirement from the Single System Change plan. It will also contribute to improving staff morale as it has been a longstanding issue.

The Trust aims to ensure that it focuses its attention and resources on delivering the greatest improvements it can, at pace and where possible ensuring one plan can address multiple needs.

Quality Improvement Plan - QIP

Within the IIF is a significant subset of activity that will be described within this document that is the Trust's Quality Improvement Plan (QIP).

The QIP brings together the actions within the overall IFF that the Trust believe are the most significantly important and believe that getting traction on these actions will deliver the improvement required to hit the short term goal of an overall Trust CQC rating of at least Requires Improvement by March 2018 and the longer term ambition of an overall Trust rating of Good by June 2020.

The plan to achieve Requires Improvement is very detailed as it is our work plan for the next 11 months, however, in this time we will introduce, implement and start to embed a continuous quality improvement culture and capability within the Trust to ensure we do not only get into a position of increased safety and stability but the foundations are in place to navigate our challenging route to Outstanding can be delivered.

We will approach our Improvement Plan through:

- ✔ robust leadership to drive recovery;
- ✔ focused Board oversight and scrutiny;
- ✔ executive Accountability for delivery of improvement plans;
- ✔ building strong leadership at all levels within the Trust
- ✔ extensive staff engagement to drive innovation;
- ✔ a rigorous QI approach throughout the organisation;
- ✔ supported Programme and Project management;
- ✔ a single reporting structure for Board, Commissioners and Regulators;
- ✔ support and work with our partners on the island;
- ✔ support and involvement from patients, service users and the public;
- ✔ relationships with the Acute and Mental Health Alliances;
- ✔ external support from experts to address capability.

We will be evidence based and systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn from research.

Quality Improvement Focus and Goals

Having reflected on the findings of the CQC report and in consideration of the root causes and themes that have led to the Trust's poor performance, the Trust has identified 5 areas of focus for Quality Improvement.

Whilst issues were found within each service category

(Acute, ambulance, mental health and community), those issues can be grouped into the focus areas below and we can achieve improvements in each service through one set of actions in most instances.

This approach should ensure we achieve maximum benefit from the work undertaken. The IIF ensures that we have not forgotten or overlooked essential single service issues and we will be driving the IIF and the QIP at the same time through the same framework, thereby ensuring that the robust programme management and governance arrangements are simple and clear.

Quality Improvement Focus
Key Theme 1 - Patient Safety
Key Theme 2 – Patient/Service User Experience
Key Theme 3 - Staff Engagement and Leadership
Key Theme 4 - Operational Performance
Key Theme 5 - Clinical and Corporate Governance

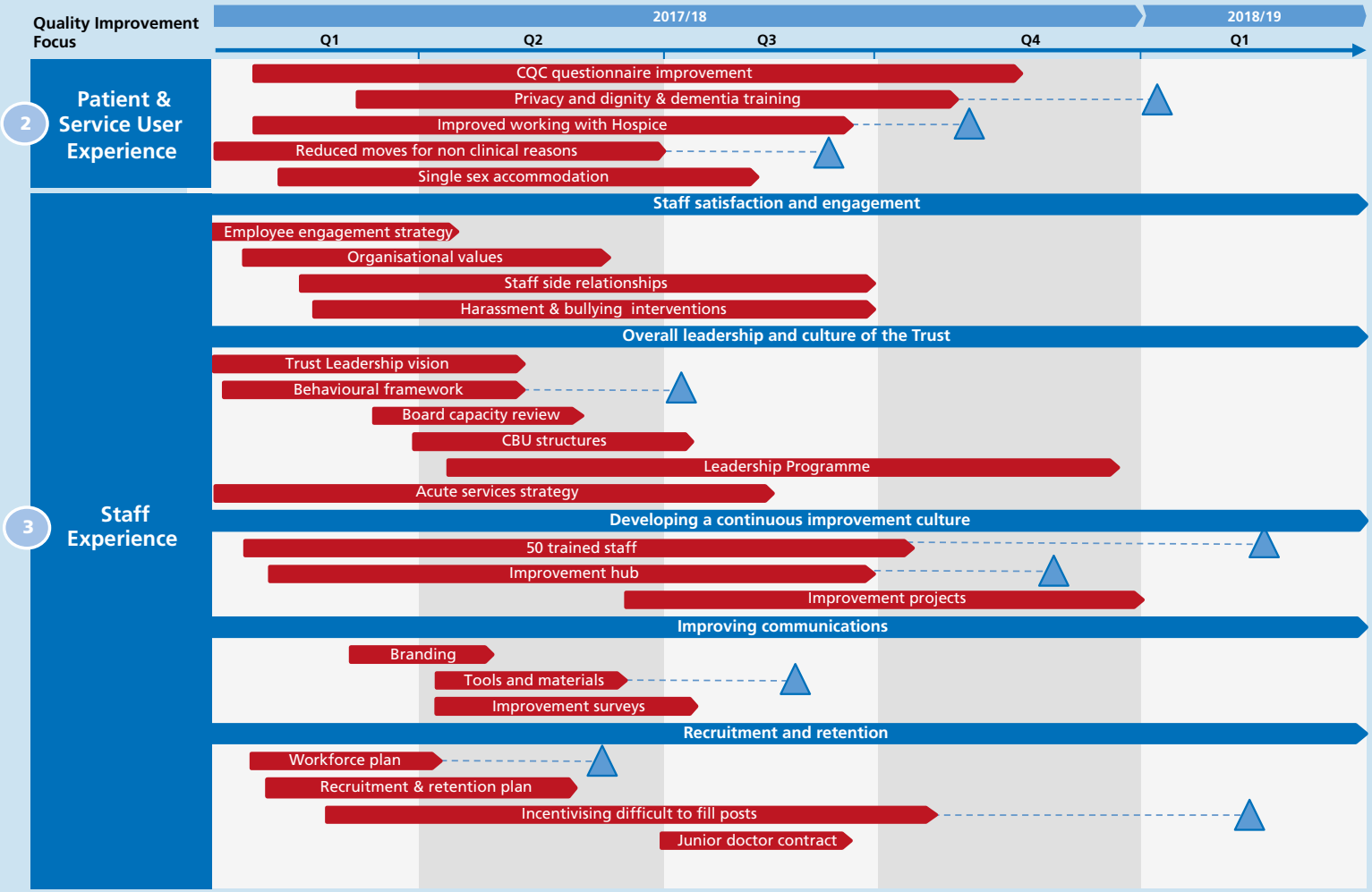
Our High Level Goals

Our QIP has goals and outcome measures to steer all its work, however, we have identified x high level goals as overall measures of success across all services to be assessed in February 2018.

- ✔ A reduction in avoidable harm to patients through improved clinical risk identification, mitigation and management
- ✔ Clear demand and capacity management of all services to improve patient experience and safety evidenced by improved access to all services and access target achievement and short wait times for assessment in all services
- ✔ An improvement in staff engagement by x
- ✔ The development of a continuous improvement culture through Board and leadership development and specific training in improvement methodology
- ✔ A reduction in reported bullying and harassment from staff about staff
- ✔ A net gain of x qualified nurses
- ✔ 80% compliance with all Mandatory training
- ✔ All operational national performance targets being met
- ✔ An increase in patient satisfaction by x

High Level Quality Improvement Plan for next 12 months commencing May 2017

High Level Quality Improvement Plan for next 12 months commencing May 2017



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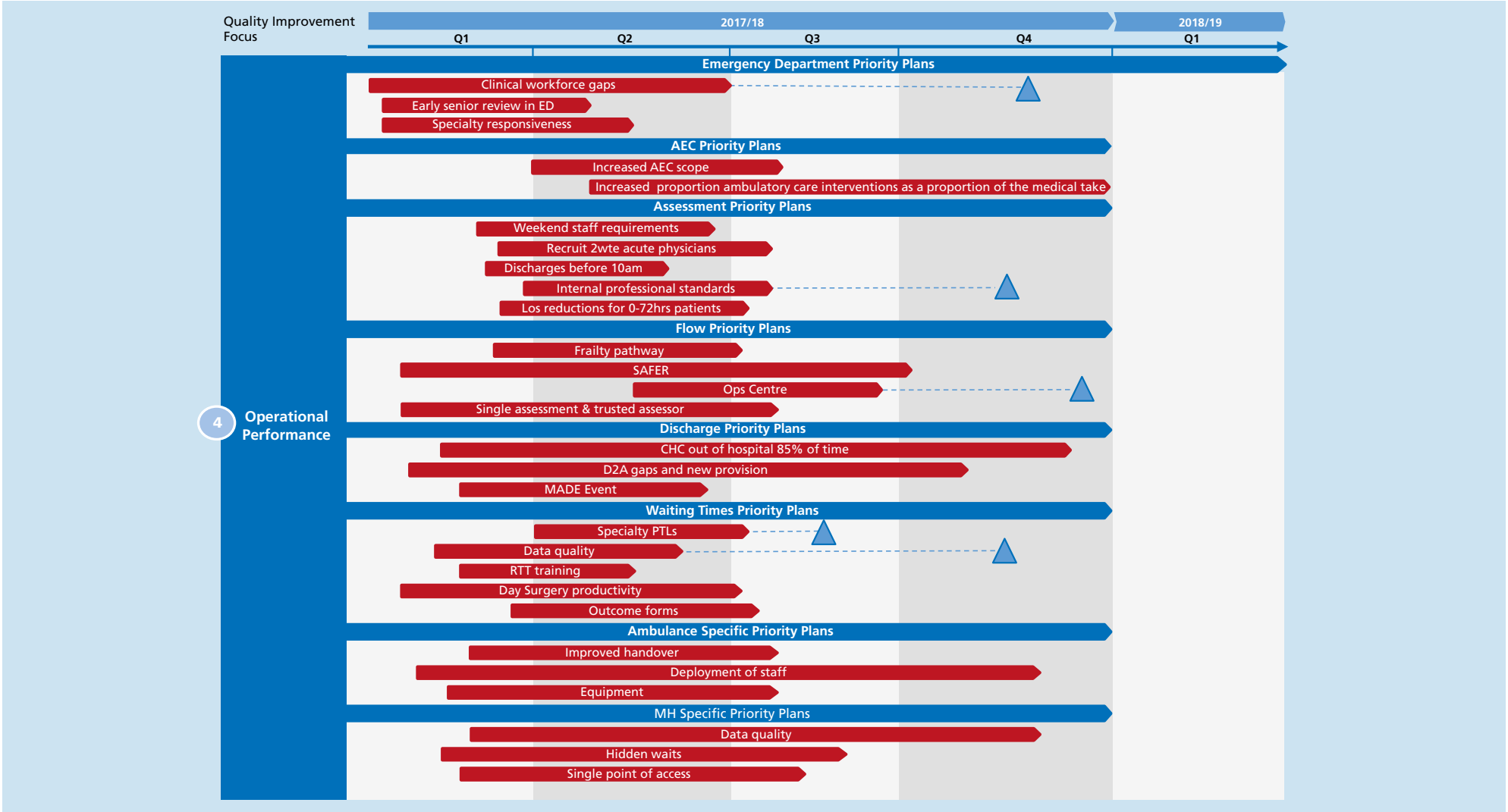
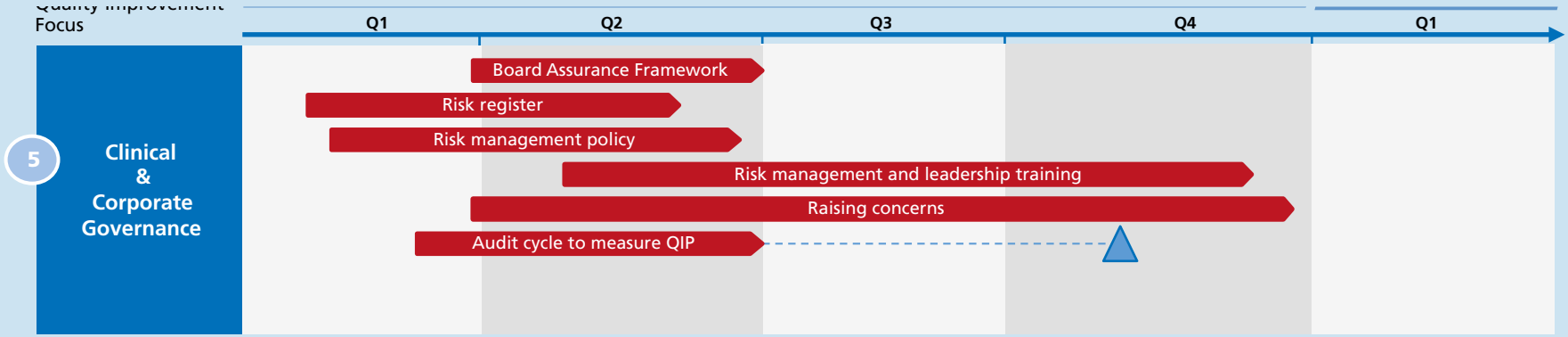


