Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Care Quality Commission Action Plan Progress Overview - Page 1

Status of all 'open' actions

'Must do' Requirements

Executive Lead	Action Point	Behind schedule	Issues identified	On schedule
Kirsten Major	**Action Point 1** - Urgent Care Pathways			**7**
David Throssell	**Action Point 2** - End of Life			**3**
David Throssell	**Action Point 3** - Medicines Management			**2**
Hilary Chapman	**Action Point 4** - Nurse Staffing			
David Throssell	**Action Point 5** - Medication Prescribing and Administration			**1**
Hilary Chapman	**Action Point 6** - Cardiotocography (CTG) Recording			**1**
Sandi Carman	**Action Point 7** - Management of External Reviews			**1**

'Should do' Requirements

Executive Lead	Action Point	Behind schedule	Issues identified	On schedule
Kirsten Major	**Action Point 1** - Urgent Care Pathways		1	2
David Throssell	**Action Point 2** - End of Life		1	1
David Throssell	**Action Point 3** - Medicines Management			1
Hilary Chapman	**Action Point 4** - Nurse Staffing			1

Executive Lead	Action Point	Behind schedule	Issues identified	On schedule
Kirsten Major	Other			3
David Throssell	Other		5	11
Hilary Chapman	Other		1	6
Sandi Carman	Other			2
Mark Gwilliam	Other			4

	8	**46**

SELECT:
View all actions with 'issues identified'
View all actions that have had a negative status change from last month
View all actions with extended completion dates

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Actions requiring comment

Actions where issues have been identified

Executive Lead	Action	Priority	Issues identified	Action taken to resolve issues	New delivery date
Kirsten Major	**Requirement 11: Action:** Undertake a review of the requirements for a Major Trauma Centre, risk assess any areas of non-compliance and implement mitigating actions where appropriate	Should do	Discussions with TEG on-going. Consultant attendance in principle agreed.		
David Throssell	**Requirement 27 / 53:** The Trust should monitor preferred place of care for patients at the end of life.	Should do	No details provided		
David Throssell	**Requirement 28: Action:** Audit and review of current compliance and improvement actions implemented. Any areas of non-compliance/deviation will be escalated as per the Trust policy.	Should do	Still requires review		
David Throssell	**Requirement 46: Action:** Continue with resuscitation Equipment checking improvement work including regular audits and training of support workers.	Should do	Audit not completed Dec 2016 – rescheduled for January		
David Throssell	**Requirement 52: Action:** Review to be undertaken of current practice and improvement actions to be undertaken. Any residual areas of concern will be managed through the risk assessment process.	Should do	Awaiting completion of redevelopment delayed till Feb 2017		
David Throssell	**Requirement 60: Action:** Review to be undertaken of the need for an early warning tool and action plan to be put in place to address any areas of concern.	Should do	Protocol to be produced and monitoring arrangements agreed		
David Throssell	**Requirement 64 / 75: Action:** Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Should do	Awaiting CCG review against the EOL template		
Hilary Chapman	**Requirement 67: Action:** Audit of nursing documentation to understand areas for improvement and implement appropriate improvement actions.	Should do	Awaiting final report and action plan from notes audit		

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Actions requiring comment

Actions that have had a negative status change from last month

Executive Lead	Requirement	Priority	Target completion date	Oct-16	Dec-16	Reasons for status change and actions being taken	New delivery date
David Throssell	28 - The Trust should review implementation of NICE urinary incontinence in neurological disease for outpatients in the spinal injuries unit.	Should do	Mar-17	On schedule	Issues identified		
David Throssell	46 - The Trust should ensure that the neonatal resuscitaires in labour suite has documented checks. We identified checklists that had signatures missing 22% of the time for the month examined.	Should do	Feb-17	On schedule	Issues identified		
David Throssell	64. 75. The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Should do	Mar-17	On schedule	Issues identified		
Hilary Chapman	10 - The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Should do	Mar-17	Sustained for 6 months	On schedule		
Hilary Chapman	67 - Ensure that patient risk assessments are fully completed in all community nursing patient records.	Should do	Mar-17	On schedule	Issues identified		

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Actions requiring comment

Actions where the completion date has been extended (2 Pages)

Priority	Lead	Requirement	Action	Original Completion date	Revised completion data	Reason for extension	Status of Action
Must Do	**Executive:** Kirsten Major	Action Point 1 - Urgent Care Pathways	The Trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.	Oct-16	Mar-17		On schedule
Must Do	**Executive:** Kirsten Major	Action Point 1 - Urgent Care Pathways	The Trust must ensure that patients in the clinical decisions unit have timely clinical reviews.	Oct-16	Mar-17		On schedule
Must Do	**Executive:** Kirsten Major	Action Point 1 - Urgent Care Pathways	The Trust must ensure robust escalation processes are implemented in the emergency department.	Oct-16	Mar-17		On schedule
Must Do	**Executive:** Kirsten Major	Action Point 1 - Urgent Care Pathways	The Trust must ensure arrangements for governance within the emergency department operate effectively.	Oct-16	Mar-17		On schedule
Must Do	**Executive:** Kirsten Major	Action Point 1 - Urgent Care Pathways	The Trust must ensure divisional risk registers reflect issues in the emergency department and demonstrate evidence of actions and reviews	Oct-16	Mar-17		On schedule
Must Do	**Executive:** David Throssell	Action Point 2 - End of Life	The Trust must ensure there is a clear strategy for the end of life care, which is implemented and monitored.	Dec-16	Oct-17		On schedule
Must Do	**Executive:** David Throssell	Action Point 2 - End of Life	The Trust must ensure that staff implement individualised, evidence based care for patients at the end of life.	Dec-16	Oct-17		On schedule
Must Do	**Executive:** David Throssell	Action Point 2 - End of Life	The Trust must ensure that DNACPR records are fully completed.	Dec-16	Jun-17		On schedule
Must Do	**Executive:** David Throssell	Action Point 5 - Medication Prescribing and Administration	The provider must ensure that all medication charts and controlled drug checks are completed in line with policy.	Sep-16	Mar-17		On schedule
Should Do	**Executive:** Kirsten Major	Action Point 1 - Urgent Care Pathways	Undertake a review of the requirements for a Major Trauma Centre, risk assess any areas of non-compliance and implement mitigating actions where appropriate	Aug-16	Mar-17		Issues identified
Should Do	**Executive:** David Throssell	28. The Trust should review implementation of NICE urinary incontinence in neurological disease for outpatients in the spinal injuries unit.	Audit and review of current compliance and improvement actions implemented. Any areas of non-compliance/deviation will be escalated as per the Trust policy.	Dec-16	Mar-17		Issues identified
Should Do	**Executive:** David Throssell	46. The Trust should ensure that the neonatal resuscitaires in labour suite has documented checks. We identified checklists that had signatures missing 22% of the time for the month examined.	Continue with resuscitation Equipment checking improvement work including regular audits and training of support workers.	Dec-16	Feb-17		Issues identified

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Should Do	**Executive:** David Throssell	52. The Trust should consider improving the way in which medicines are constituted within the neonatal unit to ensure there is a safe environment to do this, and reduce risk of medicine errors.	Review to be undertaken of current practice and improvement actions to be undertaken. Any residual areas of concern will be managed through the risk assessment process.	Sep-16	Mar-17		Issues identified
Should Do	**Executive:** David Throssell	64. 75 The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Dec-16	Mar-17		Issues identified
Should Do	**Executive:** Hilary Chapman	67. Ensure that patient risk assessments are fully completed in all community nursing patient records.	Audit of nursing documentation to understand areas for improvement and implement appropriate improvement actions.	Nov-16	Mar-17		Issues identified
Should Do	**Executive:** David Throssell	Action Point 2 - End of Life	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Dec-16	Jul-17		On schedule
Should Do	**Executive:** David Throssell	20. The Trust should ensure it reviews the process for the appropriate testing of all medical equipment used for patient care in the critical care units.	Undertake audit of current compliance and improvement action taken where required	Dec-16	Mar-17		On schedule
Should Do	**Executive:** David Throssell	21. The Trust should ensure that there are appropriate weaning plans in place for all patients with tracheostomies and that these are made in timely way.	Review of current systems to ensure appropriate and safe processes are in place. Establishment of systems to ensure on-going compliance	Dec-16	Mar-17		On schedule
Should Do	**Executive:** David Throssell	24. The Trust should consider reviewing the computer provision on CICU.	Audit of computer provision on CICU to be undertaken and areas for improvement identified and actioned, where residual concerns remain a risk assessment will be undertaken.	Dec-16	Mar-17		On schedule
Should Do	**Executive:** David Throssell	35. 77.58 The Trust should monitor access to records in the [outpatient] departments.	Trust wide OPD notes access audit to be undertaken and tailored solutions to be implemented dependent on the environment and access requirements.	Dec-16	Mar-17		On schedule
Should Do	**Executive:** David Throssell	47. The Trust should continue to improve consultant medical staffing on labour ward in accordance with Royal College of Obstetrician and Gynaecologists guidelines.	Development of workforce plans for consultant medical staffing on the labour ward. Risk assessment to be updated for areas of noncompliance and mitigating action undertaken	Dec-16	Mar-17		On schedule
Should Do	**Executive:** David Throssell	76. The Trust should review the Deprivation of Liberty Safeguards (DoLS) policy.		Dec-16	Mar-17		On schedule
Should Do	**Executive:** Hilary Chapman	30. The Trust should routinely collect waiting time information for patients waiting for [outpatient] appointments.	Review of systems and processes to be undertaken to assess the most appropriate mechanism of measuring outpatient waiting times and implement the findings.	Dec-16	Mar-17		On schedule
Should Do	**Executive:** Hilary Chapman	83. The Trust should review the access for patients requiring dental treatment at Manor Clinic who use wheelchairs.		Dec-16	Mar-17		On schedule
Should Do	**Executive:** Hilary Chapman	17/ 39 / 51 / 70 The Trust should review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.	Six month secondment of a senior nurse to review the Trust approach to Care Planning. The post holder will produce a plan to support the production of patient specific care plans which are used to direct personalised nursing care for patients through the effective use of	Dec-16	Mar-17		Sustained for 6 months

