CUH IMPROVEMENT PLAN SUMMARY

Last Updated by:	Carol Hunter SQS Quality Manager
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Use of Rag Rating
The Trust is using a 5 point rag scale in assessing progress against each action.
This RAG rating will be mirrored throughout the underpinning plans, workbooks and action logs that sit beneath each action.

The RAG rating at workstream level reflects progress towards delivery of the identified outcome rather than mechanistic completion of individual actions.
Hence amber is used where plans and actions are in progress and being tracked, with green reserved only for areas nearing completion.
Blue for embedded is only used where all actions are completed.

The RAG rating will be updated on a monthly basis by the Workstream Lead for each action, to be challenged by the PMO and signed off by the Accountable Executive prior to being reviewed by the Board.

Instructions on how to apply the RAG rating are in the table below:

Embedded as Business as Usual	Blue
On track	Green
Behind schedule / in progress but mitigations in progress & being tracked	Amber
Deadline **delayed / not started**	Red
Date **currently TBC** so cannot measure status	Grey

Ref:	Thematic Title	Origin: CUH/ CQC/ NHSI	Description of overarching action required.	Delivery Status	CQC 'must dos' & 'should dos'	Progress	Key risks & mitigations	Board Assurance Framework (BAF)	Key Performance Indicators (KPIs) or measurable outcomes.	Likely financial impact Yes/ No	Type of supporting document required	Rationale	Change Control
Leadership & Accountability - Making sure we have the correct balance of skills and experience in sufficient quantity to deliver the changes required. Underpinned by improved governance with clear systems and processes in place to drive improvement in all areas													
P1.5.3	Risk Management Improvement Plan III		During 2017/18 the team developed the Risk Management Framework and the risk module on QSIS was rolled out to the Trust. The organisation is now entering into phase two of embedding the risk management strategy into Corporate and Divisional Practice.		N/A	Project commenced April 2019			**Current Performance:** Live Risks are reviewed in line with the Risk Management Strategy and Policy Target >=90% = 80% July 2020 All 'Significant' (15-25) risks are reviewed monthly Target >=95% = 63% July 2020 New Risk Leads on risk list have completed their e-learning Target >=95% = 97% July 2020 New risks are reviewed by the risk lead within one month of entering onto QSIS and the risk is made Live/Closed/Rejected Target >= 100% = 43% July 2020 Risks recorded on the risk register are in line with requirements the Risk Management Strategy and Policy. Quarterly spot checks on risk records will be completed (50% new QSIS users, 50% existing QSIS users) Target 100% = 89% Q3 2019/20 Milestones due recorded: 100% July 2020 Project completion status: 68%		Workbook		
Well-led - Ensure the Trust is well-led and that all governance issues highlighted in the CQC report and elsewhere are fully addressed													
Q3.1.3	Divisional Governance Improvement Action Plan	CUH	Management Executive commissioned an internal review into divisional governance under the CQC Well-Led framework and during Q4 2018/19 undertook a deep dive review to determine the state of operational delivery against the expectations set within the Quality - Good Practice Guide. This workbook captures the actions to support areas for improvement identified.		N/A	Project commenced August 2019			Milestones due recorded: 100% at July 2020 Project completion status: 24%		Workbook		
Q3.7	NICE Guidance	CUH	1. A complete review of all NICE guidelines published to date, in order to determine compliance and provide assurance of adherence to all types of NICE guidance. 2. Improvement of the NICE data management system with transfer of data onto a database platform, providing robust governance, monitoring and escalation processes. 3. Clarification of the process and the lead roles in National Guidelines Policy. 4. Written guidance e.g. handbook, training and/ or e-learning packages to support staff Trustwide with new processes.		N/A	Project commenced June 2019 **28.01.2020:** Workbook revised and additional Milestones added resulting in a slight drop in percentage complete.			Milestones due recorded: 100% at July 2020 Project completion status: 24%		Workbook		
Q3.8	Fundamentals of Care Improving Patient Journeys	CUH	In Scoping		N/A	In Scoping		**BAF001/19:** The Trust does not consistently deliver fundamental standards of care and reduce variation across all services which impacts on patient safety and experience.	Milestones due recorded: Project completion status: In Scoping				
Q3.9	Maternity Transformation Improvement Plan	CUH	In Scoping		N/A	In Scoping			Milestones due recorded: Project completion status: In Scoping				

SAFE - Ensure the Trust meets safety requirements, including having sufficiently robust safety systems and processes, and appropriate staffing levels.													