High Level Quality Improvement Plan for next 12 months commencing May 2017



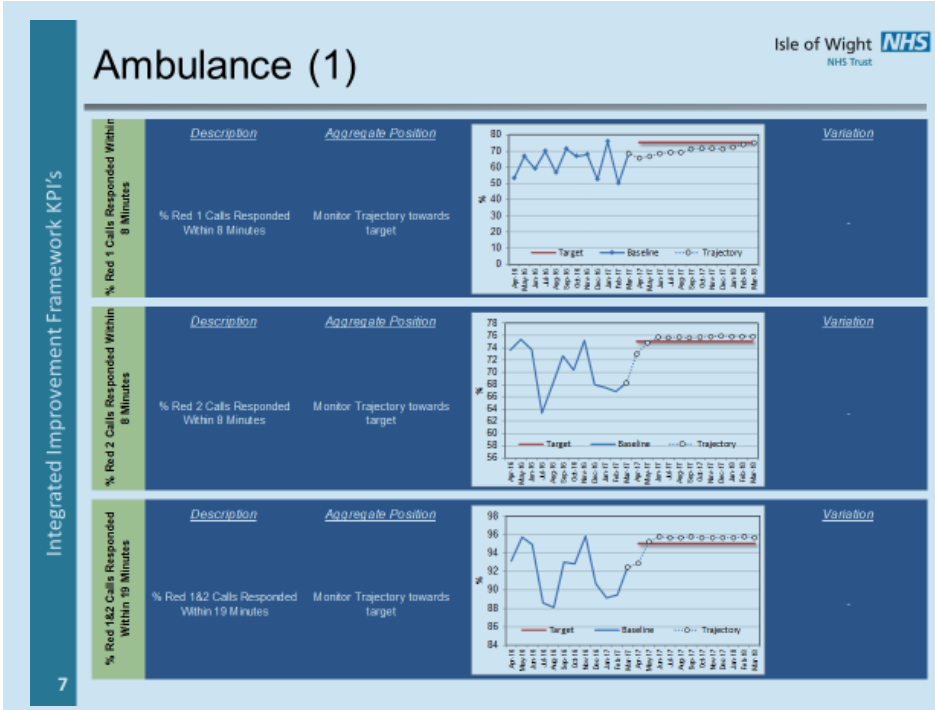
Quality Improvement Reporting

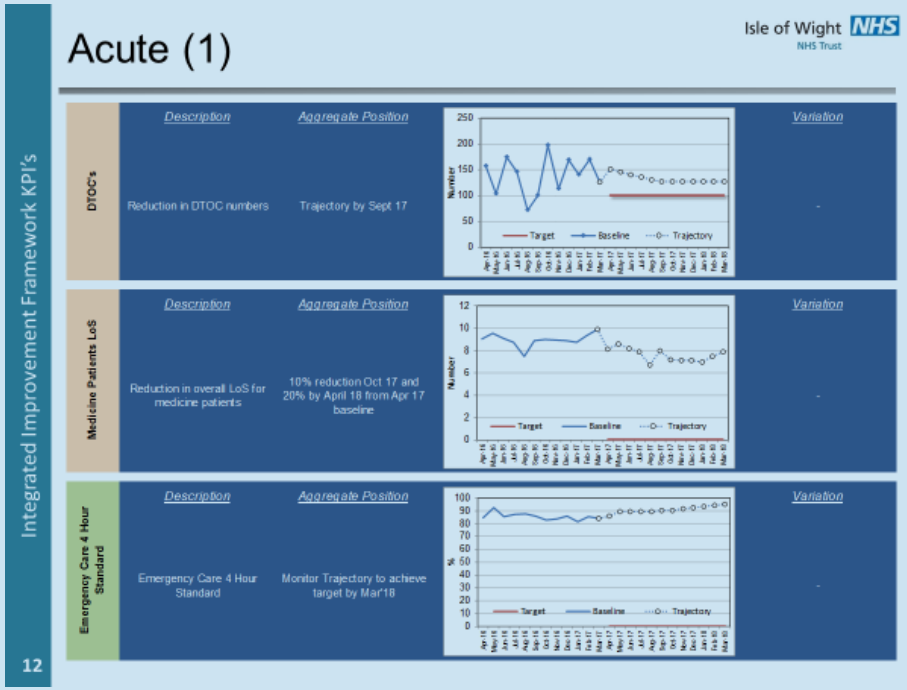
The Quality Improvement Plan is a subset of actions within the framework of the Trust's overall Improvement Plan (the IIF). The

Headline plans within the QIP are supported by very detailed actions and milestones that are captured within the IIF Framework and if included within the QIP would make it a cumbersome and unwieldy document.

Reporting to the Board, Regulators and Commissioners will be from the detailed plans that sit behind the headlines within this document.

Example Reporting of QIP Metrics





KEY THEME 1

1.0 Patient Safety

The CQC report highlighted many patient safety issues, some obviously so, and others more subtle. As a minimum the Trust must provide safe care to patients and so patient safety is of the highest priority to address.

Patent safety is about working to prevent errors in healthcare that can cause harm to patients. To deliver safe care there are foundations that need to be laid.

A safety culture

It is not simply about directly providing harm free care. A safe service is one where there is a culture that promotes safe care. This is a culture where staff feel free to state that they don't feel personally equipped or skilled to perform an activity and know they will be helped and supported to do so. A culture where helping a colleague understand that they may be just about to embark upon unsafe practice, or that they are in the midst of undertaking one, is something they know their colleague will welcome and heed the warning. A culture where reporting patient safety incidents brings review, changes to practice and shared lessons learnt. This culture must be supported by sound systems and processes that ensure that risks to patients are identified, mitigated and visible to the Board so they can ensure the required resources and actions are in place to mitigate and minimise any risk of harm to patients.

Leadership

The focus on patient safety must be led through the Board demonstrating that it is the Trust's highest priority. This is shown through the clinical governance framework, the prioritisation of activity and Board agendas, the allocation of resources and the response to clinical risk. In support of this the Trust's leaders must be supported and developed to identify and manage risk at a local service level and to escalate risks that they are unable to resolve.

These two foundation stones are clearly weak within the Trust and must be addressed for the specific actions to resolve the highlighted issues to become embedded within the Trust and to reduce the risk of further patient safety failures. They will be addressed in the Leadership and Clinical Governance chapters of this report.

Specifics

The specific patient safety issues the plan seeks to address include:

- ✔ 1.1 safe staffing levels;
- ✔ 1.2 avoidable harm to cover:
  - learning from incidents;
  - medicines management;
  - safety thermometer.
- ✔ 1.3 mandatory training
- ✔ 1.4 record keeping and IT systems
- ✔ 1.5 clinical risk identification, management and reduction

1.1 Safe Staffing Levels – Organisational Approach

Each service has a detailed plan to ensure that it can deploy the right number of staff with the right skills at all times. The actions to support increased staffing numbers and more effective deployment of staff are within this section, actions to improve skills and support personal development of staff are within the Leadership section. The Trust overall Recruitment Strategy to support these appointments is also within the Leadership section.

Safe Staffing Levels - Ambulance Services Key Priorities

Action	Outcome	Completion
To ensure vacancies in key positions [call handling, hub and operations] are filled with well trained staff	1. By March 2018 the % of calls receiving clinical advice from 111 will exceed 50% 2. Reduction in vacancy rates (frontline and Hub) by 50% from Apr baseline	31/03/2018
Using the staff in post improving the deployment of our workforce to meet the known demands of the service through the implementation of new rota's	Achievement of ambulance performance targets; completion of workforce review and associated changes to roster for front-line and the Hub	28/02/2018
Increase the coverage training and governance of the first responder volunteer service existing schemes where volunteer numbers are insufficient	Completion of audit	31/07/2017
Review demand and capacity to understand where further first responder need is going forward	Audit of areas of performance standard non-compliance for trend and placement of new schemes	31/07/2017

Safe Staffing Levels - Acute Services Key Priorities

Action	Outcome	Completion
Medical job planning and leadership in the ED to be reviewed and strengthened to ensure more Consultant presence (towards 16 hrs daily) at times of greatest demand.	Revised job plans that address the availability of current Consultants	30/06/2017
Review and update the ED medical rota to ensure it supports junior medical staff receiving education as required by their training placements.	Revised rota signed off by Medical Director. Improved junior medical staff feedback.	30/06/2017
Identify and recruit into key clinical ED workforce gaps using demand information and recognised workforce tools	Reduced vacancies by x in the department from Apr 17 baseline	30/09/2017
Review urgently staffing arrangements (medical and nursing) in the Paediatric Emergency Department and align Paediatric skills with demand	Paediatric skills available to the ED on 100% of shifts	15/05/2017
Agree skill mix in MAU requirements of the team to meet demands and Develop a plan to close the identified workforce gaps	Future position paper prepared by the department and signed off by the CBU	01/07/2017
Understand weekend staff requirements to reflect need including clinical support services (7 day working)	7 day working workforce and service requirement paper signed off by CBU	31/07/2017
Continue the recruitment of 2 WTE Acute Physicians (MAU Consultants)	Increased 2wte Acute Physicians in establishment from Apr 17 baseline	30/09/2017
Review workforce to understand the resource requirements needed to provide pathology, diagnostic imaging and endoscopy 7 days per week	7 day working resource plan	31/08/2017
Medical staffing levels need to meet national guidance for end of life care.	National guidance targets achieved 100% by Q3 Risk scoring reduced through mitigating actions from Apr 17 baseline	15/09/2017

Safe Staffing Levels - Community Services Key Priorities

Action	Outcome	Completion
Agree key posts or professional groups that could benefit from considering new type of roles	CBU identify new role options with support from the Workforce Team	30/05/2017
Understand workforce role options with HR to meet known future demand in key areas.	CBU identify new role options with support from the Workforce Team	30/06/2017
Progress and implement new roles across the CBU as identified	At least 2 specific new roles implemented	31/03/2018
Review hard to recruit medical and non medical posts	Highlight all posts that have been vacant for 6+ months or have been out to advert 2 or more times and still vacant	30/05/2017
Work with HR to discuss and agree innovative options to recruitment where applicable	Key vacancy levels reduced by 50% from Apr 17 baseline	31/07/2017

Safe Staffing Levels - Mental Health Services Key Priorities

Action	Outcome	Completion
Recruit relevant staff to provide the CRHT out of hours service.	0% gaps in OOH rota	01/07/2017
Out of hours recruitment for SPA	Posts recruited to	28/02/2018
Recruit to Consultant Psychiatrist position why are all these posts	Posts recruited to	06/01/2018
Recruit to Modern matron For Community	Community Matron in place	22/03/2018
Recruit to Modern matron For Inpatients	In Patient Matron in place	05/05/2017
Recruit to CQC Project delivery team	Project Delivery team in place	31/01/2018
Recruit to Head of Operations	Head of Operations in place	23/01/2018
Recruit to Director for Mental Health who will represent the services at Trust Board	Director for Mental Health in place	15/07/2017

1.2 Avoidable Harm – Organisational Overview

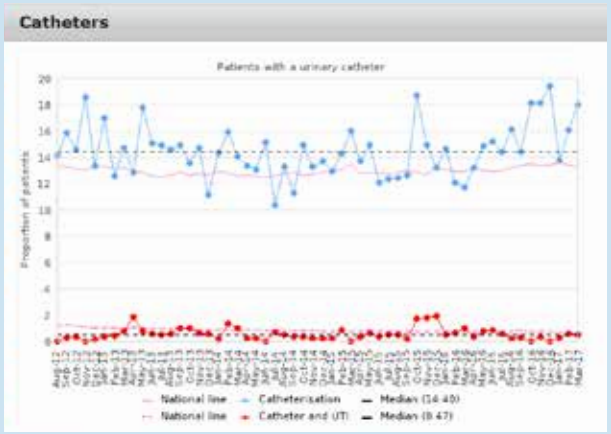
For the purpose of the QIP, avoidable harm has two meanings, firstly its harm that occurs where there is a non-adherence to well known and evidenced based practice to prevent harm, such as the areas covered with the national safety thermometers and secondly; its harm that occurs as there has been limited or no clinical risk identification and mitigation when there could have been. The approach within the QIP is to ensure that all staff are able to identify, mitigate and manage risks to patients, supported by a robust risk management and clinical governance framework, and to be sure that where we can, we use tools and evidence to monitor known risks to patients and improve our performance. The management of risk is within the Governance element of the QIP.