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'Must Do' Requirements

Action Point 1 - Urgent Care Pathways

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	Patients waited longer than the recommended standard for assessment and treatment in the emergency department; patient's vital signs were not taken and recorded consistently as part of the initial assessment in the "pit stop area" in the emergency department; 95% of patients were not admitted, transferred or discharged within four hours of arrival in the emergency department; patients were not clinically reviewed in CDU.	The Trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.	Inability to implement workforce plan	March 2017	On schedule		New model of care for walk-in and ambulance patients on arrival at A&E – developed and ratified. Minutes of meetings BPT Project plan Workforce Plan
Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.	Inability to track and monitor information 'live' should system fail Inaccurate information	March 2017	On schedule		Performance Report - validated in ED Central storage site (information services site) Lorenzo 'Captain's log' daily review in ED Information circulated to ED senior team / Clinical Ops daily
	Executive: Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.	Estate changes to be delivered on time. Inability to implement work force plan due to recruitment. Unable to meet training needs analysis.	**Original:** October 2016 **Revised:** March 2017	On schedule		Review of good practice areas. Training needs Analysis. Evaluation of service against national evidence and best practice. Audit Reports Use of Simul8 model / Service improvement model
Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure that patients in the clinical decisions unit have timely clinical reviews.	Inability to timely review patients for discharge or transfer Inability to implement work force plan Unable to develop effective clinical pathways to initiate appropriate treatment and/or escalate appropriately within the timescale	**Original:** October 2016 **Revised:** March 2017	On schedule		Audit reports: - Evidence of timely review of patients in CDU - Timely initiation of appropriate treatment for patients in CDU - Timely transfer out or discharge from CDU - No delays in discharge/transfer from CDU due to lack of clinical review
Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure robust escalation processes are implemented in the emergency department.	Engagement in working to escalation process Once escalation in place difficulty in responding due to surge and demand.	**Original:** October 2016 **Revised:** March 2017	On schedule		Escalation SOP in place Minutes of clinical governance meetings Monitoring arrangements in place to capture escalation at times of increased business activity. Audit against SOP
Trust wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure arrangements for governance within the emergency department operate effectively.	Inability to implement workforce plan	**Original:** October 2016 **Revised:** March 2017	On schedule		Meeting minutes Monthly departmental governance newsletter Business Continuity Plan and evidence of review Named Governance Lead Consultant MAJAX Plan / Table top exercise
Trust wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure divisional risk registers reflect issues in the emergency department and demonstrate evidence of actions and reviews	Non escalation of risk as appropriate No action against identified risks in a timely manner.	**Original:** October 2016 **Revised:** March 2017	On schedule		Minutes of meetings Risk Register and evidence of review, escalation or resolution Top 5 actions reviewed

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'Must Do' Requirements

Action Point 2 - End of Life

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Trust Wide	**Executive:** David Throssell **Group:** End of Life Strategy Group	There was no end of life care strategy. DNACPR records were not completed fully and accurately. There was no monitoring of preferred place of death. (Trust wide)	The Trust must ensure there is a clear strategy for the end of life care, which is implemented and monitored.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** October 2017	On schedule		End of Life Strategy Minutes of Meeting TOR Project Plan
Trust Wide	**Executive:** David Throssell **Group:** End of Life Strategy Group		The Trust must ensure that staff implement individualised, evidence based care for patients at the end of life.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** October 2017	On schedule		End of life strategy Minutes of meetings Collaborative document to enable individual evidence based care.
Trust Wide	**Executive:** David Throssell **Group:** End of Life Strategy Group		The Trust must ensure that DNACPR records are fully completed.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** June 2017	On schedule		Audit minutes Policy

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'Must Do' Requirements

Action Point 3 - Medicines Management

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Trust wide	**Executive:** David Throssell **Group:** End of Life Strategy Group	Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained. (Trust wide)	The Trust must ensure the safe storage of intravenous fluids.	Non-compliance with medicines code Breach of regulatory compliance	March 2017	On schedule		Medicine Safety Committee minutes Business case for environmental changes SOP – fridge failure Project Plan
Trust wide	**Executive:** David Throssell **Group:** End of Life Strategy Group		The Trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.	Non-compliance with national guidance and prescribing Breach of regulatory compliance	July 2017	On schedule		Action Plan Minutes Medicines Safety Committee and Clinical Governance Committee Audit report Minutes of Clinical Gases Committee

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'Must Do' Requirements

Action Point 4 - Nurse Staffing

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Weston Park	**Executive:** Hilary Chapman **Group:** Martin Salt, Nurse Director and Nurse Executive Group	Nursing staffing levels were below the planned level with many shifts having fewer registered nurses than required on duty. (Weston Park)	The hospital must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.	-Risk to delivering safe Care -Inability to deliver quality improvements -Poor patient, family and carer experience -Loss of public trust and confidence -Media interest	Continuous monitoring	Sustained for 6 months		-Monthly Staffing Report -Healthcare governance Minutes -TEG Minutes -Board Minutes -Safer Nursing Care Tool process monitoring reports -Escalation policy – Exception monitoring reports - monitoring of Datix incident reporting -Continuing with recruitment initiatives such as overseas recruitment and targeted recruitment campaigns.F7

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'Must Do' Requirements

Action Point 5 - Medication Prescribing and Administration

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Beech Hill	**Executive:** David Throssell **Group:** Medicines Safety Committee	People who use services and others were not provided with the proper and safe use of medication. (Beech Hill)	The provider must ensure that all medication charts and controlled drug checks are completed in line with policy.	-Inability to deliver safe patient Care -Non-compliance with Medication legislation and best practice in line with CQC regulation and	**Original:** September 2016 **Revised:** March 2017	On schedule		-Audit Report - 3 monthly controlled drug checks -Review of medication prescribing -Minutes Medicines Safety Committee.E8

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'Must Do' Requirements

Action Point 6 - Cardiotocography (CTG) Recording

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Jessop Wing	**Executive:** Hilary Chapman **Group:** LEGION/OGN Executive Team	In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with Trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6).	The Trust must ensure that guidance is followed in the documentation of fetal heart rate monitoring's.	-Inability to deliver safe and timely care to mother and baby -Non-compliance with National guidance and best practice	April 2017	On schedule		-Audit report and improvement plan - Review of Intrapartum Fetal Monitoring CTG Guideline -Evidence of HOT TOPIC across the service and communication strategy OGN HGC meeting minutes Training needs analysis for midwifery.

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'Must Do' Requirements

Action Point 7 - Management of External Reviews

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Trust Wide	**Executive:** Sandi Carman **Group:** Serious Incident Group	The Trust must ensure that, where concerns are raised and investigated, the reviews are undertaken promptly to ensure any necessary actions are implemented in a timely manner.	Standardised Trust processes to be implemented for all external reviews which will include monitoring and oversight by a Trust group.	-Loss of public and patient confidence -Media interest -Funding spending money wisely	April 2017	On schedule		- SOP - Minutes of TEG, HCGC

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'Should do' Requirements

Action Point 1 - Urgent Care Pathways

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	11. The Trust should continue to review the provision on 24 hour consultant medical cover within the emergency department as part of being a major trauma centre	Undertake a review of the requirements for a Major Trauma Centre, risk assess any areas of non-compliance and implement mitigating actions where appropriate	Unable to deliver ED consultant work force plans Lack of clinical engagement	**Original:** August 2016 **Revised:** March 2017	**Issues:** Discussions with TEG on-going Consultant attendance in principle agreed		Minutes of Trauma Operations Group A&EM Workforce BPT sub group minutes
NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	10. The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Cross referenced with Action point 4 Executive – Hilary Chapman	Inability to recruit and retain nursing staff Inability to maintain optimum nursing staffing levels as required on a day to day basis Difficulty in recruiting to senior nurse post's	Non identified	On schedule		Validation Results following departments involvement in the National ED specific Safer Nursing Care Tool Evidence of Inter Care Group rotation of RN arrangements Minutes of BPT
RHH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	38. Although the MIU works closely with the A&E at NGH, audits specific to the MIU should be complete effectiveness and to monitor improvement to services and treatment offered in this location.	Executive Lead Hillary Chapman	Loss of public trust and confidence in the service Media interest		On schedule		Electronic Clinical Assurance Tool clinical governance monitoring reports against key performance indicators Complaints and compliment FFT DATIX monitoring Use of external reports - Healthwatch
NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	12.The Trust should continue to take action to ensure the emergency department achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department.	Require before carrying out care and treatment.	Unable to work in partnership with YAS to improve processors for handover time and meet recognised standard of 15 minutes arrival by ambulance to handover No accurate recording of conveyance.		Sustained for 6 months		Records of daily review against performance Monitoring of ambulance handover time. Evidence of communication with senior team and clinical operations Monitoring of front door improvement work e.g. process and time reporting
NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	13. The Trust should review guidance in the emergency department to ensure it reflects current evidence-based guidelines.		Inaccurate and out of date guidelines in circulation within Emergency Department. Risk to delivering safe patient care.		Sustained for 6 months		Defined guidelines set against national evidence and appropriately referenced. Appropriate lead identified to develop / review existing guidelines for content. Training plans and associated literature revised for consistency and Review of existing guidelines
NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	15. The Trust should review the experience of patients to ensure privacy and dignity is maintained in the emergency department, particularly during busy periods.	Executive lead Hillary Chapman	Failure to deliver an environment that protects the privacy and dignity of all patients Media Interest / safeguarding concerns		Sustained for 6 months		Audit of care rounding Complaints discussed and reviewed at clinical Governance meeting Trust Patient Experience Committee minutes FFT reports
RHH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	37. The MIU should improve the monitoring of time to be seen and total time in department	Review of monitoring system to be undertaken and the processes modified as required. System to be in place to ensure sufficient data quality and monitoring of performance	System failure and requirement to implement business continuity and potential loss of real time information	November 2016	Sustained for 6 months		Performance monitoring reports available from Lorenzo

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'Should do' Requirements

Action Point 2 - End of Life

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
RHH (27) NGH (53)	**Executive:** David Throssell **Group:** End of Life Strategy Group	27 / 53 The Trust should monitor preferred place of care for patients at the end of life.		Loss of public trust and confidence Inability to deliver equality and diversity		**Issues:** Issues identified		FFT Collaborative minutes Audit
Community Services	**Executive:** David Throssell **Group:** End of Life Strategy Group	64. The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Loss of public trust and confidence Inability to deliver equality and diversity	**Original:** December 2016 **Revised:** July 2017	On schedule		Review System 1 template Audit record for recording spiritual needs Citywide minutes EOL
Community Services WP	**Executive:** David Throssell **Group:** End of Life Strategy Group	63. 74The Trust should develop a system for monitoring patients whether patients died in their preferred place of care.	Complete within Community Services Revised deadline for Hospital setting July 2017	Public trust and confidence Media interest	December 2016 Complete	Sustained for 6 months		Audit – December 2016 report Integrated care team nurse leads Records audit of System 1 EOL minutes Audit programme EOL strategy
Community Services	**Executive:** David Throssell **Group:** End of Life Strategy Group	65. The Trust should consider auditing the use of the guidelines for the care of the person who may be in the last hours to days of life.		Loss of public trust and confidence Inability to deliver equality and diversity		Sustained for 6 months		STHFT EOL Group minutes Guidelines Audit compliance