Q4.3.2	Mandatory Training - Specific Areas	CQC	Ensure that all staff complete mandatory & safeguarding training to ensure they comply with the 90% complaince target		**Jan 17 Should do (Ongoing):** The Trust should ensure that all staff complete mandatory training and safeguarding training to ensure it complies with the 90% compliance target **Nov 18 Should do (Ongoing):** The trust should ensure medical staff attendance at mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training is improved to meet the trust target.	* Overall compliance was achieved (see Q4.3.1) but specific areas identified as under achieving. * Action Log to monitor and report specific areas until mandatory 90% achieved. * Meeting with Karen Clarke & PMO to draft new action log to reflect findings in training shortfalls (30.3.2017). Project lead to provide action log signed off by Exec April 2017. Action log sent for exec. approval (April 20017) 18.04.2017 - As a result of CQC reinspection in September 2016, the Trust was awarded an overall rating of 'Good' and moved out of special measures. The Board of Directors agreed to remove risk related BAF 018/16 (from Board Assurance Framework (12.04.2017BoD minute item 3.8) [Failure to have NHS Improvement and CQC Special Measures lifted within 12 months] **CCN68.**	TBC	**BAF021/16**: Patient safety consequences as a result of a failure to recruit or adequately train junior medical staff & failure to maintain training status **BAF024/16**: Failure to protect vulnerable patient **BAF012/16**: Healthcare acquired infections **BAF015/16**:The culture & climate results in a decline in the experience & engagement of our staff with a corresponding impact on patient care, **BAF016/16**: Patient harm asa result of medication errors **BAF019/16**: Data Protection Act Breach **BAF022/16**: Patient harm as a result of wrong blood products being transferred **BAF026/16**: Inadequate Corporate Governance **BAF027/16**: Inadequate Quality Governance	**Current Performance;** KPIs Mandatory training compliance Target 90% = 91.5% July 2020 Safeguarding Lvl 3 Training Target 90% = 89.3% July 2020 Equality and Diversity Training Target 90% = 96.2% July 2020 Health and Safety Training Target 90% = 96.2% July 2020 MCA and DOLS - % of All Trust staff completed training Target 90% = 93.1.% July 2020 Resus Training - Medical and Dental Staff Target 90% = 65.4% July 2020 MCA and DOLS - % of Medical and Dental Staff completed training Target 90% = 84.4% July 2020 MCA and DOLS - % of Medical and Dental Staff in ED completed training for MCA and DoLS. Target 90% = 91.3% July 2020 Milestones due recorded:100% at July 2020 Project completion status: 100%	No	Action Log		**CC68**
Q4.4.3	ED Paediatric Waiting Area	CQC	Minor Works Programme to re-design and improve the paediatric waiting area initiated in February 2019.		**Nov 18 Should Do** The trust should ensure patients and relatives within the department cannot access the paediatric waiting room and treatment area, and staff regularly observe the paediatric waiting area.	Project commenced February 2019 **11.10.2019** - New Paediatric Waiting Area in ED handed over to Trust on schedule and now in use. An issue with the supply and fit of doors necessary to complete the build mean that the project cannot be finalised. Estates have the issue in hand. **06.07.2020:** BAU Closure Report Scheduled for Quality Steering Group 28.07.2020 **29.07.2020:** BAU Closure agreed atr Quality Steering Group 28.07.2020			Milestones due recorded: 100% July 2020 Project completion status: 100%		Workbook		
