Portsmouth Hospitals
NHS Trust

Commission for Health Improvement
Clinical Governance Review
ACTION PLAN
MARCH 2002

KEY - TEXT = URGENT

KEY AREAS FOR ACTION – Increased Risk to Patient Safety							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
To improve working relationships within Renal Services, ensure clinical collaboration and implement the findings of the external review team, which is taking place following concerns expressed by CHI following the Clinical Governance Review Page xiv (Action point 30 of 37)	To improve quality of patient care being offered through renal services To undertake external review and implement findings To ensure potential risk to patient safety is minimised	1. Undertake external review 2. Set up project steering group to define issues to be addressed and agree action plan 3. Implement action plan 4. Project steering group to monitor/review implementation and progress.	**Constraint :** Resistance to change. **Impact :** Quality of care would not improve. Increased chance of litigation.	Medical Director (Clinical Director, Renal Services) (Senior Nurse, Renal Services)			
To manage the problems caused by the high numbers of emergency admissions. These must be tackled in collaboration with the local health community. Page xiv (Action point 1 of 37)	To ensure emergency admissions : a) are appropriate and b) admitting services are streamlined and sensitive to need.	1. With the local health economy, agree appropriate criteria for referral to emergency services. 2. Streamline emergency admitting services to be responsive to local need.	**Constraints:** Resistance to change both within the hospital and the local health community. Knowledge / understanding of local population. **Impact:** Inappropriate use of beds. Increased trolley waits. Potential increase in complaints and litigation issues.	Director of Planning (Medical Director)			

KEY AREAS FOR ACTION – Strategic Importance necessary to improve Clinical Governance in the Trust							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
To review the flow of patients from admission to discharge, ensure timely and appropriate placement of patients and minimise transfers between ward areas. Page xiv (Action point 2 of 37)	To ensure timely and appropriate placement of patients and minimise transfers.	1. Set up project steering group to define issues to be addressed and agree action plan. 2. Review flow of patients from admission to discharge. 3. Implement action plan 4. Project steering group to monitor / review implementation and progress.	**Constraint :** Resistance to change **Impact :** Quality of care would not improve. Increase chance of litigation. Relatively poor performance against star ratings and national performance indicators.	Medical Director (Head of Modernisation) (Director of PFI)			

KEY AREAS FOR ACTION – Strategic Importance necessary to improve Clinical Governance in the Trust							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
To raise awareness of the need to provide high levels of security throughout the Trust to ensure staff and patient safety. Page xiv (Action point 6 of 37)	To improve security measures throughout the Trust	1. Set up 'task and finish' group to feed in to risk management committee. 2. Review current security provision and include results from root cause analyses of associated incidents. 3. Consider refocusing of resources and make business case as appropriate. 4. Support implementation of recommended measures 5. Provide feedback to risk management committee and Trust Board as appropriate.	**Constraint :** Resistance to change. Limited resources available. **Impact :** No improvement in staff and patient safety. Increased associated incidents. Increased chance of litigation.	Director of Operations (Head of Risk, Complaints and Legal Services)			

To review all human resource related policies and procedures and ensure that they are effectively implemented and communicated to staff Page xiv (Action point 32/33 of 37)	To review human resource infrastructure within PHT.	1. Devise and agree a revised Human Resource Strategy and agree at Trust Board. 2. Implement strategy, ensuring support for new ways - of - working during changeover period. 3. Promote understanding / communication of changes throughout the organisation during period of change.	**Constraints:** Resistance to change. Conflict in management styles during changeover period. **Impact :** Staff continue to feel undervalued, poorly supported and unheard.	Director of Organisational Development and Human Resources)			

To ensure a consistent approach is taken to the management of informal complaints and improved local resolution. Page xiv (Action point 7 of 37)	To ensure a consistent approach to the management of verbal complaints is adopted throughout the Trust.	1. The risk management strategy is revised ensuring incorporation of verbal complaints handling (along with other relevant items). 2. The risk management strategy is approved at the appropriate level. 3. The strategy and associated action plan is implemented, including complaints handling training. 4. Review and development of revised business plan for complaints service provision.	**Constraints :** Risk management strategy is not supported. Resourcing to support complaints department revised business plan is not made available. **Impact :** PHT Services are less responsive to patient / users. Increase in formal complaints.	Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			