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‘Should do’ Requirements

Action Point 3 - Medicines Management

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
NGH	**Executive:** David Throssell **Group:** End of Life Strategy Group	16. The Trust should ensure staff follow policy and best practice guidance in relation to the administration of intravenous fluids.		Non-compliance with national guidance and prescribing Breach of regulatory compliance		On schedule		Medicine Safety Committee minutes Business case for environmental changes Project Plan

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'Should do' Requirements

Action Point 4 - Nurse Staffing

Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
NGH	**Executive:** Hilary Chapman **Group:** Martin Salt, Nurse Director and Nurse Executive Group	10. The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Cross reference with Action Point 1.		March 2017	On schedule		
Community Services	**Executive:** Hilary Chapman **Group:** Martin Salt, Nurse Director and Nurse Executive Group	61. The provider should ensure staffing levels are appropriate to patient dependency.		Risk to delivering safe and timely care -Poor patient, family and carer experience -Loss of public trust and confidence		Sustained for 6 months		-Monthly Board Report -Minutes of Board -GSM Directorate Minutes -Monthly GSM Report - Safer Nursing Care Tool NHS Professional usage – fill rates

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‘Should do’ Requirements

Executive: Kirsten Major

Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
RHH	33 / 41. The Trust should continue to take action to reduce the number of medical outlier patients across the Trust.	Directorate action plans to be created to reduce the number of medical outlier patients. To include monitoring systems to demonstrate improvements.	Loss of public trust and confidence Inability to delivery consistent/safe care Poor FFT response.	March 2017	On schedule		TEG minutes X 3 – SOP clarifying process Audit/SOP evaluation
RHH	34 / 42. The Trust should continue to take action to reduce the number of bed moves patients experience during their hospital stay.	Develop metrics to assess, monitor and review patient pathways and identify lessons learned.	Loss of public trust and confidence Inability to delivery consistent/safe care Poor FFT response.	March 2107	On schedule		TEG minutes X 3 – SOP Cross references with (33)
RHH	49. The Trust should review the waiting times for patients with learning disabilities requiring dental treatment under general anaesthesia against the 18 week standard.	System to be developed and implemented to ensure monitoring and compliance with the 18 week standard.	None compliance against equality and diversity. Loss of public trust and confidence Poor FFT response. Minutes CD meeting New process criteria	March 2017	On schedule		Weekly monitoring and compliance report against 18wks

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'Should do' Requirements

Executive: David Throssell

Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
RHH	28. The Trust should review implementation of NICE urinary incontinence in neurological disease for outpatients in the spinal injuries unit.	Audit and review of current compliance and improvement actions implemented. Any areas of non-compliance/deviation will be escalated as per the Trust policy.	Lack of assurance delivery to best practice from NICE	**Original:** December 2016 **Revised:** March 2017	**Issues:** Still requires review		Gap analysis against NICE Action Plan Implementation Plan CEC minutes
LEGION	46. The Trust should ensure that the neonatal resuscitaires in labour suite has documented checks. We identified checklists that had signatures missing 22% of the time for the month examined.	Continue with resuscitation Equipment checking improvement work including regular audits and training of support workers.	Inability to provide safe working equipment	**Original:** December 2016 **Revised:** February 2017	**Issues:** Audit not completed Dec 2016 – rescheduled for January		spot checks undertaken by the Governance team report Minutes of Obstetrics and Gynaecology Executive Team Resuscitation Committee
OGN Executive Team & Pharmacy Services	52. The Trust should consider improving the way in which medicines are constituted within the neonatal unit to ensure there is a safe environment to do this, and reduce risk of medicine errors.	Review to be undertaken of current practice and improvement actions to be undertaken. Any residual areas of concern will be managed through the risk assessment process.	Inability to adhere to Medicines Code.	**Original:** September 2016 **Revised:** March 2017	**Issues:** Awaiting completion of redevelopment delayed till Feb 2017		Review of ready-to-use products completed by pharmacy following NPSA20 criteria Datix report for incident monitoring Medicines management minutes Estates refurbishment plan Minutes Obstetric and gynaecology
Community Services	60. The provider should review the need for an early warning tool to recognise a deteriorating patient	Review to be undertaken of the need for an early warning tool and action plan to be put in place to address any areas of concern.	Lack of assurance that early warning score in place to maintain safety	February 2017	**Issues:** Protocol to be produced and monitoring arrangements agreed		Patient Safety Team and Combined Community and Acute Executive Team minutes Working party minutes Evaluation tools Audit report TNA – training records
Community Services (64) WPH (75)	64. 75 The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Inability to fully implement equality and diversity	**Original:** December 2016 **Revised:** March 2017	**Issues:** Awaiting CCG review against the EOL template		Combined Community and Acute Executive Team and IT
NGH	19. 44 The Trust should introduce a robust process to share lessons learnt from incidents and mortality and morbidity reviews across directorates and care groups.	Systems and processes to be developed to align with the national review of mortality	Inability to review and identify areas of concern relating to deaths both expected and unexpected and implement the learning Media Interest	March 2017	On schedule		Mortality and Morbidity Group minutes Audit Report Dr Foster Analysis
NGH	20. The Trust should ensure it reviews the process for the appropriate testing of all medical equipment used for patient care in the critical care units.	Undertake audit of current compliance and improvement action taken where required	Circulation of unsafe equipment in areas used for patient care.	**Original:** December 2016 **Revised:** March 2017	On schedule		OSCCA Executive Team minutes Medical Equipment Management Group minutes Register of test Clinical engineering Medical equipment database

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'Should do' Requirements

RHH Chaplaincy Team CCAS Executive Team Equality and Human Rights Group and Estates Team	21. The Trust should ensure that there are appropriate weaning plans in place for all patients with tracheostomies and that these are made in timely way.	Review of current systems to ensure appropriate and safe processes are in place. Establishment of systems to ensure on-going compliance		**Original:** December 2016 **Revised:** March 2017	On schedule		Tracheostomy Group minutes
RHH	22. The Trust should consider reviewing data collection methods and the process for submitting ICNARC data for Cardiac Intensive Care, so that patient outcomes can be benchmarked with other similar services	Implementation of processes to ensure submission of ICNARC data including system to ensure good data quality.	Lack of assurance that the trust is collecting the right level of information to measure patient outcomes.	March 2017	On schedule		Cardiac Services governance minutes ICNARC submission
RHH	24. The Trust should consider reviewing the computer provision on CICU.	Audit of computer provision on CICU to be undertaken and areas for improvement identified and actioned, where residual concerns remain a risk assessment will be undertaken.	No streamlined computer service to CICU.	**Original:** December 2016 **Revised:** March 2017	On schedule		Cardiac Services Executive Team Information Technology Team minutes Audit Report Action plan Risk assessment
RHH	25. The Trust should consider the implementation of the electronic patient clinical information system on CICU so there is alignment with the other critical care units.	Consideration to be given to implementation of the electronic patient clinical information system whilst taking account of the future T3 objectives.	Inability to align the patient pathway with other critical care units.	March 2017	On schedule		Cardiac Services Executive Team Information Technology Team minutes Implementation plan
NGH (35) RHH (58) WPH (77)	35. 77.58 The Trust should monitor access to records in the [outpatient] departments.	Trust wide OPD notes access audit to be undertaken and tailored solutions to be implemented dependent on the environment and access requirements.	Lack of assurance that information governance standards are monitored Media risk.	**Original:** December 2016 **Revised:** March 2017	On schedule		Outstanding Outpatients Programme and Information Governance Committee minutes Audit OPD notes and access
Jessops	47. The Trust should continue to improve consultant medical staffing on labour ward in accordance with Royal College of Obstetrician and Gynaecologists guidelines.	Development of workforce plans for consultant medical staffing on the labour ward. Risk assessment to be updated for areas of noncompliance and mitigating action undertaken	Inability to provide full obstetric and gynaecology carer.	**Original:** December 2016 **Revised:** March 2017	On schedule		BPT business case Workforce plan
WPH	69. The hospital should improve the environment and the skills of staff to ensure that the needs of people living with dementia are met.	Capital scheme commenced which includes improvements to ensure the environment meets the needs of patients with dementia.	Loss of public trust and confidence in providing the right environment for patients with dementia	March 2017	On schedule		SMCR Executive Team, WPH Strategy Group and Capital Investment Team

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'Should do' Requirements

WPH	76. The Trust should review the Deprivation of Liberty Safeguards (DoLS) policy.			**Original:** December 2016 **Revised:** March 2017	On schedule		MCA/DOLS Policy MCA/DOLS flowchart MCA intranet site Updated DOLS guidance relating to ICU Patients' Survey Monkey results and audit report Tool Kit for Best Interests assessments. Audit of capacity assessments. Audit of Best Interest Decisions. Training Needs Assessment
CCDH	82. Review and establish robust procedures for gaining consent of patients for local anaesthetic extractions.	Undertake review and audit of consent processes following local and national best practice and ensure any changes are fully adopted by all relevant clinician. Put in place system for the continuous monitoring of compliance.	Inappropriateness Consent taken from patients prior to anaesthetic extractions.	December 2016	On schedule		Consent Audit Report Minutes – Clinical Services Safer Surgery Check Audit
NGH (31) RHH (55) WPH (72)	31. 55. 72 The Trust should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.	Design and implementation of checklist followed by audit programme to ensure continuous monitoring of compliance.	Inability to maintain patient safety	September 2016	Sustained for 6 months		Safer Procedures Steering Group minutes Monthly Audit Governance performance Dashboard Directorate assurance group minutes SOP
NGH (32) RHH (56) WPH (73)	32. 56. 73 The Trust should consider undertaking regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks	Audit to be designed and implemented to monitor the required checks. System to be implemented to ensure continuous monitoring and review.	Unable to ensure consistency in completing the MRI checklists	October 2016	Sustained for 6 months		MIMP Executive Team minutes Safer surgery steering group minutes SOP Monthly compliance audits
Jessops LEGION / OGN	45. The Trust should review the labelling of babies prior to their removal from the obstetric theatre.	Review of processes to be undertaken and a system implemented to ensure safe	Inability to maintain safe environment and safety Media intent Loss public trust and confidence	September 2016	Sustained for 6 months		Staff communication Weekly spot checks Audit report
Trust wide	48. The Trust should review data collection methods and introduce a system to collect patient outcomes by surgical speciality within care groups.	All Surgical Directorates will be tasked to review the systems in place to collect patient outcomes, analysed appropriately and shared to ensure lessons learned and improvement made.	Lack of assurance that the Trust collects and acts on surgical patient outcomes to improve quality and safety	March 2017	Sustained for 6 months		Surgical group minutes Audit report Lesson learnt report 1
Community Health	59. The provider should ensure that resuscitation equipment is checked in line with Trust policy.		Inability to maintain patient safety	August 2016	Sustained for 6 months		Daily/monthly checks Audit
CCDS	79. Take action in relation to compatibility of radiological imagery and the new electronic record system, to avoid the need for patients to walk between clinical areas mid procedure which negatively effects their privacy and dignity whilst being treated.	Review and improvement action to be taken to address the environmental concerns to ensure patients privacy and dignity.	Inability to maintain patients privacy and dignity.	December 2016	Sustained for 6 months		MIMP Executive Team Audit of patients attending ground floor Datix reports MIMP governance minutes