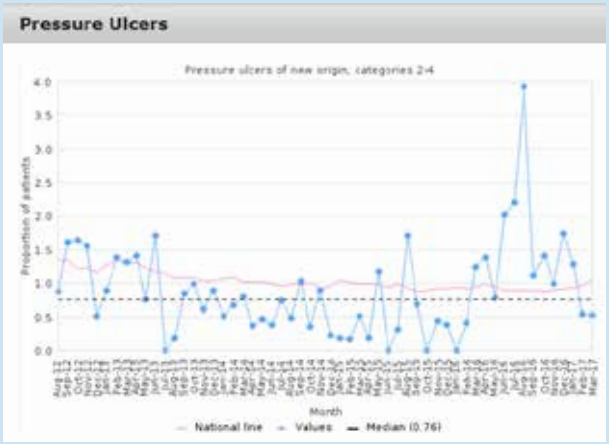
Specifics - Patient Safety Thermometer

The Trust will use the national patients safety thermometers for all services where it applicable. At present the Trust uses this tool in acute and community services, and performance in all areas other than amount of catheter usage is within national norms. Overtime the Trust will seek to understand and develop further measures, however for 17/18, the Safety Thermometers will be used.

It is the aim is to introduce the mental health tool and seek to identify and equivalent that can be used within the ambulance services

Action	Outcome	Completion
To introduce and use the mental health patient safety thermometer and improvement trajectory set	Thermometer in use	01/10/2017
Baseline output of MH safety thermometer to Board every month	Board aware of data and using for improvement	06/10/2017
Identify a tool suitable for use within Ambulance Service that is comparable to the Safety Thermometer	Tool identified	01/08/2017
Baseline output of Ambulance tool to Board every month	Board aware of data and using for improvement	01/10/2017





Serious Untoward Incidents

The Trust has a Serious Untoward Incident Policy (SUI) that reflects the national expectations of investigation and reporting and has trained many staff in good Root Cause Analysis techniques. However, the process is not working well and there is confusion about what is and what isn't a SUI, delays in reporting and investigation and little audit that lessons learnt have been actioned and embedded. It is essential that the Trust's performance improves if it is to minimise risks to patients. Furthermore, reporting and learning from incidents is an essential component of building the continuous improvement culture the Board seeks.

Action	Outcome	Completion
To run a campaign to increase awareness of the 21 National Never Events	The Trust will be more aware of national never events	01/10/2017
To undertake a table top review to ensure that the Trust has implemented learning from the 21 National Never Events and to take corrective action where required	Outcome of table top audit and actions demonstrates compliance	01/10/2017
To undertake a review of the Never Events that have occurred within the Trust and to audit to ensure that lessons learnt are in place	Audit outcome	01/09/2017
Run a campaign on the identification and escalation of Serious Untoward Incidents within the Trust	Improved identification and management of SUIs	01/09/2017
Determine the most effective means of achieving investigation of Sis to ensure they are completed within the national required timeline	Timely investigation and completion of Sis	01/09/2017
Determine the mechanism for ensuring that there is Board review and oversight of all SI Investigations	Board assurance of Sis	01/08/2017
Review and Revise the Lessons Learned Framework within the Trust	New Framework launched	01/08/2017
Roll out new method of sharing lessons learned		
Audit staff for awareness of information contained within the Lessons learned briefings	Audit complete for 300 staff	01/02/2018
Continue to monitor staff awareness of lessons learned through continuous survey and audit.	Staff survey returns and positive responses from staff	31/03/2018

1.2 Avoidable Harm – Organisational Overview

Medicines Management

Whilst a number of individual medicines management recommendations raised throughout the different CQC service reports, the Trust is clear that it needs to take a corporate approach to improvement whilst focusing in on the specific areas identified as challenges. Pharmacy currently undertakes an annual audit based on the National template, but the expected actions have at times not had any traction through the professional nursing structure. In addition each CBU is now presented with a medicines management optimisation report that includes the outputs from the monthly monitoring of doors, POD lockers, fridges, storage of medicines, incidents and interventions, missed doses, drug usage and advice, antibiotic use, medicine reconciliation rates, training and education as minimum. In terms of storage of temperatures the community sites and the ambulance service are not on centralised monitoring which has been identified as a potential risk with manual records submitted monthly.

The pharmacy service was recognised by the CQC as doing a lot of very good things but the alignment with the professional nursing, AHP and medical structures to improve general standards, governance and ownership at ward and service level is a key priority in 2017/18.

Action	Outcome	Completion
Review the medicines management policy to ensure it is up to date and addresses all appropriate areas of medicines management	Updated policy signed off by the Quality Governance Committee	31/08/2017
Pharmacy to evolve the scope of information contained within the CBU monthly optimisation report and ensure this is a standard agenda item on the quality and safety meeting.	Improved metrics at CBU level and evidence of sharing and learning across CBU's	31/07/2017
Review and update the corporate governance arrangements to ensure medicines management has visibility and owned outside Pharmacy and across the rest of the Trust	Revised ToR, including membership and agenda items for the drugs advisory group	15/08/2017
Ensure the Carter Metrics and NHS benchmarking outputs are presented back to the drugs advisory group and actions filtered down through the governance arrangements to CBU's.	Improved overall position of the Trust, by Q4, compared to the Peer group benchmarked using Apr 17 baseline	31/12/2017
Extend the system of centralised medicines storage monitoring [temperature and locked doors] into Community and the Ambulance services using the most appropriate options.	1. 100% coverage of temperature storage 2. 100% coverage of locked doors	28/02/2018

1.2 Avoidable Harm – Organisational Overview continued

Action	Outcome	Completion
Electronic Prescribing Medicines Access training compliance will be at least 85% for all relevant staff	10% reduction on prescribing errors from Apr 17 baseline	31/11/2017
Non Medical Prescribing process will be reviewed, updated and implemented to ensure supervision is improved and staff and patients/service users are not being put at risk.	1. 100% NMP on a centralised database 2. 100% NMP have a supervisor	30/10/2017
Specific attention and focus will be given to Non Medical Prescribers in the Community to understand and manage this extended role along with our GP partner colleagues.	3. At least 85% NMP have had supervision within the last 4 months	30/10/2017
A focus on patients, service users and carers to maximize the automated interfaced transfer of discharge medicines information and MOTIVE assessment level to the community pharmacist. Working with District Nurses and GP's to intervene, this will help improve patient knowledge what they should be doing with their medicine post discharge.	Improved satisfaction [by at least 20%] of the inpatient survey results relating to patients/carers and service users understanding what to do with their medicine post discharge	30/09/2017

1.2 Avoidable Harm Service Specific - Ambulance Services Key Priorities

Action	Outcome	Completion
Develop an ambulance handover protocol to eliminate handover delays (consider using the ECIP tactical guide)	1. New ambulance handover protocol signed off by ED Senior Team and CBU. 2. Reduced handover delays by 50% from Apr 17 baseline	31/07/2017
Ensure daily handover performance is part of the ambulance service performance and quality metrics	Daily handover performance is included in the service performance and quality metrics	30/06/2017
Run reports from to understand the impact of implementing the new NOC and DOD	Performance report created and used by the operational team	30/06/2017
Embed the national directives of Nature of Call & Dispatch on Disposition to assess situations correctly and despatch the right level of resource to our patients	100% Compliant against the NoC and DoD standards	31/07/2017
That appropriate standards of cleanliness are maintained in all clinical environments to provide safe patient care. That clean and dirty equipment within the equipment store are sufficiently segregated to prevent cross contamination of cleaned equipment	90% compliance with environmental audits	31/07/2017

1.2 Avoidable Harm – Service Specific – Acute Services Key Priorities

Action	Outcome	Completion
The Trust escalation plan will be reviewed and tested to ensure that meaningful action is taken in response to increasing levels of escalation.	Revised escalation plan signed off by the CBU and TLC. Testing of plan through an escalation exercise	15/07/2017
The environment to see and treat children, including the children's waiting area needs to meet the requirements of the 'Standards for Children and Young People in Emergency Care Settings' by the Royal College of Paediatrics.	Children's facilities in ED all meet Standards for Children and Young People in Emergency Care Settings - by the Royal College of Paediatrics. Where this is not possible evidence of mitigation to improve the situation from Apr 17 baseline	30/08/2017
An ED consultant to lead and implement a model of early senior review within the department (such as 'pit stop', 'SIFT' or 'RAT').	Early senior review taking place on 80% of shifts	31/07/2017
Nursing staff in the coronary care unit have competencies to care for patients on bi-level positive airway pressure (BiPAP).	100% positive results from competency assessment of all nurses on CCU in relation to BiPAP	30/09/2017
There is a sufficient and safe number of doctors working on the coronary care unit (CCU) at all times.	0% medical vacancy gaps. Medical cover on 90% of sampled rota's	15/10/2017
Daily documented checks on each resuscitation trolley are evidenced as complete	Priority equipment checked daily 100% of the time from sampled records	15/08/2017
Intravenous fluids are stored in a locked room to prevent access to members of the public.	100% compliance and 0% incidents reported	31/08/2017
All patients nearing end of life are assessed and have an individualised end of life care plan. There are monitoring mechanisms in place to ensure risks to patients were assessed.	30% increase in end of life care plans from April 17 baseline	31/07/2017
Consultants undertake training in end of life care.	50% Consultant training in place by Q3 75% Consultant training in place by Q4	31/01/2018
That appropriate standards of cleanliness are maintained in all clinical environments to provide safe patient care. That clean and dirty equipment within the equipment store are sufficiently segregated to prevent cross contamination of cleaned equipment	90% compliance with environmental audits	31/07/2017

1.2 Avoidable Harm – Service Specific - Community Services Key Priorities

Action	Outcome	Completion
Develop triggers and escalation plans for caseload management	Six monthly review process to ensure caseloads are within agreed tolerances	15/09/2017
Monitor and mitigate risks arising through new IT system	100% of risks are within date and actions taken to mitigate them	31/01/2018
The IT and phone signal is reviewed to protect patients from delays in staff accessing information and protect staff from a compromised lone worker policy	1. Technical report site by site and area by area on connectivity availability 2. 50% reduction in reported incidents relating to lone working	30/09/2017
Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or an inability to access patient records when required by staff.	1. Training needs analysis of staff's IT skills and competencies 2. 50% reduction in minimum data set omissions from records as part of the record keeping audit from Apr 17 baseline	31/10/2017
Patient risk assessments are completed and re assessed regularly at least six monthly	Risk assessments carried out for 100% of patients	31/12/2017
That appropriate standards of cleanliness are maintained in all clinical environments to provide safe patient care. That clean and dirty equipment within the equipment store are sufficiently segregated to prevent cross contamination of cleaned equipment	90% compliance with environmental audits	31/07/2017
Ensure medicines for return to pharmacy are stored securely on both wards	100% compliance with medicines management policy	30/05/2017