To act on the findings of the staff opinion survey and ensure that a commitment to resolve areas of concern is effectively demonstrated to staff. Page xiv (Action point 31 of 37)	To gain understanding and ownership by the Trust of the staff being its most valuable asset.	1. Develop a two way communication system. Ensure views are fed back right to Trust Board level. 2. Encourage staff to voice their opinions and concerns through the vehicles available to them. 3. Ensure the feedback mechanism of concerns raised to the Board is promoted. 4. Identify an appropriate executive responsible for ensuring appropriate follow up action is taken. 5. Ensure feedback of action taken is given to individuals raising concern.	Constraints : Resistance to change. Fear – employee / employer. **Impact :** Staff retain feelings of being undervalued. Staff unable to contribute to improving their work and working conditions.	Director of Organisational Development and Human Resources			

To facilitate the successful integration of military and NHS personnel. Page xiv	Wherever possible to facilitate consistency and equity for patient services across all PHT sites.	1. Set up small project steering group to define issues to be addressed and agree action plan. 2. Implement action plan. 3. Project steering group to monitor / review implementation and progress.	**Constraints :** Successful integration of two diametrically opposed cultures. Driving forces above the level of the Trust. Resistance to change from both systems. **Impact :** Inequity of care services available from PHT. Staff frustration/s remains in both systems. Patient / local population frustrations/s remain.	Medical Director (Commander of MDHU) (Divisional Clinical Director Surgery)			

To implement the findings of District Audit following a review of the identification and management of clinical risks. Page xiv	To implement the findings of the District Audit review for clinical risk management.	1. PHT to support District in undertaking the audit. 2. PHT to formally receive report and findings from District Audit at appropriate level/s. 3. Risk management strategy and action plan to take account of District Audit report. 4. Implementation of risk management action plan.	**Constraints :** Potential resistance to change at lower levels in organisation. **Impact :** Increased chance of litigation. Limited improvement in quality of care services available to patient.	Director of Nursing and Midwifery (Head of Risk, Complaints ad Legal Services)			

KEY AREAS FOR ACTION - Not identified by CHI							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
To change the culture in the organisation to one of valuing, openness and learning.	To change the culture in the organisation to one of valuing, openness and learning.	1. Ensure understanding and ownership at corporate level. 2. Agree corporate philosophy. 3. Communicate philosophy and promote understanding and ownership throughout the organisation.	**Constraint :** Resistance to change **Impact :** Quality of care has less potential for improvement. Staff dissatisfactions remain. Limited improvement against star ratings and national performance indicators.	Chief Executive (Director of Nursing and Midwifery) (Medical Director)			

To strengthen strategic capacity around clinical governance agenda.	To strengthen strategic capacity around clinical governance agenda.	1. Develop an explicit framework for clinical governance reporting to the Trust Board. 2. Secure involvement in associated action planning. 3. Corporate clinical governance team to monitor and review implementation of action plan. 4. Corporate clinical governance team to take appropriate follow up action as necessary. 5. All Board members to undertake development programme on clinical governance.	**Constraints :** Resistance to change. **Impact :** Trust unable to deliver on clinical governance agenda Trust unable to deliver on governance agenda.	Chief Executive (Chairman)			
To refocus and invest in infrastructure to be able to deliver on external and internal drivers, including clinical governance agenda.	To refocus and invest in infrastructure to be able to deliver on external and internal drivers, including clinical governance agenda.	1. Prepare business plan to identify resources in order to develop infrastructure for clinical governance associated activity. 2. Prepare business plan to agree and implement workload measurement tool that will address capacity, activity and required resources.	**Constraints :** Resistance to change. **Impact :** Trust unable to deliver on clinical governance agenda Trust unable to deliver on governance agenda. Trust limited capacity to deliver on performance indicators and other national targets.	Chief Executive (Director of Finance)			