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‘Should do’ Requirements

CCDS	80. Review governance minutes so they are clearly labelled to identify which dental clinical stream the papers apply to, and have a robust system for taking appropriate action on areas of concern raised within these meetings.	Standardised templates to be implemented that clearly identify the dental stream. Formal reference processes to be established to ensure that action points are appropriately carried forward and completed	Inability to deliver robust governance arrangements.	September 2016	Sustained for 6 months		Minutes of meetings Action Plans from meetings

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'Should do' Requirements

Executive: Hilary Chapman

Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Community	67. Ensure that patient risk assessments are fully completed in all community nursing patient records.	Audit of nursing documentation to understand areas for improvement and implement appropriate improvement actions.	Inability to deliver safe/individualised patient care	**Original:** November 2016 **Revised:** March 2017	**Issues:** Awaiting final report and action plan from notes audit		Combined Community and Acute Executive Team Minutes of group meetings Audit report meeting documentation
NGH	26. The Trust should consider a process for obtaining patient feedback following discharge from critical care.	Review of the processes in place to obtain patient feedback following discharge from critical care and implement improvement actions.	Loss of trust and confidence of patients and family Media intent Inability to meet national targets and commissioning intentions.	March 2017	On schedule		Patient Perception Survey FFT report PEC minutes Critical Care Group minutes
NGH	29. The Trust should review the fracture clinic environment to ensure meet the needs of patients.	Audit of patient flow and suitability of the environment to be undertaken. Plans to be developed and reviewed by the Capital Investment Team as required.	Inability to provide an environment that meets patients' needs	March 2017	On schedule		MSK Executive Team and Estates environment assessment Concept paper for capital investment team CIT Minutes
NGH	30. The Trust should routinely collect waiting time information for patients waiting for [outpatient] appointments.	Review of systems and processes to be undertaken to assess the most appropriate mechanism of measuring outpatient waiting times and implement the findings.	Loss of public trust and confidence Media interest	**Original:** December 2016 **Revised:** March 2017	On schedule		Escalation Policy for Outpatient Waiting Times Audit report Business case to CIT E-Check In project
RHH	57. The Trust should review oversight of the area and facilities for patients waiting for transport following the clinic appointments.	Audit to be undertaken of waiting areas for patients following clinic appointments and a plan to address any areas for improvement.	Inability to provide a sustainable, safe environment for patients and their carers.	March 2017	On schedule		Environment assessment sheets Outstanding Outpatient Board minutes
WPH With DT	69. The hospital should improve the environment and the skills of staff to ensure that the needs of people living with dementia are met.	Capital scheme commenced which includes improvements to ensure the environment meets the needs of patients with dementia.	Inability to provide an environment to meet patient safety requirements and equality and diversity	March 2017	On schedule		SMCR Executive Team, WPH Strategy Group and Capital Investment Team minutes Capital Scheme timetable and actions
Community Dental With DT	83. The Trust should review the access for patients requiring dental treatment at Manor Clinic who use wheelchairs.		□ Inability to provide a safe environment □ Deliver equality and diversity.	**Original:** December 2016 **Revised:** March 2017	On schedule		□ Access Audit □ Evaluation of new dental chair □ Minutes of Head and Neck team meeting □ Estates plans

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'Should do' Requirements

NGH (17) RHH (39) JHW (51) WPH (70)	17/ 39 / 51 / 70 The Trust should review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.	Six month secondment of a senior nurse to review the Trust approach to Care Planning. The post holder will produce a plan to support the production of patient specific care plans which are used to direct personalised nursing care for patients through the effective use of	Inability to deliver safe patient care	**Original:** December 2016 **Revised:** March 2017	Sustained for 6 months		Nurse executive Group minutes JD for 6 month secondment Commenced April 2016 Implementation plan □ Audit Report: □ Lorenzo Care Planning functionality Rollout implementation plan □ BADGER Business Plan.
NGH (18) RHH (43)	18. 43. The Trust should try to reduce the movement of staff to clinical areas outside of their speciality.	Continuation of daily staff meetings Inclusion of the rationale for any staff movement in the Nurse Managers welcome presentation for newly qualified staff. Recruitment and vacancy position regularly received Continued focus on recruitment; Continued focus on the development of new and innovative roles and ways of working Continue to work in partnership with NHS Professionals.	Inability, maintain patient safety and continuous quality of care Maintain recruitment and retention.	No deadline On-going and in place	Sustained for 6 months		Nurse executive group minutes Daily meetings Presentations from newly qualified staff Monthly nurse staffing report Minutes of Nurse Staffing Recruitment Group Winter Plan 2016/17
RHH With DT	50. The Trust should ensure appropriate medical and nursing staffing on the neonatal unit to reflect current national guidelines for safe care.	Review of staffing levels to ensure sufficient staff are in place to reflect current national guidelines for safe care	Inability to deliver against national guidelines for safe care.	December 2016	Sustained for 6 months		BADGER staffing tool monthly report Report – Yorkshire and Humber Neonatal ODN Escalation Policy Staffing Report
Community Services Beech Hill Combined Community/Acute Services	62. The provider should check that all equipment is labelled after it has been cleaned.	Audit to be undertaken to review compliance of Infection Control requirements and improvement work to be undertaken to address areas of concern.	Loss of public trust and confidence to deliver high standard infection prevention standards.	September 2016	Sustained for 6 months		Combined Community and Acute Executive Team and Infection, Prevention and Control Team minutes Monthly Matron checklist Implemented 'I am clean' sticker audit Infection Control and Prevention Committee minutes
Community	68. Review the facilities in which some clinics are held to ensure they comply with infection control standards.	Review of all community clinic settings to ensure compliance with infection control standards and compliance with the IPC accreditation programme.	Inability to provide safe patient environment Loss public trust and confidence	March 2017	Sustained for 6 months		Minutes estates and community team Refurbishment Plans e.g. for Firth Park IPC accreditation programme Capital Planning Estates record Cleaning schedule

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‘Should do’ Requirements

Executive: Sandi Carman

Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Community Health	66. The Trust should ensure that all policies are reviewed and up to date.	Continue to monitor and prompt teams to update policies. Compliance to be overseen by the Trust Executive Group	Non-compliance with national professional bodies Failure to comply with national guidance Legislation and best practice Loss of patient confidence Media risk.	March 2017	On schedule		Executive minutes Policy ratification process Community Board minutes
Charles Clifford	81. Review pathway documents so they are regularly reviewed, dated, version controlled and monitored.	Put in place systems and processes to ensure the effective management of local controlled documents to ensure regular review and version control.	Non-compliance with national professional bodies Failure to comply with national guidance Legislation and best practice	March 2017	On schedule		Control Document Group minutes Tracker held electronically Folder and data base

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'Should do' Requirements

Executive: Mark Gwilliam

Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
NGH (8) R|HH (36) CCDS (78)	8 / 36 / 78The Trust should ensure that staff have attended mandatory training in accordance with the Trust target.	Maintain and develop improvement work to increase compliance with Mandatory Training requirements to consistently achieve 90% in all subject areas.	Workforce is not sufficiently trained in Mandatory Training Inability to retain and recruit staff Maintain patients safety and safe environment for patients/?/carers and staff	March 2017	On schedule		Board & FPW minutes PALMS Scheduled dates of training Minutes of staff meetings IPR HR KPI Reports
NGH (9) RHH (40)	9 / 40 The Trust should improve the compliance rates for medical and nursing staff receiving an annual appraisal.	Maintain and develop improvement work to increase compliance with Appraisal uptake to consistently achieve 90% for all relevant staff.	Failure to retain and recruit staff Poor staff engagement Failure to learn as an organisation	March 2017	On schedule		Compliance tracker IPR HR & KPI Report Board & FPW minutes
RHH	54. The Trust should review access and the environment of the chapel and prayer room.	Review of current environment to be undertaken and improvement plans developed for submission to the Capital Investment Team. Where gaps in provision occur this will be added to the Trust Risk Register for ongoing action and monitoring	Inability to deliver equality and diversity Loss of public trust and confidence	March 2017	On schedule		Risk assessment RHH Chaplaincy Team CCAS Executive Team Equality and Human Rights Group and Estates Team minutes
WPH	71. Level of compliance with mandatory training need to be improved, in particular, basic life support for adults and paediatrics and safeguarding children and vulnerable adults.	All subjects of MT have improved. Regular data assessment and action plans are in place: - Adult basic Life Support +3% - Paediatric Life Support +47% - Safeguarding Adults – L1 +8.4%, L2 +13.7%. - Safeguarding Children – L1 - +3%, L2, +10%, L3+7.8%	Inability to safe guard patients and support staff	March 2017	On schedule		Mandatory training records Mandatory training tracker Report to HCGC Directorate reports TNA