1.2 Avoidable Harm – Service Specific - Mental Health Services Key priorities

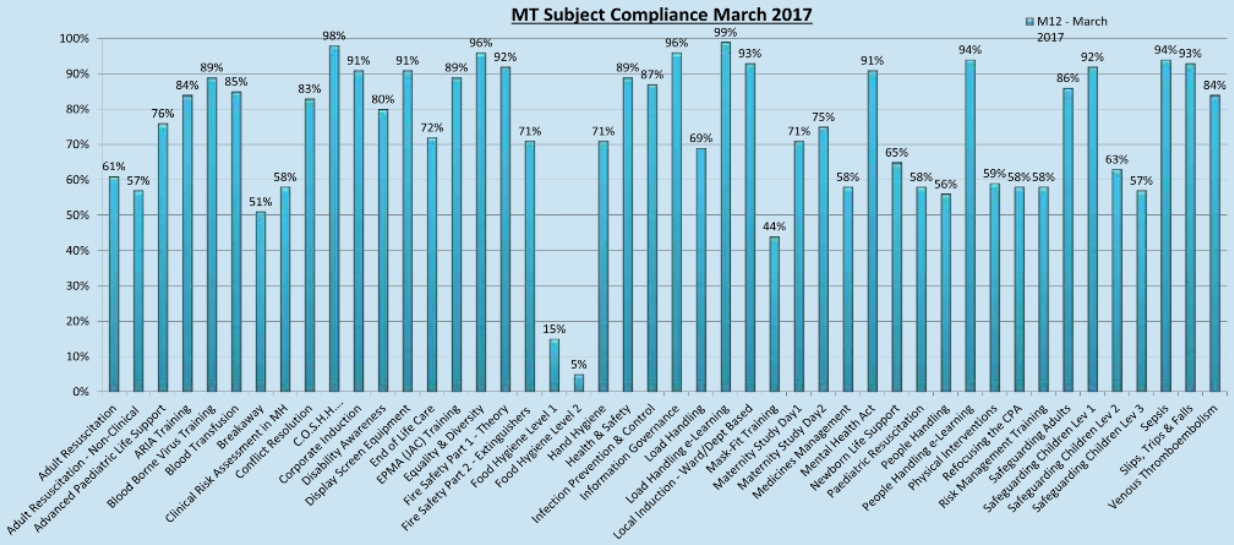
Action	Outcome	Completion
Identify current caseload for all clinicians including Consultants		05/01/2017
Ensure that all patients on consultants caseloads have been thoroughly risk assessed, CPA status allocated and care planned in conjunction with the patients	100% of patients have a risk assessment and care plan in place within PARIS and % of patients on CPA	30/06/2017
Ensure that all patients on practitioner caseloads have been thoroughly risk assessed, CPA status allocated and care planned in conjunction with the patients		31/03/2017
Devise and deliver training plan based on training needs analysis in relation to Care Planning and Risk Assessments.	% compliance with training requirement	30/06/2017
Embed new practice of line managers carrying out representative qualitative sample audit of care plans to ensure they are - Person Centered, Holistic and contain sufficient detail to enable staff to understand individual's needs and monitor progress. (including outcome measures)	- 95% of patients to have current Risk Assessment and Care Plan with date for review - Caseload Management to be undertaken monthly - Clinical supervision monthly	17/02/2017
Remind all staff of the expected standard of risk assessment and care planning set out in the MH clinical Risk assessment and management policy and the CPA policy		31/08/2017
Implement Environmental checks/safety checks 3 times per day completed by ward staff	100% Audit compliance of ward checklists	30/09/2017
Ensure that staff receive clinical, management, caseload and safeguarding supervision as required and that compliance is reported monthly through the Trust Performance report.	100% compliant and then ongoing performance management	30/05/2017
Complete all estate actions associated with ligature risk assessment	Mental Health Improvement Group sign off of completed plan	30/09/2017
Regular quality audits of individualised risk assessments and care plans to be undertaken on the inpatient wards by senior managers	Results of audits - at least 4 completed	on-going

1.3 Mandatory Training – Organisational Overview

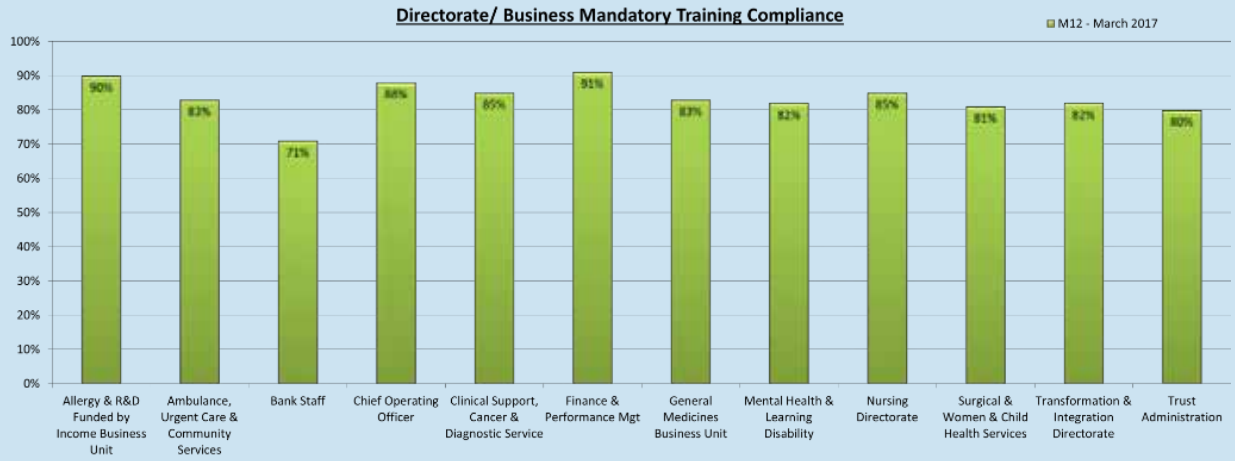
The Trust has a responsibility to provide various statutory and mandatory training and to ensure that its staff attend. Statutory training is required to ensure that the Trust is meeting any legislative duties. Mandatory training is an organisational requirement to limit risk and maintain safe working practice. The Trust must have in place a Statutory and Mandatory Training Policy that provides a training matrix to ensure that all staff can easily identify the training that is required for their role and the frequency that they must update their skills and knowledge.

To ensure that staff are able to complete this training the Trust has a responsibility to give staff the time they require to complete the activities and if necessary the training and equipment that might be required to undertake such training on line. The Trust Board must then monitor the adherence to the Policy as a qualitative measure.

The CQC highlighted that the Trust was not complying with its Policy in a number of key areas and the Improvement Plan must ensure that this is corrected although the overall performance is currently 82%



Graph 1 – Mandatory Training by Subject by



Graph 2 – Mandatory Training by CBU and Service Area

Action	Outcome	Completion
Undertake a diagnostic of current position with Mandatory Training compliance and requirement	Comprehensive understanding of Mandatory Training requirements at organisational level and the rate of compliance overall and at service level	31/07/2017
Develop a Mandatory Training Framework	Mandatory Training Framework with individual competencies identified for each role	31/08/2017
Review content of Mandatory Training modules	Up to date Mandatory Training material in line with best practice.	31/08/2017
Review Mandatory Training Policy and ensure it represents the needs to the Trust	Updated policy	31/08/2017
Develop delivery plan 2017-18 (capacity and delivery methodology)	Develop delivery plan 2017-18 (capacity and delivery methodology)	31/08/2017
Focus on core subject areas with <85% compliance including DoLs and MCA, Safeguarding and challenged CBU's and support services	Improved compliance to 85%	31/08/2017
Consider Duty of Candour training , who needs to receive it and how it should be delivered within the mandatory training framework	Updated list of mandatory training per staff grouping	30/09/2017

Safeguarding

The CQC highlighted significant concerns with regard to Safeguarding (both Adult and Children). At a high level, those concerns suggest that the Trust had not placed sufficient emphasis or priority on ensuring that Safeguarding is upper most in staff's minds when interacting with patients and service users. Furthermore, the Trust's Statutory interface with the Local Authority and CCG was weak due to poor attendance and engagement. Lack of awareness of Safeguarding and lack of a multi-agency approach does leave patients and service users at risk.

The Trust's approach to improving Safeguarding is one that will seek to ensure there strong Board focus and leadership, robust multi-agency working and sufficient resources to be able to deliver a safe set of services. This will be supported by an awareness amongst all staff of Safeguarding issues and how to report and manage them.

Action	Outcome	Completion
The Executive lead for Safeguarding is the Director of Nursing who will attend both Adult and Children's Safeguarding Boards.	Improved multi-agency working	31 June 2017
A review of the way the Trust undertakes the functions required within Safeguarding will be undertaken to include consideration of DOLs and MCA	A review of the way the Trust undertakes the functions required within Safeguarding will be undertaken to include consideration of DOLs and MCA	1/9/2017
Determine the internal governance arrangements for Safeguarding ensuring that the Board can deliver its Statutory responsibilities and assure itself of an effective Safeguarding process.	Clear description of service to Board governance process	11/9/2017
Ensure Safeguarding leads within the services have time for training and to perform their function	Full engagement of Safeguarding leads in the Operational oversight groups and of the safeguarding team in the Trust Operational Steering group.	1/9/2017
All Trust staff to have Level 1 training	85% of all staff trained	1/12/2017
All staff involved in patient/service user contact to have level 2 training	50% of eligible staff trained by 1/11/2017 70% of eligible staff trained by 1/3/2018 85% of eligible staff trained by 1/6/2018	1/6/2018
All staff identified as Safeguarding leads within the Trust to have level 3 training	95% of all staff trained by 1/11/2017	1/11/2017

1.4 Record Keeping and IT systems

Documentation issues were raised by the CQC in terms of the development of electronic records but also the quality and content of paper records that are currently in situ. The following actions will be owned and driven through by the Trust as part of its Quality Improvement Plan.

Key Health Records Actions – Organisational Overview

Action	Outcome	Completion
Review the health records policy to ensure it is fit for purpose and had all the relevant key drivers in it to deliver high quality documentation and circulate to staff.	Revised policy signed off by the Clinical Audit and Assurance Group and circulated to all staff.	15/07/2017
Review the current paper documents in place for all services, determine the documents that are to be used for each service, ensure all staff are aware of the documents to be used, how to complete them and store them	Clear sets of paper documentation for each service	01/02/2018
Agree priority areas to audit and improve over the next 12 months. As a minimum these will include risk assessment, care planning and standardisation.	Priority areas identified and scoped within the plan.	01/07/2017
Taking a risk approach, identify and train and educate key staff groups across the Trust in good quality risk assessments and care planning.	At least 250 key staff trained by Nov 17 and 500 by Apr 18. All clinical staff educated in completing risk assessments and care planning	31/03/2018
Ensure the audit schedule includes undertaking and reporting compliance with the health records policy. Report results through the Clinical Audit and Assurance Group and then SEE six monthly.	Updated action plan focusing on key learning and outcomes from the audits	31/10/2017

1.4 Electronic Patient Records

The CQC highlighted specific concerns with regard to the community and mental health services electronic patients records. This issues related to the ease of use and clarity about how to use the systems in place. The Trust will be developing an overarching Informatics Strategy, however, the immediate need is to address challenges within the systems currently in use in both these specific services.

Community Services Key Priorities

Action	Outcome	Completion
The Trust will have a fit for purpose Community District Nursing IT system rolled out and have reviewed the systems requirements of wider community services	1. District Nursing IT system in place and 100% of staff are trained on SystmOne TPP. 2. Review of wider community service requirements	09/12/2017 31/03/2018
That the IT and phone signal is reviewed to protect patients from delays in staff accessing information and staff from a compromised lone worker policy	That the IT and phone signal is reviewed to protect patients from delays in staff accessing information and staff from a compromised lone worker policy	30/09/2017
Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or an inability to access patient records when required by staff.	District Nursing IT system in place by 31/10/17 and connected to eCareLogic through a two way interface	31/01/2018

Mental Health Services Key Priorities

The Mental Health and Community services that use Paris will have a system fit for purpose supporting effective management of patient care, paperless working and reporting. The core assessment module in place 27th May 2017 and it is expected that 50% of staff will be retrained by 30th September 2017 and 100% by 31st December 2017

Roll Out Plan – Key Modules

Action	Outcome	Completion
MHSDS	Revised module developed, testing and implemented	02/05/2017
Core Assessment	Revised module developed, testing and implemented	27/05/2017
Memory Service assessment	Revised module developed, testing and implemented	07/07/2017
Break glass	Revised module developed, testing and implemented	14/07/2017
MH CDS	Revised module developed, testing and implemented	08/08/2017
Letters	Revised module developed, testing and implemented	07/10/2017
Delayed Transfers of Care	Revised module developed, testing and implemented	08/08/2017
Child Health additional module deployment	Module developed, testing and implemented	18/06/2017

1.5 Clinical Risk Management

Clinical risk is an avoidable increase in the probability of harm occurring to a patient. Events or incidents occur in our daily practice that will, or could potentially, affect the quality of patient care. Sometimes this can lead to harm, sometimes harm is avoided (a near miss). When an incident occurs many factors relating to the system, the environment and the individuals concerned interplay in the process. Errors do occur but given the same set of circumstances mistakes will occur again, regardless of the people involved. The risk management process is designed to help all staff understand how to identify risks, report them, seek actions to mitigate them and learn from incidents in endeavour to reduce the risk of recurrence.