Q4.5.1	Equipment	CQC	Ensure that the equipment used to deliver care is well maintained and fit for purpose (specific issue resus trolleys & maternity), as well as use of equipment & compliance with policies Trust-wide.		**Must do:** All emergency equipment is checked in line with policy. See below. **Jan 17 Should do (Ongoing)**: Ensure that all equipment is appropriately checked and safety tested where requested [downgraded from Must do]	• Regular checks embedded into local practice for medical devices following the issuing of a poster highlighting user responsibilities. • Equipment maintenance data regularly presented at Divisional board. • Induction pack developed identifying user responsibilities around medical devices and will be issued to all new starters and as part of annual clinical updates. • Resuscitation Policy updated to reflect a new more robust checking system. • In relevant areas equipment checking compliance being monitored via the Nursing Quality Metrics. • Trust-wide audit undertaken in August 2016, report due in September. • On-going 'rolling' audit (spot checks) being carried out by Resuscitation Services. Project lead to review workbook and add additional milestones / KPIs / Risks in light of January 2017 CQC report (February 17). Recommendation to Quality Steering Group 09.03.2017 to remove Resus elements within workbook to new Resus action log. Resus element approved to be moved to independent log Q7.13. QSG 09.03.2017. **CCN67** push back risk 7 'Due to insufficient resource and equipment accessibility target date has been put back to July 2017'. *Currently delivering 71% of milestones against the plan (June 2017) 18.04.2017 - As a result of CQC reinspection in September 2016, the Trust was awarded an overall rating of 'Good' and moved out of special measures. The Board of Directors agreed to remove risk related BAF 018/16 (from Board Assurance Framework (12.04.2017BoD minute item 3.8) [Failure to have NHS Improvement and CQC Special Measures lifted within 12 months] **CCN68.** **12.03.2020**: BAU Closure Report Scheduled for Quality Steering Group 09.04.2020 - QSG cancelled due to Covid-19 **03.06.2020:** BAU Closure Report Scheduled for Quality Steering Group 28.07.2020 **29.07.2020**: BAU Closure agreed at Quality Steering Group 28.07.2020	**Risks:** • Capital implications of the workstream may impact on financial recovery workstreams. • Out-of-date devices and consumables could compromise patient care. • If equipment is unserviceable or did not have auxiliary items present could lead to patient harm. **Mitigations:** • Capital implications assessed to enable Board decisions about prioritisation. This will be informed by the Trust capital strategy when this is agreed. • User Checks to be undertaken on a daily basis.	**BAF 010/16:** Patient harm/clinical service disruption and/or regulatory non-compliance as a result of aging and insufficient medical equipment **BAF026/16:** Inadequate Corporate Governance **BAF027/16:** Inadequate Quality Governance **BAF030/16**: Trust Estates Strategy is not aligned to the Trust Strategy and Clinical Services Strategy resulting in poor, compromised or delayed investment decisions.	**Current Performance:** KPIs ≥98% of High Risk devices maintained as planned. = 97% July 2020 ≥90% of Medium Risk devices maintained as planned = 79% July 2020 ≥60% of Low Risk devices maintained as planned. = 70% July 2020 Milestones due recorded: 100% July 2020 Project Completion status: 100%	Yes	Workbook (Full Plan Equipment)	The profile and scale of works to be carried out indicate that a full plan is required	**CC58; CC61; CC67, CC68**
Q4.5.2	Medical Device Training	CQC	Ensure that Medical device training across all staff groups is recorded, this includes Nursing, Midwifery, Health Care Scientists, Pharmacists, Allied Health Professionals, Medics and dentistry. For CQC Compliance and all external accreditation this data must be recorded centrally.		**Jan 17 Should do (Ongoing)**: Ensure that all equipment is appropriately checked and safety tested where requested [downgraded from Must do]	In Scoping			Milestones due recorded: Project completion status: In Scoping		Workbook		
Q4.5.3	Medical Device Management	CQC	In Scoping		**Jan 17 Should do (Ongoing)**: Ensure that all equipment is appropriately checked and safety tested where requested [downgraded from Must do]	In Scoping			Milestones due recorded: Project completion status: In Scoping		Workbook		