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Executive: Kirsten Major

Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Action Point 1 - Urgent Care Pathways K.Major	Trust Wide	Patients waited longer than the recommended standard for assessment and treatment in the emergency department; patient's vital signs were not taken and recorded consistently as part of the initial assessment in the "pit stop area" in the emergency department; 95% of patients were not admitted, transferred or discharged within four hours of arrival in the emergency department; patients were not clinically reviewed in CDU.	The Trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.	Inability to implement workforce plan	March 2017	On schedule		New model of care for walk-in and ambulance patients on arrival at A&E – developed and ratified. Minutes of meetings BPT Project plan Workforce Plan
Must Do	Action Point 1 - Urgent Care Pathways K.Major	Trust Wide		The Trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.	Inability to track and monitor information 'live' should system fail Inaccurate information	March 2017	On schedule		Performance Report - validated in ED Central storage site (information services site) Lorenzo 'Captain's log' daily review in ED Information circulated to ED senior team / Clinical Ops daily
Must Do	Action Point 1 - Urgent Care Pathways K.Major			The Trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.	Estate changes to be delivered on time. Inability to implement work force plan due to recruitment. Unable to meet training needs analysis.	**Original:** October 2016 **Revised:** March 2017	On schedule		Review of good practice areas. Training needs Analysis. Evaluation of service against national evidence and best practice. Audit Reports Use of Simul8 model / Service improvement model
Must Do	Action Point 1 - Urgent Care Pathways K.Major	Trust Wide		The Trust must ensure that patients in the clinical decisions unit have timely clinical reviews.	Inability to timely review patients for discharge or transfer Inability to implement work force plan Unable to develop effective clinical pathways to initiate appropriate treatment and/or escalate appropriately within the timescale	**Original:** October 2016 **Revised:** March 2017	On schedule		Audit reports: - Evidence of timely review of patients in CDU - Timely initiation of appropriate treatment for patients in CDU - Timely transfer out or discharge from CDU - No delays in discharge/transfer from CDU due to lack of clinical review
Must Do	Action Point 1 - Urgent Care Pathways K.Major	Trust Wide		The Trust must ensure robust escalation processes are implemented in the emergency department.	Engagement in working to escalation process Once escalation in place difficulty in responding due to surge and demand.	**Original:** October 2016 **Revised:** March 2017	On schedule		Escalation SOP in place Minutes of clinical governance meetings Monitoring arrangements in place to capture escalation at times of increased business activity. Audit against SOP
Must Do	Action Point 1 - Urgent Care Pathways K.Major	Trust wide		The Trust must ensure arrangements for governance within the emergency department operate effectively.	Inability to implement workforce plan	**Original:** October 2016 **Revised:** March 2017	On schedule		Meeting minutes Monthly departmental governance newsletter Business Continuity Plan and evidence of review Named Governance Lead Consultant MAJAX Plan / Table top exercise
Must Do	Action Point 1 - Urgent Care Pathways K.Major	Trust wide		The Trust must ensure divisional risk registers reflect issues in the emergency department and demonstrate evidence of actions and reviews	Non escalation of risk as appropriate No action against identified risks in a timely manner.	**Original:** October 2016 **Revised:** March 2017	On schedule		Minutes of meetings Risk Register and evidence of review, escalation or resolution Top 5 actions reviewed
Should Do	Action Point 1 - Urgent Care Pathways K.Major	NGH	11. The Trust should continue to review the provision on 24 hour consultant medical cover within the emergency department as part of being a major trauma centre	Undertake a review of the requirements for a Major Trauma Centre, risk assess any areas of non-compliance and implement mitigating actions where appropriate	Unable to deliver ED consultant work force plans Lack of clinical engagement	**Original:** August 2016 **Revised:** March 2017	**Issues:** Discussions with TEG on-going Consultant attendance in principle agreed		Minutes of Trauma Operations Group A&EM Workforce BPT sub group minutes

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Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	Action Point 1 - Urgent Care Pathways K.Major	NGH	10. The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Cross referenced with Action point 4 Executive – Hilary Chapman	Inability to recruit and retain nursing staff Inability to maintain optimum nursing staffing levels as required on a day to day basis Difficulty in recruiting to senior nurse post's	Non identified	On schedule		Validation Results following departments involvement in the National ED specific Safer Nursing Care Tool Evidence of Inter Care Group rotation of RN arrangements Minutes of BPT
Should Do	Action Point 1 - Urgent Care Pathways K.Major	RHH	38. Although the MIU works closely with the A&E at NGH, audits specific to the MIU should be complete effectiveness and to monitor improvement to services and treatment offered in this location.	Executive Lead Hillary Chapman	Loss of public trust and confidence in the service Media interest		On schedule		Electronic Clinical Assurance Tool clinical governance monitoring reports against key performance indicators Complaints and compliment FFT DATIX monitoring Use of external reports - Healthwatch
Should Do	Action Point 1 - Urgent Care Pathways K.Major	NGH	12.The Trust should continue to take action to ensure the emergency department achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department.	Require before carrying out care and treatment.	Unable to work in partnership with YAS to improve processors for handover time and meet recognised standard of 15 minutes arrival by ambulance to handover No accurate recording of conveyance.		Sustained for 6 months		Records of daily review against performance Monitoring of ambulance handover time. Evidence of communication with senior team and clinical operations Monitoring of front door improvement work e.g. process and time reporting
Should Do	Action Point 1 - Urgent Care Pathways K.Major	NGH	13. The Trust should review guidance in the emergency department to ensure it reflects current evidence-based guidelines.		Inaccurate and out of date guidelines in circulation within Emergency Department. Risk to delivering safe patient care.		Sustained for 6 months		Defined guidelines set against national evidence and appropriately referenced. Appropriate lead identified to develop / review existing guidelines for content. Training plans and associated literature revised for consistency and Review of existing guidelines
Should Do	Action Point 1 - Urgent Care Pathways K.Major	NGH	15. The Trust should review the experience of patients to ensure privacy and dignity is maintained in the emergency department, particularly during busy periods.	Executive lead Hillary Chapman	Failure to deliver an environment that protects the privacy and dignity of all patients Media Interest / safeguarding concerns		Sustained for 6 months		Audit of care rounding Complaints discussed and reviewed at clinical Governance meeting Trust Patient Experience Committee minutes FFT reports
Should Do	Action Point 1 - Urgent Care Pathways K.Major	RHH	37. The MIU should improve the monitoring of time to be seen and total time in department	Review of monitoring system to be undertaken and the processes modified as required. System to be in place to ensure sufficient data quality and monitoring of performance	System failure and requirement to implement business continuity and potential loss of real time information	November 2016	Sustained for 6 months		Performance monitoring reports available from Lorenzo
Should Do	K.Major	RHH	33 / 41. The Trust should continue to take action to reduce the number of medical outlier patients across the Trust.	Directorate action plans to be created to reduce the number of medical outlier patients. To include monitoring systems to demonstrate improvements.	Loss of public trust and confidence Inability to delivery consistent/safe care Poor FFT response.	March 2017	On schedule		TEG minutes X 3 – SOP clarifying process Audit/SOP evaluation
Should Do	K.Major	RHH	34 / 42. The Trust should continue to take action to reduce the number of bed moves patients experience during their hospital stay.	Develop metrics to assess, monitor and review patient pathways and identify lessons learned.	Loss of public trust and confidence Inability to delivery consistent/safe care Poor FFT response.	March 2107	On schedule		TEG minutes X 3 – SOP Cross references with (33)
Should Do	K.Major	RHH	49. The Trust should review the waiting times for patients with learning disabilities requiring dental treatment under general anaesthesia against the 18 week standard.	System to be developed and implemented to ensure monitoring and compliance with the 18 week standard.	None compliance against equality and diversity. Loss of public trust and confidence Poor FFT response. Minutes CD meeting New process criteria	March 2017	On schedule		Weekly monitoring and compliance report against 18wks

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Executive: David Throssell

Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Action Point 2 - End of Life D.Throssell	Trust Wide	There was no end of life care strategy. DNACPR records were not completed fully and accurately. There was no monitoring of preferred place of death. (Trust wide)	The Trust must ensure there is a clear strategy for the end of life care, which is implemented and monitored.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** October 2017	On schedule		End of Life Strategy Minutes of Meeting TOR Project Plan
Must Do	Action Point 2 - End of Life D.Throssell	Trust Wide		The Trust must ensure that staff implement individualised, evidence based care for patients at the end of life.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** October 2017	On schedule		End of life strategy Minutes of meetings Collaborative document to enable individual evidence based care.
Must Do	Action Point 2 - End of Life D.Throssell	Trust Wide		The Trust must ensure that DNACPR records are fully completed.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** June 2017	On schedule		Audit minutes Policy
Must Do	Action Point 3 - Medicines Management D.Throssell	Trust wide	Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained. (Trust wide)	The Trust must ensure the safe storage of intravenous fluids.	Non-compliance with medicines code Breach of regulatory compliance	March 2017	On schedule		Medicine Safety Committee minutes Business case for environmental changes SOP – fridge failure Project Plan
Must Do	Action Point 3 - Medicines Management D.Throssell	Trust wide		The Trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.	Non-compliance with national guidance and prescribing Breach of regulatory compliance	July 2017	On schedule		Action Plan Minutes Medicines Safety Committee and Clinical Governance Committee Audit report Minutes of Clinical Gases Committee
Must Do	Action Point 5 - Medication Prescribing and Administration D.Throssell	Beech Hill	People who use services and others were not provided with the proper and safe use of medication. (Beech Hill)	The provider must ensure that all medication charts and controlled drug checks are completed in line with policy.	-Inability to deliver safe patient Care -Non-compliance with Medication legislation and best practice in line with CQC regulation and	**Original:** September 2016 **Revised:** March 2017	On schedule		-Audit Report - 3 monthly controlled drug checks -Review of medication prescribing -Minutes Medicines Safety Committee.E8
Should Do	Action Point 2 - End of Life D.Throssell	RHH (27) NGH (53)	27 / 53 The Trust should monitor preferred place of care for patients at the end of life.		Loss of public trust and confidence Inability to deliver equality and diversity		**Issues:** Issues identified		FFT Collaborative minutes Audit
Should Do	D.Throssell	RHH	28. The Trust should review implementation of NICE urinary incontinence in neurological disease for outpatients in the spinal injuries unit.	Audit and review of current compliance and improvement actions implemented. Any areas of non-compliance/deviation will be escalated as per the Trust policy.	Lack of assurance delivery to best practice from NICE	**Original:** December 2016 **Revised:** March 2017	**Issues:** Still requires review		Gap analysis against NICE Action Plan Implementation Plan CEC minutes
Should Do	D.Throssell	LEGION	46. The Trust should ensure that the neonatal resuscitaires in labour suite has documented checks. We identified checklists that had signatures missing 22% of the time for the month examined.	Continue with resuscitation Equipment checking improvement work including regular audits and training of support workers.	Inability to provide safe working equipment	**Original:** December 2016 **Revised:** February 2017	**Issues:** Audit not completed Dec 2016 – rescheduled for January		spot checks undertaken by the Governance team report Minutes of Obstetrics and Gynaecology Executive Team Resuscitation Committee
Should Do	D.Throssell	OGN Executive Team & Pharmacy Services	52. The Trust should consider improving the way in which medicines are constituted within the neonatal unit to ensure there is a safe environment to do this, and reduce risk of medicine errors.	Review to be undertaken of current practice and improvement actions to be undertaken. Any residual areas of concern will be managed through the risk assessment process.	Inability to adhere to Medicines Code.	**Original:** September 2016 **Revised:** March 2017	**Issues:** Awaiting completion of redevelopment delayed till Feb 2017		Review of ready-to-use products completed by pharmacy following NPSA20 criteria Datix report for incident monitoring Medicines management minutes Estates refurbishment plan Minutes Obstetric and gynaecology
Should Do	D.Throssell	Community Services	60. The provider should review the need for an early warning tool to recognise a deteriorating patient	Review to be undertaken of the need for an early warning tool and action plan to be put in place to address any areas of concern.	Lack of assurance that early warning score in place to maintain safety	February 2017	**Issues:** Protocol to be produced and monitoring arrangements agreed		Patient Safety Team and Combined Community and Acute Executive Team minutes Working party minutes Evaluation tools Audit report TNA – training records