The CQC report highlighted many areas where the Trust's risk management approach and process had failed to identify and mitigate risk, so placing patients at risk of harm. Furthermore, it highlighted areas where the Trust had failed to understand the risks posed to patients and this suggests that a comprehensive, trust wide plan must be implemented.

Action	Outcome	Completion
The Trust will develop a new Risk Management Policy	New Policy approved	01/08/2017
The Trust will train all staff in leadership roles in Risk Management	80% of all staff in a leadership role trained	01/12/2017
The Trust will make all staff aware of the Risk Management Policy and how to report risks, issues and raise concerns	85% of all Trust staff trained	01/04/2018

To support improved knowledge and expertise of clinical risk management within the workforce the Trust must ensure that it has robust systems and processes in place to record and review risks and a methodology for ensuring that they are mitigated. This needs to be in place for every service within the Trust and work within a clear escalation framework to ensure there is a line of sight from the direct services to the Trust Board.

Action	Outcome	Completion
The Trust will review, refresh and cleanse the Risk Register	A revised, relevant Risk Register	01/07/2017
The Trust will develop a Board Assurance Framework	A Board Assurance Framework and Policy	01/08/2017
The Trust will develop clear Terms of Reference, Membership, meeting cycles and data sets for all elements of the Framework	Within the BAF	01/08/2017

1.5 Clinical Risk Management

Information

To support the delivery of a meaningful Board Assurance Framework it is essential that activity and performance information is collected and reported to enable individuals, teams, Business Units and the Board to understand trends and indicators that will highlight any issues with the quality our outcome of patient/service user care.

The absence of and/or the timeliness and/or accuracy of the data the Trust has been using has hindered staff from being able to make good, informed decisions of how to improve care, or to see when care has fallen below an acceptable standard. To address this the Trust must improve its Performance reporting.

Action	Outcome	Completion
The Trust will review its current dashboard and undertake gap analysis against best practice and findings of CQC	New Operational Performance Management Report	01/09/2017
The Trust will revise the dashboard and data sets that feed it to ensure it supports the information flow required to provide robust oversight of clinical, quality, financial, managerial and operational performance of the Trust using benchmarks from the Model Hospital where relevant	New Operational Performance Management Report	01/09/2017
The Trust will develop reporting for the CBUs to undertake their function	New Reporting set for CBUs	01/10/2017
The Trust will develop reporting that supports clinical quality assurance	New Reporting set for Clinical Quality Assurance	01/09/2017
The Trust will develop reporting that ensures the views of patients, staff, the public and stakeholders are included within the data set	New Operational Performance Management Report	01/09/2017
The Trust will develop reporting that enables the Trust to benchmark itself against others and best practice.	New Operational Performance Management Report	01/09/2017

KEY THEME 2

2.0 Patient/Service User Experience

Formal Methods

It is widely acknowledged that the experience of patients/service users is an essential component of any assessment of the quality of health services. For some time the CQC have been undertaking independent regular surveys of patients/service users across all health services and the information gathered enables the organisation to understand its performance year on year but also in comparison to other health providers. In addition to these surveys, patients/service users are able to rate their care on NHS Choices, a site that enables people to log a score and make comments about the service they received.

Finally the Department of Health has required providers to undertake more regular feedback through the use of the Friends and Family test, a survey that patients complete voluntarily during or at the end of treatment/ intervention to determine whether they would recommend the service to others. The Trust's scores for these formal tests that took place in 2016 are shown.

CQC Survey Methodology

"We asked people to answer questions about different aspects of their care and treatment. Based on their responses, we gave each NHS trust a score out of 10 for each question (the higher the score the better).

Each trust also received a rating of 'About the same', 'Better' or 'Worse'.

- **Better:** the trust is better for that particular question compared to most other trusts that took part in the survey.
- **About the same:** the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- **Worse:** the trust did not perform as well for that particular question compared to most other trusts that took part in the survey."

Results: Mental Health

At the start of 2016, a questionnaire was sent to 850 people who received community mental health services.

Responses were received from 223 people at Isle of Wight NHS Trust.

The survey showed that for almost all categories, the Trust was worse than most others that took part in the survey

Results: Inpatient – Acute Hospital

Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust.

Responses were received from 646 patients at Isle of Wight NHS Trust. T

The survey showed that for almost all categories the service was about the same as most others that took part in the survey but worse for waiting lists and planned admissions.

2.0 Patient/Service User Experience

NHS Choices

It would seem that the Trust does not promote the use of this service to patients/ service users as there are only 2 ratings given in 2017. Better use of this site by patients/service users would offer the Trust a valuable insight into their services.

Friends and Family Test

The trust's Friends and Family Test performance was better than the overall England performance in nine of the 12 months between December 2015 and November 2016. In November 2016 trust performance was 95.9% compared to an overall England performance of 95.4%. Between March and September 2016 there was a downward trend in trust performance. This was followed by an improvement in October and November 2016. The response rate of 21.9% was similar to the overall England response rate of 24.2%.

Action	Outcome	Completion
Increase the CQC questionnaire response rates for Mental Health Services to at least 50% of the total distributed	Increase the CQC questionnaire response rates for Mental Health Services to at least 50% of the total distributed	28/02/2018
To implement the acute improvement programme and improve the Acute Hospital experience for the people of the Isle of Wight in the CQC survey	50% response rate to be achieved\ "about the same" rating for waiting lists and admissions "better" rating for at least 10% of the other questions	28/02/2018
As part of the overall communications and engagement strategy encourage at least 10 patients to leave comments of their experience on the NHS Choices website	More intelligence gathered around patient experience	30/12/2017
Promote the Friend and Family test through the organisation to increase the response rate to at least the England average of 24%	Achieve at least the England performance for 50% of the 12 months	30/12/2017
Conduct 4 focus groups with GPs and primary care Professionals to understand their perspective on the Trusts services and the perspectives of what their patients report to them	Conduct 4 focus groups with GPs and primary care Professionals to understand their perspective on the Trusts services and the perspectives of what their patients report to them	1/12/17

2.0 Patient/Service User Experience

In addition to the independent surveys and ratings discussed, the Trust will have feedback through formal Complaints and Compliments and through the Patient Advisory and Liaison Service (PALS). Ensuring the systems and process to encourage and capture feedback through those routes are robust and effective is an essential elements of ensuring continuous improvement by learning lessons and correcting errors.

Finally, within the formal arrangements are reports and visits from organisations such as Healthwatch or through Scrutiny by the Local Authority and Commissioners.

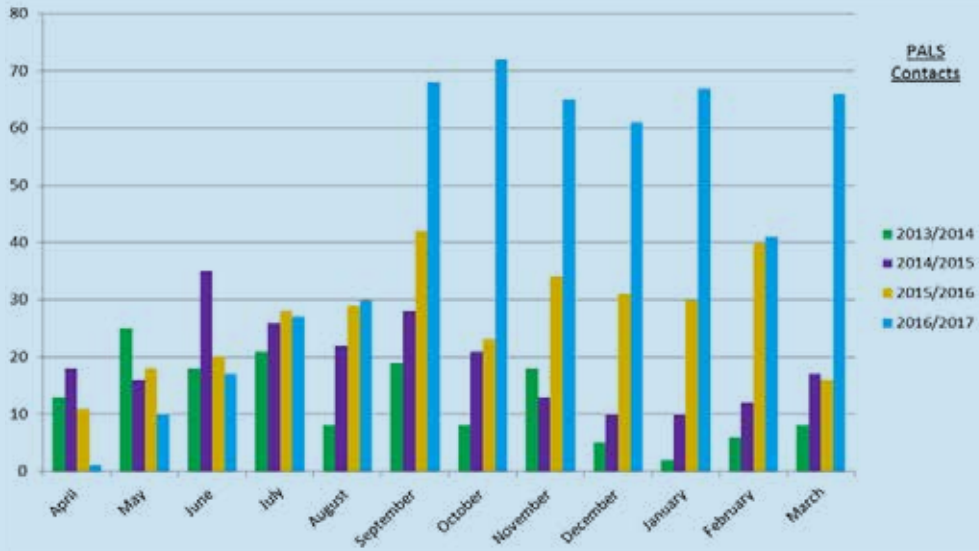
The Trust will seek the views of GPs and Primary Care professionals regarding its services from their perspective and from the perspective their patients report to them. This will be done in focus groups so free flowing discussion can take place.

It is essential that findings and information from all sources is fed into the Trust's clinical quality management to provide a view of how the experience of care feels for those who receive it.

Informal Methods

In addition to acquiring specific feedback through asking patients/service users about their experience it is important the Trust recognises the impact of its care on people. Whilst it should be acknowledged that the CQC found staff to be caring and compassionate, the report highlighted a number of issues that would have led to a very poor patients experience including moves of patients at night, mixed sex breaches, inappropriate environments for people in the last days of their life and for those with dementia as examples.

The Improvement Plan must address the formal and informal issues raised through the examination of the experience of patients and service users and ensure that there are sound systems going forward to capture and utilise this information to provide continuous improvement. Furthermore, the Trust must ensure that it undertakes thorough quality impact assessments when making decisions that effect the care of those they serve.



- Significant increase in PALS contacts in 16/17. For 17/18 it will be promoted to encourage at least the same levels;
- 10% increase in compliments targeted on 17/18 from the 3200 received in 16/17;
- 10% increase in informal complaints targeted for 17/18 from the 953 received in 16/17 as this is seen as a rich source of feedback to the trust.

Patient Experience - Ambulance Services Key Priorities Plans

Action	Outcome	Completion
To have visibility of the service's response to patient needs and demonstrate improvements in it's performance	1. Meet performance targets, Improved FFT results, reduction in complaints 2. Clinical Support Officers in place	30/09/2017
High level audit of clinical advisor and call handler performance and identification of outliers	Audit complete and CSD/Call handling outliers identified	15/07/2017
Training delivered	Completion of training required as identified	30/09/2017
Establish an updated KPI dashboard for ongoing visibility and monitoring	KPI dashboard in place and compliance reported on at service SMG monthly	15/08/2017

Patient Experience - Mental Health Services Priority Plans

Action	Outcome	Completion
Ensure privacy and dignity of patients across the CBU at all times	1. Revised Privacy and Dignity Policy ratified and in place 2. Briefing/training sessions facilitated 3. Jack and Jill bathrooms no longer in use	31/08/2017
Privacy and Dignity Policy to be reviewed to ensure it is robust	Privacy and Dignity Policy reviewed and approved	31/03/2018
Briefing/training sessions to be facilitated with all staff in relation to the updated Privacy and Dignity policy to enhance understanding	All sessions facilitated with % all staff trained	30/06/2017