Q4.6.2	Medicines storage and security	CQC	Ensure that medicines included controlled medicines, are securely stored at all times		**January 2017 Must Do (Ongoing):** Continue to ensure that medicines including controlled medicines, are securely stored at all times	. Medicines security and handling in the mortuary. . Medicines storage key control. . Phamacy top up services. . Security of medicines during medicines rounds. . Medicines storage and security policy compliance audits. . FP10 pad governance. . Outpatient medicines storage. March 2017 project lead scoping action log in readiness for executive sign off (March 2017). 24.03.2017 Exec sign off received, action log now LIVE and collating data 18.04.2017 - As a result of CQC reinspection in September 2016, the Trust was awarded an overall rating of 'Good' and moved out of special measures. The Board of Directors agreed to remove risk related BAF 018/16 (from Board Assurance Framework (12.04.2017BoD minute item 3.8) [Failure to have NHS Improvement and CQC Special Measures lifted within 12 months] **CCN68.**	**Risk:** Delay in completing enabling work to replace outdated storage infrastructure **Mitigation:** Prioritisation of cost-driven enablers such as remedial estate small works, pay and non-pay resources etc. ; communication and engagement with all key stakeholders including Monitor if anticipating delay **Risk:** Affordability of the medicines storage solutions and enabling works (business case for modernisation) **Mitigation:** These solutions will cost the Trust but may be essential based on CQC requirements. T3 to be informed and ensure it is aware of the implications and for Pharmacy to submit a clear business case for modernisation strategy work; weigh the benefits of such solutions and ensure that these demonstrate good value for money.	**BAF016/16**: Patient harm asa result of medication errors **BAF026/16**: Inadequate Corporate Governance **BAF027/16**: Inadequate Quality Governance	**Current Performance:** KPIs Clinical areas have a daily check of all CD register balances: Target 95% = 94.6% Q4 Every medicine storage area is lockable Target 95% = 100% Q4 Drug storage areas are locked in accordance with policy (Pharmacy Audit). Target: 95% = 86.9% Q4 Fridge temperature monitors in use Target 95% = 100% Q4 Daily records of fridge temperatures Target 95% = 99.3% Q4 Room temperature monitors in use Target 95% = 100% Q4 If not 24Hr Service keys are secure Target 95% = 100.% Q4 Keys held by trained staff Target 97.8% = 99% Q4 Milestones due recorded: 98% at July 2020 Project Completion status: 98%	No	Action Log		**CC68**
Q4.6.3	Automated Fridge Monitoring System for Clinical Areas	CUH	In Scoping		N/A	In Scoping			Milestones due recorded: Project completion status: In Scoping		Workbook		
Q4.12	Mental Health Standards in ED	CUH	To make the improvements identified in a Peer Review undertaken in Feb/March 2018. Strengthen safeguarding, breakaway compliance and training in relation to Mental Health, Improve general policies and procedures for Mental Health and review the policies and procedures for care of paediatrics and adolescents with Mental Health problems.		N/A	Project commenced in May 2018 **12.03.2020:** BAU Closure Report Scheduled for Quality Steering Group 09.04.2020 - QSG cancelled due to Covid-19 **03.06.2020:** BAU Closure Report Scheduled for Quality Steering Group 28.07.2020 **29.07.2020**: BAU Closure agreed at Quality Steering Group 28.07.2020			Milestones due recorded: 100% July 2020 Project completion status: 100%		Workbook		
Q4.13	Blood Transfusion - Standards and Training	CUH	Action Plan for Compliance with National Blood Transfusion Committee Requirements for Training and Assessment in Blood Transfusion		N/A	Project commenced in September 2018. **11.10.2019** - Project Update from Transfusion Lead at Quality Steering Group on 10 October 2019 confirmed that the project has stalled. Reasons cited include a lack of staff resource and a workable IT training environment. Escalated as CKI for resolution. **12.12.2019** - CKI update - A decision was made to revert to the original plan i.e. providing a one day course for 'Train the trainers' and discontinue the work book approach for this particular piece of work.			Milestones due recorded: 100% July 2020 Project completion status: 68%		Action Log		