THE PATIENT EXPERIENCE							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Emergency Services							
To deal with the problems caused by high numbers of emergency admissions. These must be tacked in collaboration with the local health community. Page 9 (Action point ES2)							
Organisation of Care							
To review the flow of patients from admission to discharge, ensure timely and appropriate placement of patients and minimise transfers between ward areas. Page 11 (Action point ES3 and Board Paper G)							

To ensure that the policy on discharges is communicated to all staff and the effectiveness of implementation is monitored. Page 11 (Action point ES3 Board Paper A, F, G and N)	1. Secure Corporate ownership of policies and their implementation.	1. Design and implement corporate framework for policy development. 2. Design and implement educational framework to support communication and associated training / development 3. Develop associated audit tool and plan, alongside policy. 4. Gain local ownership of corporate policy auditing through divisional performance review mechanism.	**Constraint** : Cultural change required by key stakeholders. **Impact :** Increased potential for litigation. Limited improved quality in care delivery				
To ensure continued clear and robust specialist paediatric support for the paediatric surgical ward until it can be sited with the main paediatric service. Page 11				Chief Executive (Clinical Director Paediatrics)			

THE PATIENT EXPERIENCE – cont'd							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Humanity of Care							
To review the use of some patient areas and facilities to ensure that privacy and dignity are maintained to the highest possible standards. Page 12 (Board Paper C and Q)				Director of Nursing and Midwifery (Director of Capital Estate)			
The Environment							
To review the levels of security throughout the Trust to ensure staff and patient safety. Page 13 (ES4 and Board Paper Y)				Director of Operations (Head of Risk, Complaints and Legal Services)			

USE OF INFORMATION							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
To ensure a consistent approach is taken to the management of informal (verbal) complaints. Page 17 (ES6 and Board Paper U, V and Draft Risk Management Strategy)				Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			
To review the quality and timeliness of patient information communicated to General Practitioner's and on transfer between clinical areas. Page 17 (ES3 and Board Paper G)				Medical Director			
To ensure that the performance management framework for reporting progress in clinical governance is fully understood by staff. Page 17 (Clinical Governance Manager involvement in Divisional Performance Reviews)				Director of Nursing and Midwifery Medical Director			
To review Caldicott arrangements and ensure that staff are aware of their responsibilities. Page 17				Medical Director			

To review the process for the management of formal complaints to ensure performance targets are achieved. Page 17 (Current Process already being revised)			Requires Infrastructure funding to sustain	Director of Nursing and Midwifery (Head of risk, Complaints and Legal Services)			

USE OF INFORMATION – Cont'd							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
To ensure that patient information from all relevant professional groups is available at the point of care delivery. Page 18 (Dedicated post now filled to take this forward)			Constraint: Availability of funding for documentation. Impact: Failure to meet national requirements Potential increase of litigation	Director of Nursing and Midwifery Medical Director			
To ensure that clinical staff at all levels are aware of the extent of information available and are fully involved in developing information systems. Page 18 (Trust action 4 and Board Paper M, N, O and P)			Constraint: Prevailing culture Impact: Inability to	Medical Director (Head of IT)			

RESOURCES AND PROCESSES							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Consultation and Patient Involvement							
To ensure that the policy for informed consent to treatment is fully understood throughout the organisation and the effectiveness of implementation is monitored. Page 21 (Board Paper A and F and Revised Head of Education, Training and Development post)			Constraint: Pace of cultural shift Inability to appoint to vacant post	Medical Director			
To review the effectiveness and implementation of the do not resuscitate (DNR) policy and ensure staff have access to the policy at all times. Page 21 (Board Paper A, and Revised Head of Education, Training and Development post)			Constraint: Individual responsibilities for clinical governance National Guidance is actually difficult to adhere to	Medical Director			
To ensure that staff are made aware of, and participate in, training to handle complaints. Page 21 (ES6 Board Paper W and post with dedicated training responsibilities)			Impact: Failure to achieve star ratings Lack of confidence of the local population	Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			
Clinical Risk Management							