Patient Experience - Acute Services Priority Plans

Action	Outcome	Completion
The environment to see and treat children, including the children's waiting area needs to meet the requirements of the 'Standards for Children and Young People in Emergency Care Settings' by the Royal College of Paediatrics.	Children's facilities in ED all meet Standards for Children and Young People in Emergency Care Settings - by the Royal College of Paediatrics. Where this is not possible evidence of mitigation to improve the situation from Apr 17 baseline	30/08/2017
Agree baselines and improvement trajectory for LoS reductions for patients in the 0-72 hrs category	1. 15% increase in numbers with a LoS less than 24hrs from Apr 17 baseline 2. 15% increase in numbers with a LoS greater than 24hrs and less than 72 hrs from Apr 17 baseline	30/06/2017
Single sex accommodation requirements for patients are maintained and any breaches are reported in a timely way.	Reduced single sex accommodation breaches by 75% from Apr 17 baseline	15/10/2017
Update the escalation policy and monitor moves for non clinical reasons between 8pm and 7am	1. Reduced complaints from patients and relatives relating to non clinical moves 2. Reduced LoS in medicine from Apr 17 baseline	30/09/2017
Targeted dementia training to staff in priority areas i.e. ED, MAU, Medical Wards, Stroke and Rehab	1. As a minimum 85% of all staff in the areas identified trained	15/03/2018

need to address Community mental health service user survey improvements

Patient Experience - End of Life Care – Specific Plans

Action	Outcome	Completion
The Trust will work with the Hospice to determine the optimum service model of Specialist Palliative Care and end of life care for the future	An improved Specialist Palliative Care pathway and increased number of patients dying in their preferred choice of place of death.	01/01/2018
All patients nearing end of life are assessed and have an individualised end of life care plan. There are monitoring mechanisms in place to ensure risks to patients were assessed.	30% increase in end of life care plans from April 17 baseline	31/07/2017
Medical staffing levels need to meet national guidance for end of life care.	Medical staffing levels need to meet national guidance for end of life care.	15/09/2017
Consultants undertake training in end of life care.	50% Consultant training in place by Q3 75% Consultant training in place by Q4	31/01/2018
End of life care patients are not moved for non clinical reasons	0% end of life care patients moved for non clinical reasons by Q3	30/06/2017
Patients are able to die in their preferred place of care. There is a robust rapid discharge system in place for end of life care patients and this is monitored	50% increase in end of life patients dying in their preferred place of care from Apr 17 baseline	15/09/2017
Suitable arrangements are in place to identify, assess and manage risk in end of life care services, through actively reviewed risk register.	Risk registers 100% up to date for all inpatient services	30/09/2017
The quality, risk and performance issues within end of life care are monitored and improved through the executive governance framework.	End of life performance and risks discussed at quality and performance review meetings	31/08/2017
There are improved discussions with the family/friends regarding end of life care.	75% positive response on feedback from local questionnaire	01/10/2017

KEY THEME 3

3.0 Staff Engagement and Leadership

The CQC report highlights that throughout the Trust, staff feel disengaged, lacking in autonomy and that they work with an Executive team that is removed from them and the work they do. This is echoed within the national staff survey that shows the Trust as one of the worst performing Trusts for this measure across the country. Furthermore, the CQC report shows that the Trust does not have a clear vision and strategy for the future.

Reflecting on this, the Trust recognises that some of its actions with regard to the development of the Clinical Business Units and approaches to short term cost savings have had an adverse impact on staff morale. The Trust also understands that without the engagement of its staff, there will be no improvement to the quality of care those it serves receive.

The improvement route to achieving an engaged, motivated workforce is multi faceted. The plan to achieve and improvement in staff satisfaction and engagement is in effect the Trust's plan for whole Organisational Development and includes the recruitment and retention of staff.

It seeks to ensure that staff have sufficient colleagues to work with to ensure they do not have to work excessive hours or compromise standards, that they are aware of what is required of them and have regular opportunity for feedback and discussion about their performance, that the feel skilled, equipped and supported to perform their roles as best they can and importantly that they feel their contribution is sought, welcomed and valued as a vital part of improving services. To that end the Trust will equip staff to be able to undertake continuous improvement within their own are of work and to be involved in wider Trust improvements.

Evidence tells us that the extent to which staff are engaged has a direct impact on outcomes for patients. High levels of engagement result from a combination of experiences at work which include involvement in decision making, personal development and training, great management and leadership and a healthy, safe, work environment where every role counts . It follows therefore that three important measures from the staff survey will be the focus for improvement in 2017-18.

Overall Staff Engagement

Sector	Trust Score 2016	National Average Median for Sector
Acute	3.63	3.80
Ambulance	3.07	3.41
Mental Health	3.42	3.80

"I would recommend my organisation as a place to work"

Sector	Trust Score 2016	National Average Median for Sector
Acute	47%	62%
Ambulance	43%	46%
Mental Health	44%	56%

"if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"

Sector	Trust Score 2016	National Average Median for Sector
Acute	49%	70%
Ambulance	45%	70%
Mental Health	49%	59%

The Trust aim for 2017-18 annual staff survey is to achieve the national average score for each sector under the three measures.

3.0 Staff Engagement and Leadership - To improve staff satisfaction and engagement

Action	Outcome	Completion
Develop an Employee Engagement Strategy & delivery plan to support cultural development - winning the hearts & minds of our people and creating a great place to work	Improved score of staff recommending the Trust as a place to work or receive treatment to > 3.71 (national average for MH/ LD & Community Trusts)	30/06/2017
Define Employer Value Proposition/Brand promoting IOW NHS Trust as the employer of choice	Increase % staff recommending IOW as place to work to < national average	01/10/2017
Relaunch Trust strategic vision & organisational values	Reduce Cultural Development Risk 675	01/09/2017
Develop a communications strategy to improve the effectiveness of communications between senior managers & staff in response to Staff Survey	Improve staff survey result to > national average xx %	31/07/2017
Develop & implement Reward & Recognition Plan (staff experience & celebration groups)	Improve the Trust EE score from 3.63 to >3.80	15/11/2017
Increase diversity & inclusion provision and ensure compliance with EDS2 and WRES	Compliance with EDS2 and WRES	28/02/2018
Build on positive relationship with Staff Side colleagues and revise Partnership agreement	Improve the Trust EE score from 3.63 to >3.80	01/03/2018
Support development and promotion of mechanisms to enable employee voice and make it easy for staff to raise concerns in confidence that the Trust will act	Improved Staff Survey Results to > national average	31/12/2017
In conjunction with the nominated interim F2SU guardian - recruit & train & support F2SU Advocates to roll out the F2SU national campaign	Improved Staff Survey Results to > national average	31/11/2017
Relaunch/introduce Whistle Blowing Policy, Dignity at Work Policy and 'See Something, Say Something' Campaign	Raising a concern campaign introduced	15/06/2017
Implement a programme of interventions and events to raise awareness of and support those in relation to Harassment, Bullying and Abuse (HBA) including recruiting, training and supporting 'Behaviour Buddies'	Improved Staff Survey Results to > national average	01/03/2018

3.0 Staff Engagement and Leadership - To improve the overall leadership and culture of the Trust

Action	Outcome	Completion
Develop and launch Trust Leadership vision	Trust Leadership Vision agreed and published	30/08/2017
Develop and launch an integrated leadership competency & behavioural framework for IOW NHS Trust leaders with corresponding self-assessment audit and modular programme of training/coaching & mentoring interventions	Leadership Competency & behavioural framework approved and implemented	30/08/2017
Develop and deliver 2017-18 delivery plan underpinning the HR and OD Strategies	Delivery Plan in place and monitored through Workforce Group	01/03/2018
NHSI will undertake a Board Capacity and Capability Review	A plan to strengthen Board performance	01/08/2017
The Trust will review the CBU and Senior Management structures to ensure they are robust	An agreed CBU structure that reflects the services provided by the Trust and the optimum route to deliver high quality services	01/09/2017
The Trust will undertake a review of the capacity and capability of its senior leadership to ensure it is fit for purpose	The Trust will undertake a review of the capacity and capability of its senior leadership to ensure it is fit for purpose	02/01/2018
The Trust will develop a management development and leadership programme to support senior managers	All senior managers will have completed a Trust wide management and leadership programme	01/04/2018
The Trust will develop a Trust Wide performance management approach and Policy to support all staff to be fully equipped and capable of undertaking their roles.	A Performance Management Framework will launched within the Trust for all staff.	01/10/2017
The Board will develop and consider its strategy as part of the wider STP and MLaFL plans	An agreed plan for future shape and form of organisation	02/01/2018
The Board will develop a clinical service strategy for Acute services within the Acute Service Redesign	A clear plan for acute services on the Island	01/06/2018
The Board will seek approval for its Strategy with the STP, CCG, NHSI and the local population	Regulatory Approvals given	01/06/2018
The Board will develop an implementation plan for its strategy (2-5 years) to inform its Annual Business Plan	2018/19 Business Plan reflects strategic plan	01/04/2018

3.0 Staff Engagement and Leadership - Developing a Continuous Improvement Culture

Action	Outcome	Completion
To develop a Trust wide culture of improvement by skilling up key staff in recognised techniques and methodology based on developing people, delivering care.	At least 50 staff trained in quality improvement techniques	31/12/2017
Create an Improvement Hub within the Trust	A core of 6 people, highly skilled in Improvement methodology to support practitioners on the ground and to conduct Trust wide improvements	01/12/2017
60% of staff trained have completed at least 2 improvement projects	Evidence in case study	31/03/2018

3.0 Staff Engagement and Leadership - Improving Communications

Action	Outcome	Completion
Design and brand the Quality Improvement Plan including a simple visual "tag" within the context of the overall Trust Integrated Improvement Framework.	Options for Branding, approach and methodology designed and a preferred option approved by Trust Leadership Committee and Trust Board by week 4 of the project	30/06/2017
Design the products, tools and materials for the whole approach that can be left with the Trust as owners at the end of the engagement for their future use.	Launch of project into the Trust completed by week 7 of the project	20/07/2017
Design and tailor the communications strategy to ensure the plan, what it seeks to achieve and how its outcome will be measured, is widely known across all staff groups within all services across the Trust	Impact survey shows at least 50% of staff (grouping to be determined) are aware of the purpose of the plan and the Quality Improvements for patients and or staff it seeks to achieve by week 12 of the project and 85% of staff by week 20	01/09/2017
Design the methodology and framework for staff engagement as part of the plan, ensuring that staff are fully informed and aware of the plan, understand its relevance to them.	Impact survey shows that at least 25% of the staff within each service (Ambulance, Mental Health, Acute, Community, Support Services) can articulate the top 3 quality improvements for patients and or staff that are being worked on in their area by week 15 of the project increasing to 40% by week 20, 60% by week 25 and 85% by week 30	01/10/2017

3.0 Staff Engagement and Leadership – Recruitment and Retention

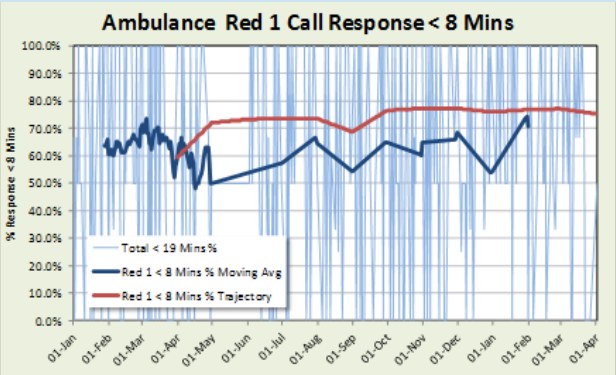
Action	Outcome	Completion
Develop 2017-18 Workforce Plan bridging the gap between current workforce skills & capacity and future business needs in the context of STP & 'My Life a Full Life' (MLAFL)	Workforce plan approved and published	30/06/2017
Develop the Trust Recruitment & Retention plan to position the Trust in a better place to be able to attract, recruit and retain people with the right competencies and values	Recruitment & Retention plan approved and published	15/08/2018
Design and implement a programme of targeted recruitment campaigns for difficult to recruit posts (Inc. overseas) promoting the Trust 'Brand' as an attractive IOW employment proposition aligned to MLAFL	Recruitment campaign schedule approved and delivered to achieve a reduction in vacancy rate from 5% to 3%	31/12/2017
Reduce reliance on agency & locums by recruiting to substantive post & Bank	Reduce vacancy rate from 5% to 3%	31/01/2018
Introduce a more systematic approach and increase the number of opportunities for Apprenticeships across all disciplines	Increase Apprenticeships from 50 to 70 by Q4	31/03/2018
Increase opportunities for education links, careers fairs and work experience across the Trust and continuously improve the quality and capacity of student placement to grow our talent pipeline	Increased student utilisation from 60% student to 75%	28/02/2018
Facilitate implementation of Healthroster Optima, including Safe Care to maximise effective use of available resources (inter-dependency with DofN & COO)	100% compliance with rostering targets	31/12/2017
Complete implementation of 2016 Junior Doctor Contract	Full implementation of junior doctor contract	01/11/2017
Develop Retention Strategy in preparation for the potential impact of Brexit on current Trust employed EU workers	Retain 90% of EEA Nationals that were employed on 1.4.17	01/03/2018
Work with Partners on the Island to develop and agree a consistent approach to incentivising overall recruitment with a focus on affordable housing, flexible and cost effective childcare and flexi working as priority areas	1. Net gain of nursing staff in the Trust from April 17 baseline 2. Overall reduction on vacancy gaps 3. Reduced agency costs and hours used	31/12/2017