Q4.14	Patient Safety Improvement Programme	CUH	The Trust is committed to the implementation of the principles within the Department of Health's commissioned report from Donald Berwick, A promise to learn - a commitment to act: Improving the safety of the patients in England. The Trust therefore will have in place a continuous programme of Patient Safety Improvement; the current Patient Safety Improvement Plan (2018-202) is focused on strengthening how we continually learn, embedding a Just Culture within the Trust, and improving our recognition and management of the deteriorating patient.		**Nov 18 Should Do** The trust should ensure that the severe sepsis and septic shock audit continues to improve to meet the national standards.	Project commenced in December 2018.			Milestones due recorded: 100% July 2020 Project completion status: 76%		Workbook		
Q4.15	Prevention of HAPU's	CUH	A review and revision of Standards, Guidelines, Educational Resources, Training and Governance to reduce the instance of preventable HAPU's		N/A	Project commenced June 2019			Milestones due recorded: 100% at July 2020 Project completion status: 72%		Workbook		

Q4.16	After Action Reviews	CUH	This project is for CUH to adopt and sustain the 'After Action Review' (AAR) model of debriefing across the organisation, with the intention of also becoming a system faculty leader. AAR is a methodology for clinical and non clinical teams to adopt after an event to discuss team performance and what happened. The methodology centres on examining what happened, what should have happened, what went well, what didn't and why. The impact of this project is multi faceted. It allows teams to examine events in a physchologically safe space and creates learning. Consistent use across all teams, will develop a mature culture for safety and improvement within CUH. This will have a positive impact on staff wellbeing, patient safety and organisational culture.			Project commenced April 2020			Milestones due recorded: 100% at July 2020 Project completion status: 18%				
Q4.17	National Patient Safety Framework	CUH	In Scoping		N/A	In Scoping			Milestones due recorded: Project completion status: In Scoping		Workbook		
Effective - Ensure that care provided by the Trust is as effective as possible in all areas.													
Q5.7	Q-Pulse Data Management System	CUH	Develop and install of document Management System for Q-Pulse		N/A	Project Commenced August 2018 **11.10.2019** - Transition to new Trust IT Contractor is causing delays to the integration of key systems necessary for the progression of the project. **10.02.2020** - New IT Contractor now embedded and work on the project is moving forward again.			Milestones due recorded: 100% at July 2020 Project completion status: 14.29%		Workbook		
Q5.8	Datix Cloud IQ	CUH	Upgrade of the current 'Datix Web' (QSIS) system, implementing the new Datix Cloud IQ software, utilising Toolkits and Modules to cover the management of Incidents, Serious Investigations, Risks, Clinical Audits, PALS and Complaints, Claims & Safety Alerts for the Trust.		N/A	Project Commenced August 2018 **03.12.2019** - Delays to Q5.7 are now having an impact on the progress of Q5.8 **10.02.2020** - New IT Contractor now embedded and work on the project is moving forward again.			Milestones due recorded: 100% at July 2020 Project completion status: 16.13%		Workbook		
Q5.9	Nutritional Supplements	CUH	To standardise procedures for giving prescribed nutritional supplements and improve the recording of intake.		N/A	Project Commenced August 2019			Milestones due recorded: 100% at July 2020 Project completion status: 33%		Workbook		
Q5.10	Clinical Audit Process Review	CUH	Improve the Clinical Audit process to improve assurance and accountability at Divisional Level as well as improving the availability of assurance data for the Trust.		N/A	Project commenced June 2019			Milestones due recorded: 100% at July 2020 Project completion status: 64%		Workbook		
Caring - Ensure outstanding levels of caring are maintained.													