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Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	D.Throssell	Community Services (64) WPH (75)	64. 75 The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Inability to fully implement equality and diversity	**Original:** December 2016 **Revised:** March 2017	**Issues:** Awaiting CCG review against the EOL template		Combined Community and Acute Executive Team and IT
Should Do	Action Point 2 - End of Life D.Throssell	Community Services	64. The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Loss of public trust and confidence Inability to deliver equality and diversity	**Original:** December 2016 **Revised:** July 2017	On schedule		Review System 1 template Audit record for recording spiritual needs Citywide minutes EOL
Should Do	Action Point 3 - Medicines Management D.Throssell	NGH	16. The Trust should ensure staff follow policy and best practice guidance in relation to the administration of intravenous fluids.		Non-compliance with national guidance and prescribing Breach of regulatory compliance		On schedule		Medicine Safety Committee minutes Business case for environmental changes Project Plan
Should Do	D.Throssell	NGH	19. 44 The Trust should introduce a robust process to share lessons learnt from incidents and mortality and morbidity reviews across directorates and care groups.	Systems and processes to be developed to align with the national review of mortality	Inability to review and identify areas of concern relating to deaths both expected and unexpected and implement the learning Media Interest	March 2017	On schedule		Mortality and Morbidity Group minutes Audit Report Dr Foster Analysis
Should Do	D.Throssell	NGH	20. The Trust should ensure it reviews the process for the appropriate testing of all medical equipment used for patient care in the critical care units.	Undertake audit of current compliance and improvement action taken where required	Circulation of unsafe equipment in areas used for patient care.	**Original:** December 2016 **Revised:** March 2017	On schedule		OSCCA Executive Team minutes Medical Equipment Management Group minutes Register of test Clinical engineering Medical equipment database
Should Do	D.Throssell	RHH Chaplaincy Team CCAS Executive Team Equality and Human Rights Group and Estates Team	21. The Trust should ensure that there are appropriate weaning plans in place for all patients with tracheostomies and that these are made in timely way.	Review of current systems to ensure appropriate and safe processes are in place. Establishment of systems to ensure on-going compliance		**Original:** December 2016 **Revised:** March 2017	On schedule		Tracheostomy Group minutes
Should Do	D.Throssell	RHH	22. The Trust should consider reviewing data collection methods and the process for submitting ICNARC data for Cardiac Intensive Care, so that patient outcomes can be benchmarked with other similar services	Implementation of processes to ensure submission of ICNARC data including system to ensure good data quality.	Lack of assurance that the trust is collecting the right level of information to measure patient outcomes.	March 2017	On schedule		Cardiac Services governance minutes ICNARC submission
Should Do	D.Throssell	RHH	24. The Trust should consider reviewing the computer provision on CICU.	Audit of computer provision on CICU to be undertaken and areas for improvement identified and actioned, where residual concerns remain a risk assessment will be undertaken.	No streamlined computer service to CICU.	**Original:** December 2016 **Revised:** March 2017	On schedule		Cardiac Services Executive Team Information Technology Team minutes Audit Report Action plan Risk assessment
Should Do	D.Throssell	RHH	25. The Trust should consider the implementation of the electronic patient clinical information system on CICU so there is alignment with the other critical care units.	Consideration to be given to implementation of the electronic patient clinical information system whilst taking account of the future T3 objectives.	Inability to align the patient pathway with other critical care units.	March 2017	On schedule		Cardiac Services Executive Team Information Technology Team minutes Implementation plan

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Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	D.Throssell	NGH (35) RHH (58) WPH (77)	35. 77.58 The Trust should monitor access to records in the [outpatient] departments.	Trust wide OPD notes access audit to be undertaken and tailored solutions to be implemented dependent on the environment and access requirements.	Lack of assurance that information governance standards are monitored Media risk.	**Original:** December 2016 **Revised:** March 2017	On schedule		Outstanding Outpatients Programme and Information Governance Committee minutes Audit OPD notes and access
Should Do	D.Throssell	Jessops	47. The Trust should continue to improve consultant medical staffing on labour ward in accordance with Royal College of Obstetrician and Gynaecologists guidelines.	Development of workforce plans for consultant medical staffing on the labour ward. Risk assessment to be updated for areas of noncompliance and mitigating action undertaken	Inability to provide full obstetric and gynaecology carer.	**Original:** December 2016 **Revised:** March 2017	On schedule		BPT business case Workforce plan
Should Do	D.Throssell	WPH	69. The hospital should improve the environment and the skills of staff to ensure that the needs of people living with dementia are met.	Capital scheme commenced which includes improvements to ensure the environment meets the needs of patients with dementia.	Loss of public trust and confidence in providing the right environment for patients with dementia	March 2017	On schedule		SMCR Executive Team, WPH Strategy Group and Capital Investment Team
Should Do	D.Throssell	WPH	76. The Trust should review the Deprivation of Liberty Safeguards (DoLS) policy.			**Original:** December 2016 **Revised:** March 2017	On schedule		MCA/DOLS Policy MCA/DOLS flowchart MCA intranet site Updated DOLS guidance relating to ICU Patients' Survey Monkey results and audit report Tool Kit for Best Interests assessments. Audit of capacity assessments. Audit of Best Interest Decisions. Training Needs Assessment
Should Do	D.Throssell	CCDH	82. Review and establish robust procedures for gaining consent of patients for local anaesthetic extractions.	Undertake review and audit of consent processes following local and national best practice and ensure any changes are fully adopted by all relevant clinician. Put in place system for the continuous monitoring of compliance.	Inappropriateness Consent taken from patients prior to anaesthetic extractions.	December 2016	On schedule		Consent Audit Report Minutes – Clinical Services Safer Surgery Check Audit
Should Do	Action Point 2 - End of Life D.Throssell	Community Services WP	63. 74The Trust should develop a system for monitoring patients whether patients died in their preferred place of care.	Complete within Community Services Revised deadline for Hospital setting July 2017	Public trust and confidence Media interest	December 2016 Complete	Sustained for 6 months		Audit – December 2016 report Integrated care team nurse leads Records audit of System 1 EOL minutes Audit programme EOL strategy
Should Do	Action Point 2 - End of Life D.Throssell	Community Services	65. The Trust should consider auditing the use of the guidelines for the care of the person who may be in the last hours to days of life.		Loss of public trust and confidence Inability to deliver equality and diversity		Sustained for 6 months		STHFT EOL Group minutes Guidelines Audit compliance
Should Do	D.Throssell	NGH (31) RHH (55) WPH (72)	31. 55. 72 The Trust should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.	Design and implementation of checklist followed by audit programme to ensure continuous monitoring of compliance.	Inability to maintain patient safety	September 2016	Sustained for 6 months		Safer Procedures Steering Group minutes Monthly Audit Governance performance Dashboard Directorate assurance group minutes SOP
Should Do	D.Throssell	NGH (32) RHH (56) WPH (73)	32. 56. 73 The Trust should consider undertaking regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks	Audit to be designed and implemented to monitor the required checks. System to be implemented to ensure continuous monitoring and review.	Unable to ensure consistency in completing the MRI checklists	October 2016	Sustained for 6 months		MIMP Executive Team minutes Safer surgery steering group minutes SOP Monthly compliance audits

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Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	D.Throssell	Jessops LEGION / OGN	45. The Trust should review the labelling of babies prior to their removal from the obstetric theatre.	Review of processes to be undertaken and a system implemented to ensure safe	Inability to maintain safe environment and safety Media intent Loss public trust and confidence	September 2016	Sustained for 6 months		Staff communication Weekly spot checks Audit report
Should Do	D.Throssell	Trust wide	48. The Trust should review data collection methods and introduce a system to collect patient outcomes by surgical speciality within care groups.	All Surgical Directorates will be tasked to review the systems in place to collect patient outcomes, analysed appropriately and shared to ensure lessons learned and improvement made.	Lack of assurance that the Trust collects and acts on surgical patient outcomes to improve quality and safety	March 2017	Sustained for 6 months		Surgical group minutes Audit report Lesson learnt report 1
Should Do	D.Throssell	Community Health	59. The provider should ensure that resuscitation equipment is checked in line with Trust policy.		Inability to maintain patient safety	August 2016	Sustained for 6 months		Daily/monthly checks Audit
Should Do	D.Throssell	CCDS	79. Take action in relation to compatibility of radiological imagery and the new electronic record system, to avoid the need for patients to walk between clinical areas mid procedure which negatively effects their privacy and dignity whilst being treated.	Review and improvement action to be taken to address the environmental concerns to ensure patients privacy and dignity.	Inability to maintain patients privacy and dignity.	December 2016	Sustained for 6 months		MIMP Executive Team Audit of patients attending ground floor Datix reports MIMP governance minutes
Should Do	D.Throssell	CCDS	80. Review governance minutes so they are clearly labelled to identify which dental clinical stream the papers apply to, and have a robust system for taking appropriate action on areas of concern raised within these meetings.	Standardised templates to be implemented that clearly identify the dental stream. Formal reference processes to be established to ensure that action points are appropriately carried forward and completed	Inability to deliver robust governance arrangements.	September 2016	Sustained for 6 months		Minutes of meetings Action Plans from meetings

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Executive: Hilary Chapman

Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Action Point 6 - Cardiotocography (CTG) Recording H.Chapman	Jessop Wing	In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with Trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6).	The Trust must ensure that guidance is followed in the documentation of fetal heart rate monitoring's.	-Inability to deliver safe and timely care to mother and baby -Non-compliance with National guidance and best practice	April 2017	On schedule		-Audit report and improvement plan - Review of Intrapartum Fetal Monitoring CTG Guideline -Evidence of HOT TOPIC across the service and communication strategy OGN HGC meeting minutes Training needs analysis for midwifery.
Must Do	Action Point 4 - Nurse Staffing H.Chapman	Weston Park	Nursing staffing levels were below the planned level with many shifts having fewer registered nurses than required on duty. (Weston Park)	The hospital must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.	-Risk to delivering safe Care -Inability to deliver quality improvements -Poor patient, family and carer experience -Loss of public trust and confidence -Media interest	Continuous monitoring	Sustained for 6 months		-Monthly Staffing Report -Healthcare governance Minutes -TEG Minutes -Board Minutes -Safer Nursing Care Tool process monitoring reports -Escalation policy – Exception monitoring reports - monitoring of Datix incident reporting -Continuing with recruitment initiatives such as overseas recruitment and targeted recruitment campaigns.F7
Should Do	H.Chapman	Community	67. Ensure that patient risk assessments are fully completed in all community nursing patient records.	Audit of nursing documentation to understand areas for improvement and implement appropriate improvement actions.	Inability to deliver safe/individualised patient care	**Original:** November 2016 **Revised:** March 2017	**Issues:** Awaiting final report and action plan from notes audit		Combined Community and Acute Executive Team Minutes of group meetings Audit report meeting documentation
Should Do	Action Point 4 - Nurse Staffing H.Chapman	NGH	10. The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Cross reference with Action Point 1.		March 2017	On schedule		
Should Do	H.Chapman	NGH	26. The Trust should consider a process for obtaining patient feedback following discharge from critical care.	Review of the processes in place to obtain patient feedback following discharge from critical care and implement improvement actions.	Loss of trust and confidence of patients and family Media intent Inability to meet national targets and commissioning intentions.	March 2017	On schedule		Patient Perception Survey FFT report PEC minutes Critical Care Group minutes
Should Do	H.Chapman	NGH	29. The Trust should review the fracture clinic environment to ensure meet the needs of patients.	Audit of patient flow and suitability of the environment to be undertaken. Plans to be developed and reviewed by the Capital Investment Team as required.	Inability to provide an environment that meets patients' needs	March 2017	On schedule		MSK Executive Team and Estates environment assessment Concept paper for capital investment team CIT Minutes
Should Do	H.Chapman	NGH	30. The Trust should routinely collect waiting time information for patients waiting for [outpatient] appointments.	Review of systems and processes to be undertaken to assess the most appropriate mechanism of measuring outpatient waiting times and implement the findings.	Loss of public trust and confidence Media interest	**Original:** December 2016 **Revised:** March 2017	On schedule		Escalation Policy for Outpatient Waiting Times Audit report Business case to CIT E-Check In project
Should Do	H.Chapman	RHH	57. The Trust should review oversight of the area and facilities for patients waiting for transport following the clinic appointments.	Audit to be undertaken of waiting areas for patients following clinic appointments and a plan to address any areas for improvement.	Inability to provide a sustainable, safe environment for patients and their carers.	March 2017	On schedule		Environment assessment sheets Outstanding Outpatient Board minutes