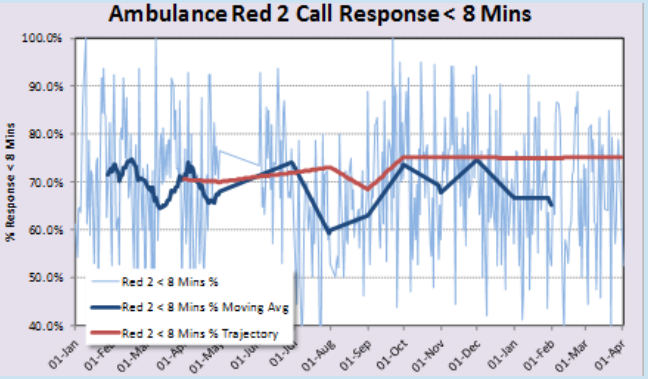
KEY THEME 4

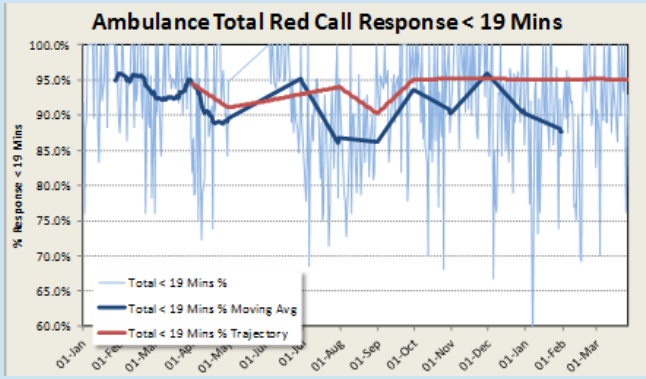
4. Operational Performance

Like some other organisations the Trust has been struggling to hit its operational performance targets and constitutional standards for some time. In small part this is due to the rising demand seen all over the country, however, the CQC and other have highlighted to the Trust that the clinical practice in the Emergency Department together with the way the Trust manages its "flow" of patients through the hospital is having an adverse Impact in achieving the important requirements of access to timely care for patients/service users.

The operational performance plan will address how the Trust will improve services to meet the required targets.







4. Operational Performance - Mental Health

	Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	15/16 YE	16/17 YTD
Improving Access to Psychological Therapies	1. The proportion of people that enter treatment against the level of need in the general population	22% Year End Target	23%	20%	23%	19%	20%	22%	20%	22%	15%	27%	26%	26%	22%	22.0%
	2. The number of people who are moving to recovery.	50% Year End Target	48%	51%	49%	56%	51%	52%	52%	55%	54%	50%	63%	62%	49%	53%
	3. The proportion of people that wait 6 weeks or less from referral to ENTERING A COURSE OF IAPT TREATMENT against the number of people that finish a course of treatment in the reporting period	75% 2016/17	98%	96%	94%	100%	99%	98%	97%	98%	98%	97%	93%	95%	N/A	N/A
	4. Proportion of people that wait 18 weeks or less from referral to ENTERING A COURSE OF IAPT TREATMENT against the number of people who finish a course of treatment within the reporting period.	95% 2016/17	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A
	5. Proportion of people that wait 6 weeks or less from referral to THEIR FIRST IAPT APPOINTMENT against the number of people who enter treatment in the reporting people	75% 2016/17	95%	96%	99%	100%	98%	97%	98%	97%	98%	86%	96%	99%	N/A	N/A
	6. The proportion of people that wait 18 weeks or less from referral to FIRST IAPT APPOINTMENT against the number of people who enter treatment in the reporting period	95% by March 2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A

	Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	15/16 YE	16/17 YTD
EIP	7. Early Intervention Psychosis - Waiting Times	50% from April 2016	50%	100%	100%	67%	75%	75%	100%	100%	100%	100%	50%	60%	63%	81%
Gate Keeping	8. Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	95%	100%	97%	95%	95%	91%	98%	81%	100%	97%	97%	94%	100%	95%	95%
Care Programme Approach	9. Care Programme Approach (CPA) - The Proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	98%	95%	100%	98%	92%	94%	100%	96%	91%	94%	97%	89%	96%	95%
	10. Care Programme Approach (CPA) patients, comprising: Formal Review within 12 months	95%	95%	95%	92%	93%	92%	99%	98%	99%	99%	99%	98%	98%	96%	97%
	11. Mental Health Data Completeness: Outcomes for Patients on CPA	50%	77%	78%	77%	76%	77%	86%	72%	84%	83%	83%	82%	85%	66%	81%
DTOC	12. Delayed Transfers of Care	>7.5%	13%	12%	5%	8%	10%	10%	14%	10%	13%	12%	10%	7%	12%	10%

CONSTITUTIONAL STANDARDS

4. Operational Performance – Emergency Department Priority Plans

As part of the Quality Improvement plan the Trust will ensure Quality Impact Assessments are carried out to ensure the following has no unintended negative consequences on quality of care whilst driving up improved access and flow for patients.

Action	Outcome	Completion
Identify and recruit into key clinical workforce gaps using demand information and recognised workforce tools	Reduced vacancies in the department from Apr 17 baseline	30/09/2017
Review urgently staffing arrangements (medical and nursing) in the Paediatric Emergency Department and align Paediatric skills with demand	Paediatric skills available to the ED on 100% of shifts	15/05/2017
Develop an ambulance handover protocol to eliminate handover delays (consider using the ECIP tactical guide)	Develop an ambulance handover protocol to eliminate handover delays (consider using the ECIP tactical guide)	30/06/2017
An ED consultant to lead and implement a model of early senior review within the department (such as 'pit stop', 'SIFT' or 'RAT').	Early senior review taking place on 80% of shifts	31/07/2017
Implement a zero tolerance approach to non admitted and minor breaches including the use and protection of ENPs running minors	0% non admitted and minor breaches by end of June 17	30/06/2017
Review processes in specialty teams to improve the responsiveness to ED for a specialty opinion. Align with potential SAU and PAU developments.	Reduced breaches for specialty review by 50% from Apr 17 baseline	30/06/2017
Align and develop the frailty pathway into ED to contribute towards avoiding admissions and the deconditioning of the over 65's from baseline number.	50% increase in avoided admissions for over 65's from Apr 17 baseline	30/08/2017
Review the department and make available a room for ED staff to assess patients in mental health crisis that does not compromise the safety of the patients or staff.	A new safe space made available to deal with patients in mental health crisis	31/07/2017

4. Operational Performance – Ambulatory Care Priority Plans

Driving forward ambulatory care across the Trust is a key component to the unscheduled care improvement plan. Clinical Leadership in this area is crucial as is the protection of the service even during challenging days where admissions are high and overall flow is slow.

Action	Outcome	Completion
Agree and document the strategic next steps for AEC including new pathways and interventions	Agreed next step actions with responsible owners identified	31/07/2017
As a priority devise pathway that links with frailty service/ access to Comprehensive Geriatric Assessment if clinically appropriate	Key content of new pathway agreed. Increased Comprehensive Geriatric Assessment [CGA] by 50% from April 17 baseline	30/05/2017
Increase the proportion ambulatory care interventions as a proportion of the medical take	As a minimum 30% increase in ambulatory care activity as a proportion of the medical take from Apr 17 baseline	31/03/2018
Identify organisations through ECIP that have well developed AEC in place	Feedback of organisations from ECIP	15/06/2017
Assess the benefits of joining the Ambulatory Emergency Care Network to ensure a collaborative and best practice approach is taken.	Pro's and cons analysis of joining the network completed by the department and signed off by the CBU	17/05/2017
Make contact and arrange a learning visit to include the CD and relevant Consultant(s) with other key clinical staff	At least one site visit and learning completed	31/07/2017
Feedback outcomes from the learning visit to through the unscheduled care programme Group and Programme Board, and as a minimum specifically highlighting changes to the local service that will be taken forward	Agenda item and highlight report to Programme Group and Programme Board	30/09/2017

4.0 Operational Performance – Assessment Units Key Priorities

The first 72 hrs is crucial for recovering an individual especially those 65 years of age and above. Beyond this the probability of deconditioning increases significantly. The Trust will build an assessment philosophy that is supported by diagnostics and therapies in an attempt to maximise the number of patients discharged safely within 72 hours of an appropriate admission.

Action	Outcome	Completion
Review and understand MAU Medical and non medical staffing current positon	Current position paper prepared by the department and signed off by the CBU	30/04/2017
Agree skill mix requirements of the team to meet demands	Future position paper prepared by the department and signed off by the CBU	15/05/2017
Understand weekend staff requirements to reflect need including clinical support services (7 day working)	7 day working workforce and service requirement paper signed off by CBU	31/07/2017
Continue the recruitment of 2 WTE Acute Physicians (MAU Consultants)	Increased 2wte Acute Physicians in establishment from Apr 17 baseline	30/09/2017
Develop the SOPs to receive appropriate GP admissions directly to MAU as standard.	SOPs written, signed off by AEC staff as having read and understood and communicated to the wider Trust	31/07/2017
Align frailty pathway into MAU and identify new potential resource	Frailty pathway requirements presented in a paper by CBU	15/07/2017
Update and re-launch Internal Professional Standards (IPS) across MAU, ensuring the Medical staff are involved.	IPS agreed and signed of by all clinical staff. At least 5 discharges before noon 6-7 days per week	30/09/2017
Agree baselines and improvement trajectory for LoS reductions for patients in the 0-72 hrs category	1. 15% increase in numbers with a LoS less than 24hrs from Apr 17 baseline 2. 15% increase in numbers with a LoS greater than 24hrs and less than 72 hrs from Apr 17 baseline	30/06/2017
Identify 10% patients daily who could be discharged before 10am. As a starting point work back from noon.	10% of overall MAU daily discharges before 10am	31/07/2017
Agree location of SAU & PAU and the philosophy of approach	Options paper from SAU	30/06/2017
Review Consultant rota's and job plans to determine available model options.	Options paper from SAU	30/06/2017
Develop the model, including the Protocols and SOPs	Protocols and SOPs written and signed off by the CBU	30/11/2017
Communicate the model internally [ED and Wards] and externally to GPs and other stakeholders	Various communication medium	30/11/2017
Implement the model	1. 30% increase in numbers with a LoS less than 24hrs from Apr 17 baseline 2. 30% increase in numbers with a LoS greater than 24hrs and less than 72 hrs from Apr 17 baseline	31/03/2018

4.0 Operational Performance – Flow Key Priorities

The Trust are fully aware of the importance of flow across the organisation in real time to ensure patients that we admit and discharge are cared for safely and in a timely manner by our healthcare teams. A focus on embedding more efficient and effective processes across all ward areas will be a priority. It is expected that our medics and ward leaders take real ownership and drive forward this change.

Action	Outcome	Completion
Review and develop a strategy for a properly resourced frailty service, that enables frail older people to be managed assertively from the time they arrive at hospital to their discharge.	Agreed frailty strategy signed up to by system partners	31/08/2017
Monitor the increase the number of 75+ comprehensive geriatric assessments and increase the proportion of patients discharged within 72 hrs	Increased Comprehensive Geriatric Assessment [CGA] by 50% from April 17 baseline	31/07/2017
Implement the SAFER patient flow bundle & Red2Green processes across all wards following the ECIP rapid improvement guides	The % of PDD's set increased by 50% against Apr 17 baseline Admissions and discharges balance daily at least 85% of the time	31/12/2017
Co-design and launch internal professional standards with clinical staff.	IPS agreed and signed off by ward clinical staff	15/08/2017
Design and undertake a review the operations centre function, resource, IM & T capabilities, integration with CBU's and wards outside site meetings etc.	Review paper of current position signed off by CBU and presented to Unscheduled Care Programme Group	30/06/2017
Align the discharge resource into one team and develop a single operational lead	Agreed single team structure	30/11/2017
Review current paperwork and develop/evolve a single assessment form	Single assessment form agreed and in use across 100% wards	30/09/2017
Further consideration of how best to deploy the Trusted Assessor Model	Discussions between health and social care and subsequent actions signed off through respective governance arrangements	30/09/2017

4.0 Operational Performance – Discharge Key Priorities

Working with Partners to ensure discharge arrangements are in place on admission. Where there are provision gaps the Trust is committed to working with the CCG and Local Authority in a collaborative way to agree a way forward that is best for all three organisations on the island.