Responsive - Rectify the concerns which are identified in the Quality Report, taking into account all of the recommendations made by the CQC.													
Q7.2.2	Service Provision for Children and Young People (CYP)		Improve service provision for children and young people coming into the Trust to offer a more child orientated environment for the safe treatment of CYP		N/A	Project commenced April 2018 **10.10.2019** - Project reviewed in August with revision to some Milestones and additional actions added. This has had an impact on the percentage complete figures.			Milestones due recorded: 100% at July 2020 Project completion status: 33%		Workbook		
Q7.5.4	Transition from UFTO to ReSPECT	CUH	Ensure Smooth transition from UFTO to ReSPECT		N/A	Project commenced in September 2018. All milestones due are completed and project on track		N/A	Milestones due recorded: 100% July 2020 Project completion status: 97%		Action Log		

Q7.11.2	Critical Care Skill Mix & Discharges	CQC	Ensure the safe, effective and responsive functioning of the Critical Care Unit. [See also Q4.7 Nursing Staffing & Q7.11 Critical Care]		**Must do (Ongoing)**: Patients are discharged from critical care units to the wards in a timely manner and minimises the number of patients being discharged after 10pm. **Should do (Ongoing)**: Improve the skill miz across critical care to ensure that 50% of staff complete their certificate in critical care in line with best practice standards **Jan 2017 Should do (Ongoing)**: Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am in the critical care and intensive care units	**Critical care skill mix -** • Successfully bid for 8 additional Critical Care course places and now have 20 staff were undertaking the course across NCCU and ICU in September 2015. • A bid for a further 20 Critical Care courses has been made for 2016-17 Academic year, which should enable both units to exceed 50% of staff with a critical care course. This is not expected to be achieved by the end of September 2016. • Bid for courses for 2016-17 - 20 places (10 each for ICU and NCCU) • Funding – not released yet for 2016-17 academic year **Discharges after 10pm -** • All night time discharges from Critical Care reported as an incident and investigated for the root cause. • Duty consultant identify patients to be discharged as early as possible. • Operations centre prioritise patients to be discharged from critical care -aim to ensure all cc patients moved ≤4 hours. • Adaptation of the SAFER Bundle to improve patient flow. Action log scoped and waiting exec sign off (February 2017). Executive sign off received 28.02.2017, action log now LIVE 18.04.2017 - As a result of CQC reinspection in September 2016, the Trust was awarded an overall rating of 'Good' and moved out of special measures. The Board of Directors agreed to remove risk related BAF 018/16 (from Board Assurance Framework (12.04.2017 BoD minute item 3.8) [Failure to have NHS Improvement and CQC Special Measures lifted within 12 months] **CCN68.**	**Risk:** Failure to comply with Intensive Care Standard that patients should not be transferred to wards after 10pm. CQC highlight as area of concern and requires improvement **Mitigations:** Patients are discharged from critical care units to the wards in a timely manner and minimises the number of patients being discharged after 10pm. All night time discharges from Critical Care reported as an incident and investigated for the root cause. • Duty consultant identify patients to be discharged as early as possible. • Operations centre prioritise patients to be discharged from critical care and try to ensure all patients are moved within 4 hours. •Adaptation of the SAFER Bundle to improve patient flow to be introduced **Risk:** Failure to improve the skill mix across critical care to ensure that 50% of staff complete their certificate in critical care in line with best practice standards. Risk of staff turnover once course is completed and Staff completing the course **Mitigations**: Ensure time in rotas for staff to attend the course Allocate experienced mentors	**BAF008/16:** Patient harm arising from delays in being seen **BAF009/16:** financial sanction arising from delays in patients being seen **BAF017/16**: Implementation of new junior