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Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	H.Chapman	WPH With DT	69. The hospital should improve the environment and the skills of staff to ensure that the needs of people living with dementia are met.	Capital scheme commenced which includes improvements to ensure the environment meets the needs of patients with dementia.	Inability to provide an environment to meet patient safety requirements and equality and diversity	March 2017	On schedule		SMCR Executive Team, WPH Strategy Group and Capital Investment Team minutes Capital Scheme timetable and actions
Should Do	H.Chapman	Community Dental With DT	83. The Trust should review the access for patients requiring dental treatment at Manor Clinic who use wheelchairs.		□ Inability to provide a safe environment □ Deliver equality and diversity.	**Original:** December 2016 **Revised:** March 2017	On schedule		□ Access Audit □ Evaluation of new dental chair □ Minutes of Head and Neck team meeting □ Estates plans
Should Do	Action Point 4 - Nurse Staffing H.Chapman	Community Services	61. The provider should ensure staffing levels are appropriate to patient dependency.		Risk to delivering safe and timely care -Poor patient, family and carer experience -Loss of public trust and confidence		Sustained for 6 months		-Monthly Board Report -Minutes of Board -GSM Directorate Minutes -Monthly GSM Report - Safer Nursing Care Tool NHS Professional usage – fill rates
Should Do	H.Chapman	NGH (17) RHH (39) JHW (51) WPH (70)	17/ 39 / 51 / 70 The Trust should review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.	Six month secondment of a senior nurse to review the Trust approach to Care Planning. The post holder will produce a plan to support the production of patient specific care plans which are used to direct personalised nursing care for patients through the effective use of	Inability to deliver safe patient care	**Original:** December 2016 **Revised:** March 2017	Sustained for 6 months		Nurse executive Group minutes JD for 6 month secondment Commenced April 2016 Implementation plan □ Audit Report: □ Lorenzo Care Planning functionality Rollout implementation plan □ BADGER Business Plan.
Should Do	H.Chapman	NGH (18) RHH (43)	18. 43. The Trust should try to reduce the movement of staff to clinical areas outside of their speciality.	Continuation of daily staff meetings Inclusion of the rationale for any staff movement in the Nurse Managers welcome presentation for newly qualified staff. Recruitment and vacancy position regularly received Continued focus on recruitment; Continued focus on the development of new and innovative roles and ways of working Continue to work in partnership with NHS Professionals.	Inability, maintain patient safety and continuous quality of care Maintain recruitment and retention.	No deadline On-going and in place	Sustained for 6 months		Nurse executive group minutes Daily meetings Presentations from newly qualified staff Monthly nurse staffing report Minutes of Nurse Staffing Recruitment Group Winter Plan 2016/17
Should Do	H.Chapman	RHH With DT	50. The Trust should ensure appropriate medical and nursing staffing on the neonatal unit to reflect current national guidelines for safe care.	Review of staffing levels to ensure sufficient staff are in place to reflect current national guidelines for safe care	Inability to deliver against national guidelines for safe care.	December 2016	Sustained for 6 months		BADGER staffing tool monthly report Report – Yorkshire and Humber Neonatal ODN Escalation Policy Staffing Report
Should Do	H.Chapman	Community Services Beech Hill Combined Community/Acute Services	62. The provider should check that all equipment is labelled after it has been cleaned.	Audit to be undertaken to review compliance of Infection Control requirements and improvement work to be undertaken to address areas of concern.	Loss of public trust and confidence to deliver high standard infection prevention standards.	September 2016	Sustained for 6 months		Combined Community and Acute Executive Team and Infection, Prevention and Control Team minutes Monthly Matron checklist Implemented 'I am clean' sticker audit Infection Control and Prevention Committee minutes

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Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	H.Chapman	Community	68. Review the facilities in which some clinics are held to ensure they comply with infection control standards.	Review of all community clinic settings to ensure compliance with infection control standards and compliance with the IPC accreditation programme.	Inability to provide safe patient environment Loss public trust and confidence	March 2017	Sustained for 6 months		Minutes estates and community team Refurbishment Plans e.g. for Firth Park IPC accreditation programme Capital Planning Estates record Cleaning schedule

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Executive: Sandi Carman

Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Action Point 7 - Management of External Reviews S.Carman	Trust Wide	The Trust must ensure that, where concerns are raised and investigated, the reviews are undertaken promptly to ensure any necessary actions are implemented in a timely manner.	Standardised Trust processes to be implemented for all external reviews which will include monitoring and oversight by a Trust group.	-Loss of public and patient confidence -Media interest -Funding spending money wisely	April 2017	On schedule		- SOP - Minutes of TEG, HCGC
Should Do	S.Carman	Community Health	66. The Trust should ensure that all policies are reviewed and up to date.	Continue to monitor and prompt teams to update policies. Compliance to be overseen by the Trust Executive Group	Non-compliance with national professional bodies Failure to comply with national guidance Legislation and best practice Loss of patient confidence Media risk.	March 2017	On schedule		Executive minutes Policy ratification process Community Board minutes
Should Do	S.Carman	Charles Clifford	81. Review pathway documents so they are regularly reviewed, dated, version controlled and monitored.	Put in place systems and processes to ensure the effective management of local controlled documents to ensure regular review and version control.	Non-compliance with national professional bodies Failure to comply with national guidance Legislation and best practice	March 2017	On schedule		Control Document Group minutes Tracker held electronically Folder and data base

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Executive: Mark Gwilliam

Priority	Action Point	Location	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	M.Gwilliam	NGH (8) R|HH (36) CCDS (78)	8 / 36 / 78The Trust should ensure that staff have attended mandatory training in accordance with the Trust target.	Maintain and develop improvement work to increase compliance with Mandatory Training requirements to consistently achieve 90% in all subject areas.	Workforce is not sufficiently trained in Mandatory Training Inability to retain and recruit staff Maintain patients safety and safe environment for patients/?/carers and staff	March 2017	On schedule		Board & FPW minutes PALMS Scheduled dates of training Minutes of staff meetings IPR HR KPI Reports
Should Do	M.Gwilliam	NGH (9) RHH (40)	9 / 40 The Trust should improve the compliance rates for medical and nursing staff receiving an annual appraisal.	Maintain and develop improvement work to increase compliance with Appraisal uptake to consistently achieve 90% for all relevant staff.	Failure to retain and recruit staff Poor staff engagement Failure to learn as an organisation	March 2017	On schedule		Compliance tracker IPR HR & KPI Report Board & FPW minutes
Should Do	M.Gwilliam	RHH	54. The Trust should review access and the environment of the chapel and prayer room.	Review of current environment to be undertaken and improvement plans developed for submission to the Capital Investment Team. Where gaps in provision occur this will be added to the Trust Risk Register for ongoing action and monitoring	Inability to deliver equality and diversity Loss of public trust and confidence	March 2017	On schedule		Risk assessment RHH Chaplaincy Team CCAS Executive Team Equality and Human Rights Group and Estates Team minutes
Should Do	M.Gwilliam	WPH	71. Level of compliance with mandatory training need to be improved, in particular, basic life support for adults and paediatrics and safeguarding children and vulnerable adults.	All subjects of MT have improved. Regular data assessment and action plans are in place: - Adult basic Life Support +3% - Paediatric Life Support +47% - Safeguarding Adults – L1 +8.4%, L2 +13.7%. - Safeguarding Children – L1 - +3%, L2, +10%, L3+7.8%	Inability to safe guard patients and support staff	March 2017	On schedule		Mandatory training records Mandatory training tracker Report to HCGC Directorate reports TNA

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Action Point 1 - Urgent Care Pathways

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	Patients waited longer than the recommended standard for assessment and treatment in the emergency department; patient's vital signs were not taken and recorded consistently as part of the initial assessment in the "pit stop area" in the emergency department; 95% of patients were not admitted, transferred or discharged within four hours of arrival in the emergency department; patients were not clinically reviewed in CDU.	The Trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.	Inability to implement workforce plan	March 2017	On schedule		New model of care for walk-in and ambulance patients on arrival at A&E – developed and ratified. Minutes of meetings BPT Project plan Workforce Plan
Must Do	Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.	Inability to track and monitor information 'live' should system fail Inaccurate information	March 2017	On schedule		Performance Report - validated in ED Central storage site (information services site) Lorenzo 'Captain's log' daily review in ED Information circulated to ED senior team / Clinical Ops daily
Must Do		**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.	Estate changes to be delivered on time. Inability to implement work force plan due to recruitment. Unable to meet training needs analysis.	**Original:** October 2016 **Revised:** March 2017	On schedule		Review of good practice areas. Training needs Analysis. Evaluation of service against national evidence and best practice. Audit Reports Use of Simul8 model / Service improvement model
Must Do	Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure that patients in the clinical decisions unit have timely clinical reviews.	Inability to timely review patients for discharge or transfer Inability to implement work force plan Unable to develop effective clinical pathways to initiate appropriate treatment and/or escalate appropriately within the timescale	**Original:** October 2016 **Revised:** March 2017	On schedule		Audit reports: - Evidence of timely review of patients in CDU - Timely initiation of appropriate treatment for patients in CDU - Timely transfer out or discharge from CDU - No delays in discharge/transfer from CDU due to lack of clinical review
Must Do	Trust Wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure robust escalation processes are implemented in the emergency department.	Engagement in working to escalation process Once escalation in place difficulty in responding due to surge and demand.	**Original:** October 2016 **Revised:** March 2017	On schedule		Escalation SOP in place Minutes of clinical governance meetings Monitoring arrangements in place to capture escalation at times of increased business activity. Audit against SOP
Must Do	Trust wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure arrangements for governance within the emergency department operate effectively.	Inability to implement workforce plan	**Original:** October 2016 **Revised:** March 2017	On schedule		Meeting minutes Monthly departmental governance newsletter Business Continuity Plan and evidence of review Named Governance Lead Consultant MAJAX Plan / Table top exercise
Must Do	Trust wide	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group		The Trust must ensure divisional risk registers reflect issues in the emergency department and demonstrate evidence of actions and reviews	Non escalation of risk as appropriate No action against identified risks in a timely manner.	**Original:** October 2016 **Revised:** March 2017	On schedule		Minutes of meetings Risk Register and evidence of review, escalation or resolution Top 5 actions reviewed
Should Do	NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	11. The Trust should continue to review the provision on 24 hour consultant medical cover within the emergency department as part of being a major trauma centre	Undertake a review of the requirements for a Major Trauma Centre, risk assess any areas of non-compliance and implement mitigating actions where appropriate	Unable to deliver ED consultant work force plans Lack of clinical engagement	**Original:** August 2016 **Revised:** March 2017	**Issues:** Discussions with TEG on-going Consultant attendance in principle agreed		Minutes of Trauma Operations Group A&EM Workforce BPT sub group minutes