Action	Outcome	Completion
Work with Partners to ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting	85% CHC assessments take place outside hospital by 31st Mar 18	28/02/2018
Understand the barriers to achieving a Discharge to Assess model based on 3 pathways namely home first, care homes and complex nursing homes	Opportunity paper signed off by health and social care partners	15/06/2017
Identify D2A commissioning needs where there are service provision gaps i.e home first and complex dementia	Gaps analysis by CCG	31/08/2017
Work with Commissioners to close the service provision gaps	Increase in D2A placements/beds by 40-50% from Apr 17 baseline	31/03/2018
Prepare for and undertake an ECIP led Multi Agency Discharge Event [MADE]	MADE undertaken and actions signed of by the Trust, the CCG and LA	30/08/2017
Agree simple discharge definition across the organisation	Definition of simple discharges agreed at OMG	30/04/2017
Collect numbers of discharges, including achievement before 12 noon, and feedback as part of the daily reporting	Ops centre daily minimum data set includes discharge numbers	30/06/2017
Agree complex discharge definition across the organisation	Definition of complex discharges agreed at OMG	30/04/2017
Collect number of discharges and feedback as part of the daily reporting	Ops centre daily minimum data set includes discharge numbers	30/06/2017
Ensure there is a weekly meeting that systematically reviews all patients that have a LoS greater than 7 days [stranded patients]. Agree escalation process.	Weekly meeting takes place 90% of the time. Escalation process documented and tested	30/05/2017

4.0 Operational Performance – Waiting Times Priority Plans

Well developed and professional waiting list management will improve waiting times for patients from the isle of Wight and the Trust will invest in this over the next 12 months.

Action	Outcome	Completion
Revise structure to establish standardised PTL meetings at specialty level e.g.. H&N. In some cases this may be more appropriate covering up to 3 specialties aligned with the management structure	PTL service specific governance diagram	09/06/2017
Revise patient access meeting inc ToR, agenda and what level of information that is used.	Revised patient access meeting and new information to support its function	30/06/2017
All specialties to complete RTT tool self assessment	Outputs of compliance self assessment tool presented to OMG	31/07/2017
Agree which DQ pathway metrics, that are being collected by PiDS, should be the responsibility of which staff function i.e. clerks, medical secretaries etc.	DQ metrics mapped to delivery functions/staff roles	30/06/2017
Review trial of revised clinic outcome forms & required actions	Output of assessment documented by head of operations	14/07/2017
Develop standardised prepping of notes model	Standardised notes prepping protocol	15/09/2017
Assess Trust access policy against checklist and best practice	New access policy signed off by OMG	15/06/2017
Review Trust's performance management framework & revise to reflect changes	Updated performance management framework	30/11/2017
Schedule training sessions and communicate to all expected attendees (focused staff groups)	Training plan communicated to organisation	15/07/2017
Review Pre-assessment capacity, resource, documentation and anaesthetic requirements	Current position paper prepared by the department and signed off by the CBU	15/05/2017
Review DSU demand at HRG and specialty level	Analysis of DSU opportunity	30/04/2017
Explore the options for to have a more dedicated and protected day surgery unit e.g. modular Day Surgical Unit, conversion of wards etc.	Options appraisal to CBU Leadership Team	30/05/2017
Agree a set of actions to address the top 5 reasons for poor patient flow through DSU to increase beyond 1.5 procedures per bed	Action plan to address top 5 priority improvements	31/08/2017
Agree which procedures could be carried out as outpatient procedures	Current day surgery procedures marked as potential outpatient procedures	15/07/2017
Review and agree a pragmatic list of performance metrics by consultant and specialty, as part of a performance board, in preparation for the theatre programme	Visible and up to date performance board on theatre complex walls	15/07/2017
Review of all local diagnostic testing to ensure all diagnostics to be performed within 7 days of receipt of referral	Knowledge of local demand and capacity availability 90% seen within 5 days and 100% seen within 7 days of referral	30/08/2017
Audit of current model & identify pressure on each MDT	Outcome of MDT audits as part of an update report	15/08/2017
Recruitment drive of one additional Radiologists and one additional Histopathologist to provide MDT cover	Radiologist and Histopathologist input into 80% of MDTs	30/09/2017
Embed completion of Treatment Summaries and Holistic Needs Assessments	80% compliance against record keeping audit	30/10/2017
Clinical Referral proforma to be trialled by Lung team	100% ling Consultants to trial clinical referral proforma	31/08/2017

4.0 Operational Performance – Ambulance

Action	Outcome	Completion
To make the hospital handover process as timely and safe as possible so that ambulances can get back onto the road and respond to further life threatening calls	1. 75% of Red 1 calls on scene within 8 minutes 2. 75% of Red 2 calls on scene within 8 minutes 3. 95% of calls on scene within 19 minutes	31/07/2017
To increase the coverage of the volunteer community first responder provision across the island using well trained staff who have access to the right level of equipment	Daily Community First Responder cover in existing scheme areas and expansion of schemes to all required areas across the Island	31/12/2017
The deployment of our workforce to meet the known demands of the service through the implementation of new rota's	Achievement of ambulance performance targets; completion of workforce review and associated changes to roster for front-line and the Hub	31/12/2017
To assess the accuracy of data provided during the last two years to ensure Trust has correctly reported its ambulance performance	Completion of data dashboard for ambulance and system wide activity and demand. Meeting performance targets	30/11/2017
To ensure equipment is available to for use by our ambulance crews to respond quickly to all patient needs	Reduction in activation delays from April 17 baseline	30/10/2017

4.0 Operational Performance – Access to Mental Health Services

Much of the work required to ensure the Mental Health Services meet national standards will be dictated by improved data quality and more visibility and understanding of hidden internal waits. Increase capacity could be supplied through group session rather than individual appointments where appropriate. Working with our Partners to control and improve DTOC numbers will be vital along with improved links between our community and acute teams to manage patients on a CPA immediately after they leave our inpatient facilities.

Action	Outcome	Completion
Systematic review of the key performance data across the MH CBU to put in place more robust systems that have a single source of data and definitions to support accuracy and assurance	Assurance that all Constitutional standards for MH are being reported accurately	31/108/2017
Pathway reviews and re-modelling of the Community and Acute models of care	New model of Community MH care agreed and signed off by Trust and CCG New model of Acute MH care agreed and signed off by Trust and CCG	15/01/2017 31/03/2018
Review waiting times for all parts of the client users journey and not just those report nationally to identify bottlenecks and hidden waits	Action plan to resolve the most significant hidden waits	30/09/2017
Increase demand options by looking at alternative ways of interacting with service users. In particular a focus on where group sessions would work and have the most impact	Between 5-10 group sessions taken place and feedback from clients users received	31/12/2017
Undertake a detailed review of the Single Point of Access (SPA) service looking at agreeing, writing and implementing key SOPS, guidelines and policies.	New operational policy written, agreed and launched for SPA	30/10/2017
Due to increased demand, establish more robust links between community and acute staff and better manage service users on a CPA who should be followed up within 7 days	1. 25% increase in numbers of CPA's from Apr baseline. 2. 95% of service users on a CPA and followed up within 7 days	31/01/2018
Work closely with Partners to maximise the alternatives to impatient care and further reduce DTOC numbers to less than 7.5%.	DTOC numbers less than 7.5% for at least 3 months in 17/18	31/03/2018

KEY THEME 5

CLINICAL AND CORPORATE GOVERNANCE

5.0 Clinical and Corporate Governance

The Trust recognises that the issues highlighted by the CQC are the manifestation of poor governance. The Trust Board was not sighted on many of the issues, and where they were, the actions they considered to be appropriate to address the issues were not effective.

The Board had undertaken a review of its Governance in 2015, but a recent stocktake shows that many of the recommendations from that review were not implemented, or if they were, were not embedded into the organisation to ensure a sustainable governance structure.

The Trust implemented a new management structure in 2015 and in doing so, failed to ensure that the systems and processes required to support the governance of those structures were in place. This has left the Trust with a deeply fragmented approach to governance with significant gaps in assurance.

The Quality Improvement plan must address these fundamental flaws in governance to ensure that the Trust is able to provide safe, effective care to all those it serves and to monitor its own progress in improving services to achieve the ambition of "Outstanding" by 20/20.

The core elements of good governance within health services are:

- ✔ Culture
- ✔ Data
- ✔ Systems
- ✔ Audit

5.1 Culture

The culture of the organisation is addressed within both the patient safety staff engagement/leadership sections of this plan. The Trust must introduce, nurture and promote a culture that is one of open and transparent communication where all feel free to raise concerns and identify errors. A culture where respectful, courteous challenge is understood to be a cornerstone of good governance. A culture where all staff learn from their own and others mistakes, are early adopters of good practice and are equipped with the skills to continuously review, adapt and improve their practice.

5.2 Data

Data is essential to understanding the performance of the organisation. The production of hard, accurate data on activity, the ability to analyse that data for trends, comparisons with others and anomalies is the foundation of purposeful questioning and investigation that leads to improved care. However, hard data alone is not sufficient to understand the experience of care and so soft data through informal patient, staff and carer feedback must be added together with high visibility of all the leaders within the organisation. Staff should know who the leaders are be able to approach them and know that they can be heard. Leaders need to see for themselves what services are like and how they feel for staff and patients. The plan addresses hard data within the Patient Safety section of the plan and soft data through the Patient Experience and Staff Engagement/Leadership sections.

5.3 Systems

The Trust will develop and embed systems and processes to ensure that the information captured through improvements to culture and data is organised into a structure that enables it to be presented in the right format for individuals and teams to review, consider and act upon its findings. This structure needs to be rebuilt and the plan for that is within this section.

5.4 Audit

Audit is essential for the Trust to understand is the actions it is taking to improve services are effective. It is built into every plan within this plan as clear outcome measures.

5.0 Clinical and Corporate Governance

Action	Outcome	Completion
The Trust will develop a Board Assurance Framework	A Board Assurance Framework and Policy	01/08/2017
The Trust will develop clear Terms of Reference, Membership, meeting cycles and data sets for all elements of the Framework	Within the BAF	01/08/2017
The Trust will review, refresh and cleanse the Risk Register	A revised, relevant Risk Register	01/07/2017
The Trust will develop a new Risk Management Policy	New Policy approved	01/08/2017
The Trust will train all staff in leadership roles in Risk Management	80% staff trained	01/02/2018
The Trust will make all staff aware of the Risk Management Policy and how to report risks, issues and raise concerns	85% staff trained	01/04/2018
The Trust will develop its audit cycle to ensure that the outcomes of actions within the QIP are robustly tested and that once achieved, move into continuous improvement and/or monitoring to ensure success is embedded	A Board approved Audit plan to inform the BAF	01/09/2018

Key Programme Risks

Key Risk	Risk Status	Mitigation
Executive team capacity	12	Interim Chief Exec, Interim Director of workforce & OD new role.
PMO capability and capacity	12	Interim Chief Exec, Interim Director of workforce & OD new role.
Capacity of the CBU teams to deliver at the desired pace	16	MBI support into the CBU's
Challenges relating to clinical Engagement	12	Clinical leads as part of the Programme Groups Extensive communication plan
Financial support required to implement the scale of changes required	20	Clinical leads as part of the Programme Groups Extensive communication plan
Perception by partners that the Trust is not supporting the LDS or STP development opportunities	8	Clinical leads as part of the Programme Groups Extensive communication plan
Inability to recruit into the key workforce gaps	20	Clinical leads as part of the Programme Groups Extensive communication plan
Higher than average turnover of staff due to interpretation of CQC report	8	Clinical leads as part of the Programme Groups Extensive communication plan
Too much emphasis on reporting internally and externally which deflects from taking forward the actions	8	Clinical leads as part of the Programme Groups Extensive communication plan
Inability for the Programme to be communicated to staff, partners and the public in a way that they understand and can be part of the improvements	12	Increased specialist communications resource to be brought in. Specification written.
Partner organisations support is not forthcoming	8	Regular review of partner commitments

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