To ensure a consistent organisational approach to embedding an open learning culture. Page 24 (Trust 1, ES9, Board Paper Y. Clinical Governance Strategy, Divisional Clinical Governance Strategies and Draft Risk Management Strategy)			Constraint: Limited understanding of key leaders at all levels throughout the Trust Impact: Status Quo maintained or even further deterioration	Chief Executive (All Trust Board Members)			

RESOURCES AND PROCESSES – Cont'd							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Clinical Risk Management – cont'd							
To undertake a comprehensive trustwide risk assessment involving all key stakeholders to foster a unified approach to the management of identified risk. Page 24 (Has already begun)				Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			
To ensure that staff from all professions are aware of the importance of reporting incidents and understand what and when to report. Page 24 (ES9, Board Paper Y and draft Risk Management Strategy)			Impact: Increased litigation Lack of confidence in local population Failure to review practice	Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			
To test the robustness of risk reporting procedures, particularly in relation to near miss reporting. Page 24 (ES9, Board Paper Y and draft Risk Management Strategy)				Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			
To ensure that feedback on the outcome and action resulting from clinical incident reporting is consistently given to staff. Page 24 (Trust 4 and draft Risk Management Strategy)				Director of Nursing and Midwifery (Head of Risk, Complaints and Legal Services)			
Clinical Audit							

To ensure that staff understand and comply with the Trust approach to clinical audit activity. Page 26 (Board Paper F and Performance Management Framework)			Constraint: Lack of a unified approach and prioritisation on external and internal imperatives Limited understanding of these imperatives at all levels throughout the Trust	Medical Director (Head of Audit)			

RESOURCES AND PROCESSES – Cont'd							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Clinical Audit – cont'd							
To ensure a consistent approach is taken to multidisciplinary audit and the sharing of results throughout the organisation. Page 26 (Board Paper F, review audit strategy and refine corporate audit structure)			Constraint: Resistance to change Limited understanding of imperatives at all levels throughout the Trust Impact: Uncertainty around priorities	Medical Director (Head of Audit)			
To ensure that changes in practice resulting from audit activity are re-audited to monitor progress. Page 26 (Board Paper A and F)			Constraint: Resistance to change Limited understanding of imperatives at all levels throughout the Trust Impact: Uncertainty around priorities	Medical Director (Head of Audit)			
Research & Effectiveness							

To ensure that staff understand the corporate approach to research and effectiveness. Page 28 (Board Paper A, R, S, T and H). An appropriate member of RSDU has joined the clinical governance team)			Constraint: Limited understanding at all levels	Medical Director			
To develop systems to ensure that outputs are generated from research Page 28				Medical Director			
To prioritise future care pathway development and ensure this is effectively communicated to staff. Page 29							

RESOURCES AND PROCESSES – cont'd							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Research & Effectiveness – Cont'd							
To develop a multidisciplinary approach to research and effectiveness and ensure the involvement of patients. Page 29							
To ensure that relevant NICE guidelines are identified and their subsequent implementation is monitored. Page 29							
Staffing and Staff Management							
To develop working relationships within Renal Services and ensure clinical collaboration. This should include implementation of current action plans and the recommendations of the review team following the external review. Page 33							
To act on the findings of the staff opinion survey and to ensure that a commitment to resolve areas of concerns is effectively demonstrated to staff. Page 33							

RESOURCES AND PROCESSES – cont'd							
Action Point	**Objective**	**Action required and timescale**	**Constraints and/or impact of not taking the action**	**Accountability**	**Intended Outcome**	**Monitoring**	**Reference**
Staffing and Staff Management – cont'd							
Review all human resource related policies and procedures and ensure that they are effectively implemented and communicated to staff. Page 33							
To progress the appraisal process and ensure the implementation of personal development plans. Page 33							
To ensure all relevant disciplines are represented in clinical team development. Page 34							
Education, Training and Continuing Personal and Professional Development							
To review and implement the education, training and development strategy and ensure this is effectively communicated throughout the organisation. Page 35							
To ensure that staff receive timely updates for mandatory training. Page 35							
To ensure that outcomes of training are evaluated. Page 35							