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Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Should Do	NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	10. The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Cross referenced with Action point 4 Executive – Hilary Chapman	Inability to recruit and retain nursing staff Inability to maintain optimum nursing staffing levels as required on a day to day basis Difficulty in recruiting to senior nurse post's	Non identified	On schedule		Validation Results following departments involvement in the National ED specific Safer Nursing Care Tool Evidence of Inter Care Group rotation of RN arrangements Minutes of BPT
Should Do	RHH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	38. Although the MIU works closely with the A&E at NGH, audits specific to the MIU should be complete effectiveness and to monitor improvement to services and treatment offered in this location.	Executive Lead Hillary Chapman	Loss of public trust and confidence in the service Media interest		On schedule		Electronic Clinical Assurance Tool clinical governance monitoring reports against key performance indicators Complaints and compliment FFT DATIX monitoring Use of external reports - Healthwatch
Should Do	NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	12.The Trust should continue to take action to ensure the emergency department achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department.	Require before carrying out care and treatment.	Unable to work in partnership with YAS to improve processors for handover time and meet recognised standard of 15 minutes arrival by ambulance to handover No accurate recording of conveyance.		Sustained for 6 months		Records of daily review against performance Monitoring of ambulance handover time. Evidence of communication with senior team and clinical operations Monitoring of front door improvement work e.g. process and time reporting
Should Do	NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	13. The Trust should review guidance in the emergency department to ensure it reflects current evidence-based guidelines.		Inaccurate and out of date guidelines in circulation within Emergency Department. Risk to delivering safe patient care.		Sustained for 6 months		Defined guidelines set against national evidence and appropriately referenced. Appropriate lead identified to develop / review existing guidelines for content. Training plans and associated literature revised for consistency and Review of existing guidelines
Should Do	NGH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	15. The Trust should review the experience of patients to ensure privacy and dignity is maintained in the emergency department, particularly during busy periods.	Executive lead Hillary Chapman	Failure to deliver an environment that protects the privacy and dignity of all patients Media Interest / safeguarding concerns		Sustained for 6 months		Audit of care rounding Complaints discussed and reviewed at clinical Governance meeting Trust Patient Experience Committee minutes FFT reports
Should Do	RHH	**Executive:** Kirsten Major **Group:** Emergency Department Exec Team / A&E Improvement Group	37. The MIU should improve the monitoring of time to be seen and total time in department	Review of monitoring system to be undertaken and the processes modified as required. System to be in place to ensure sufficient data quality and monitoring of performance	System failure and requirement to implement business continuity and potential loss of real time information	November 2016	Sustained for 6 months		Performance monitoring reports available from Lorenzo

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Action Point 2 - End of Life

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Trust Wide	**Executive:** David Throssell **Group:** End of Life Strategy Group	There was no end of life care strategy. DNACPR records were not completed fully and accurately. There was no monitoring of preferred place of death. (Trust wide)	The Trust must ensure there is a clear strategy for the end of life care, which is implemented and monitored.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** October 2017	On schedule		End of Life Strategy Minutes of Meeting TOR Project Plan
Must Do	Trust Wide	**Executive:** David Throssell **Group:** End of Life Strategy Group		The Trust must ensure that staff implement individualised, evidence based care for patients at the end of life.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** October 2017	On schedule		End of life strategy Minutes of meetings Collaborative document to enable individual evidence based care.
Must Do	Trust Wide	**Executive:** David Throssell **Group:** End of Life Strategy Group		The Trust must ensure that DNACPR records are fully completed.	Loss of patient and public trust and confidence Media interest Inability to deliver equality and diversity.	**Original:** December 2016 **Revised:** June 2017	On schedule		Audit minutes Policy
Should Do	RHH (27) NGH (53)	**Executive:** David Throssell **Group:** End of Life Strategy Group	27 / 53 The Trust should monitor preferred place of care for patients at the end of life.		Loss of public trust and confidence Inability to deliver equality and diversity		**Issues:** Issues identified		FFT Collaborative minutes Audit
Should Do	Community Services	**Executive:** David Throssell **Group:** End of Life Strategy Group	64. The Trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.	Template to be updated in collaboration with NHS Sheffield CCG. To specifically include the recording of patient's spiritual needs	Loss of public trust and confidence Inability to deliver equality and diversity	**Original:** December 2016 **Revised:** July 2017	On schedule		Review System 1 template Audit record for recording spiritual needs Citywide minutes EOL
Should Do	Community Services WP	**Executive:** David Throssell **Group:** End of Life Strategy Group	63. 74The Trust should develop a system for monitoring patients whether patients died in their preferred place of care.	Complete within Community Services Revised deadline for Hospital setting July 2017	Public trust and confidence Media interest	December 2016 Complete	Sustained for 6 months		Audit – December 2016 report Integrated care team nurse leads Records audit of System 1 EOL minutes Audit programme EOL strategy
Should Do	Community Services	**Executive:** David Throssell **Group:** End of Life Strategy Group	65. The Trust should consider auditing the use of the guidelines for the care of the person who may be in the last hours to days of life.		Loss of public trust and confidence Inability to deliver equality and diversity		Sustained for 6 months		STHFT EOL Group minutes Guidelines Audit compliance

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Action Point 3 - Medicines Management

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Trust wide	**Executive:** David Throssell **Group:** End of Life Strategy Group	Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained. (Trust wide)	The Trust must ensure the safe storage of intravenous fluids.	Non-compliance with medicines code Breach of regulatory compliance	March 2017	On schedule		Medicine Safety Committee minutes Business case for environmental changes SOP – fridge failure Project Plan
Must Do	Trust wide	**Executive:** David Throssell **Group:** End of Life Strategy Group		The Trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.	Non-compliance with national guidance and prescribing Breach of regulatory compliance	July 2017	On schedule		Action Plan Minutes Medicines Safety Committee and Clinical Governance Committee Audit report Minutes of Clinical Gases Committee
Should Do	NGH	**Executive:** David Throssell **Group:** End of Life Strategy Group	16. The Trust should ensure staff follow policy and best practice guidance in relation to the administration of intravenous fluids.		Non-compliance with national guidance and prescribing Breach of regulatory compliance		On schedule		Medicine Safety Committee minutes Business case for environmental changes Project Plan

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Action Point 4 - Nurse Staffing

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Weston Park	**Executive:** Hilary Chapman **Group:** Martin Salt, Nurse Director and Nurse Executive Group	Nursing staffing levels were below the planned level with many shifts having fewer registered nurses than required on duty. (Weston Park)	The hospital must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.	-Risk to delivering safe Care -Inability to deliver quality improvements -Poor patient, family and carer experience -Loss of public trust and confidence -Media interest	Continuous monitoring	Sustained for 6 months		-Monthly Staffing Report -Healthcare governance Minutes -TEG Minutes -Board Minutes -Safer Nursing Care Tool process monitoring reports -Escalation policy – Exception monitoring reports - monitoring of Datix incident reporting -Continuing with recruitment initiatives such as overseas recruitment and targeted recruitment campaigns.F7
Should Do	NGH	**Executive:** Hilary Chapman **Group:** Martin Salt, Nurse Director and Nurse Executive Group	10. The Trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.	Cross reference with Action Point 1.		March 2017	On schedule		
Should Do	Community Services	**Executive:** Hilary Chapman **Group:** Martin Salt, Nurse Director and Nurse Executive Group	61. The provider should ensure staffing levels are appropriate to patient dependency.		Risk to delivering safe and timely care -Poor patient, family and carer experience -Loss of public trust and confidence		Sustained for 6 months		-Monthly Board Report -Minutes of Board -GSM Directorate Minutes -Monthly GSM Report - Safer Nursing Care Tool NHS Professional usage – fill rates

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Action Point 5 - Medication Prescribing and Administration

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Beech Hill	**Executive:** David Throssell **Group:** Medicines Safety Committee	People who use services and others were not provided with the proper and safe use of medication. (Beech Hill)	The provider must ensure that all medication charts and controlled drug checks are completed in line with policy.	-Inability to deliver safe patient Care -Non-compliance with Medication legislation and best practice in line with CQC regulation and	**Original:** September 2016 **Revised:** March 2017	On schedule		-Audit Report - 3 monthly controlled drug checks -Review of medication prescribing -Minutes Medicines Safety Committee.E8

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Action Point 6 - Cardiotocography (CTG) Recording

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Jessop Wing	**Executive:** Hilary Chapman **Group:** LEGION/OGN Executive Team	In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with Trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6).	The Trust must ensure that guidance is followed in the documentation of fetal heart rate monitoring's.	-Inability to deliver safe and timely care to mother and baby -Non-compliance with National guidance and best practice	April 2017	On schedule		-Audit report and improvement plan - Review of Intrapartum Fetal Monitoring CTG Guideline -Evidence of HOT TOPIC across the service and communication strategy OGN HGC meeting minutes Training needs analysis for midwifery.

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Action Point 7 - Management of External Reviews

Priority	Location	Lead	Requirement	Action	Risks to delivery	Target completion date	Status of Action	Actual completion date	Evidence of Assurance
Must Do	Trust Wide	**Executive:** Sandi Carman **Group:** Serious Incident Group	The Trust must ensure that, where concerns are raised and investigated, the reviews are undertaken promptly to ensure any necessary actions are implemented in a timely manner.	Standardised Trust processes to be implemented for all external reviews which will include monitoring and oversight by a Trust group.	-Loss of public and patient confidence -Media interest -Funding spending money wisely	April 2017	On schedule		- SOP - Minutes of TEG, HCGC

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