doctor contract with effect from October 2016 **BAF020/16:** Insufficient nurse staffing levels **BAF021/16**: Patient safety consequences asa result of a failure to recruit or adegately train junior medical staff and failure to maintain training status **BAF024/16:** Failure to protect a vulnerable patient **BAF026/16:** Inadequate Corporate Governance **BAF027/16:** Inadequate Quality Governance	**Current Performance:** KPIs Discharges from critical care between 10pm and 7am Target 0 = 30 June 2020 Delayed discharges from critical care of more than 4 hours but less than 24 Target 0 = 91 June 2020 Number of registered nurses with a certificate in intensive care NCCU Target 50% = 48% June 2020 ICU Target 50% = 52% June 2020 Milestones due recorded: 87.5% at June 2020 Project completion status: 87.5%		Action Log		**CC68**
Q7.14.3	CQC 2018 Inspection Plan		. The Trust Corporate objectives are to provide harm free care which is patient centred and where patients are treated with kindness, dignity and respect. Furthermore the Trust aims to provide sustainable services that are operationally effective. This project aims to support the workforce and the Trust in delivery of these goals which will ultimately be reflected at the next CQC inspection.		N/A	Project commenced May 2019 **03.06.2020:** BAU Closure Report Scheduled for Quality Steering Group 28.07.2020 **29.07.2020:** BAU Closure agreed at Quality Steering Group 28.07.2020			Milestones due recorded: 100% at July 2020 Project completion status: 100%		Workbook		
Q7.15	Patient Experience	CUH	Review the efficiency and quality of, and introduce standard operating procedures to, the patient experience workstreams (i) complaints (ii) PALS (iii) patient feedback and introduce and evaluate changes arising from reviews. The overarching aims are to improve efficiency and to introduce clarity and resilience into the existing processes. This aim is to benefit patients using the services, departmental staff experience and may have wider Trust implications in terms of improved, more timely case management and also reporting of patient experience data across the Trust.		N/A	Project commenced in February 2018.	**Risk:** There is a risk of significant reduction in speed of resolution of cases handled by the complaints and Patient Advice and Liaison Service (PALS) teams and ability to analyse and report on data caused by inability to enter or access information on the QSIS complaints and PALS module if the module is not accessible or runs at an unacceptably slow speed **Mitigation:** 1. Immediately highlight any QSIS issues to QSIS team. 2. QSIS team's business case for Cloud IQ curerently with finance (Jan 18) 3. Explore alternative systems to analyse and report on patient experience data in the absence of QSIS, or consider whether Trust would accept this risk. Completion date: April 2018		Milestones due recorded: 100% at July 2020 Project completion status: 81%		Workbook		
Q7.16	Public and Patient Involvement and Engagement (PPIE)	CUH	To undertake an information gathering exercise within CUH in order to determine the extent of patient and public engagement activity currently being undertaken (as distinct from Patient Experience (feedback) activities); undertake information gathering exercise to look at activities undertaken at other acute hospital providers in order to provide comparative material; determine whether there is scope for improvement and expansion of CUH activity within existing resources of the Patient Experience department; build foundation for CUH Patient and Public Engagement Plan		N/A	In Scoping			Milestones due recorded: Project completion status: In Scoping		Workbook		
Q7.17	Accessible Information	CUH	The Accessible Information Standard was introduced in July 2016, which all organisations providing health and social care must meet. The Trust must now improve the availability of patient information leaflets in other formats to support the needs of patients with identified communication needs. The first stage of this project will focus on the two larger groups of patients that fall within the standard: sight and hearing difficulties.		N/A	Project commenced in December 2018.			Milestones due recorded: 100% July 2020 Project completion status: 84%		Workbook		