EXECUTIVE SUMMARY
REPORT TO THE BOARD OF DIRECTORS
HELD ON 24 MAY 2022

Subject	CQC Action plan
Supporting TEG Member	Jennifer Hill, Medical Director (Operations)
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Status[1]	Note

PURPOSE OF THE REPORT:

To present the action plan in response to the CQC Inspection Report 'Must do' actions and Section 29a Warning Notice requirements

KEY POINTS:

- The Trust CQC Action Plan addresses the 85 'Must do' requirements and the requirements of the Section 29a Warning Notice. It also incorporates the 11 outstanding actions from the Action Plan in response to the CQC Letter of Intent issued in October 2021.
- The draft CQC Action Plan was presented to Trust Executive Group on 20 April 2022 and to the Board of Directors on 26 April 2022.
- Following a meeting with CQC on 22 April, it has been clarified that progress against maternity services 'Must do' actions will be reported via the monthly submission to CQC.
- The final CQC Action Plan was approved by the Trust Executive Group on 4 May 2022 and submitted to CQC on 5 May 2022.
- Following submitting the action plan to CQC, with the exception of Maternity Services, progress reports are not required however the action plan will be discussed at monthly CQC Engagement Meetings.
- Monthly progress reports will be provided to the Trust Executive Group and the Quality Committee. These will include updates in relation to the two priority 'must-do' Trust-wide workstreams implementing Safety Huddles and Ward Boards.
- A new column 'How will we know the outcome has been delivered?' is being added to the action plan for internal reporting. Operational Leads are in the process of providing this information, which will define the point at which reporting via the CQC Action Plan ends and on-going performance is monitored by the relevant oversight committee.
- A programme of 'walkabout' visits to clinical areas will commence from mid-May 2022. Visits will focus on Outcomes within the CQC Action Plan and checklists to support the visits have been provided by Operational Leads. A process has been agreed for providing feedback to wards visited, Operational Leads, and via the monthly report to Trust Executive Group and the Quality Committee.

IMPLICATIONS[2]

	AIM OF THE STHFT CORPORATE STRATEGY 2017-2020	**TICK AS APPROPRIATE**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	✓
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Board of Directors is asked to note the CQC Action Plan.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	4 May 2022	Y
Quality Committee	16 May 2022	Y
Board of Directors	24 May 2022	

CQC Action Plan

Outcome	Oversight	Top 3 high level actions (deliverable by 17 July)	Metrics (to measure delivery of the actions)	How will you measure delivery of actions (e.g. audit, spot checks, observation/walkabout)	Target date (for delivery of action)	Completion date (date action was completed)
Outcome 1: Mental Health needs are identified and actioned	**Executive Lead:** Medical Director (Development) **Operational Lead:** Associate Medical Director for Mental Health, Learning Disability and Autism **Oversight Committee:** Mental Health Steering Group	(1.1) Ensure that increasing numbers of patients with mental health needs have a daily mental health risk assessment completed and actions carried out to manage their risk	Improvement in % of patients referred on to liaison mental health or reason not referred documented Improvement in documentation of decision-making regarding need for 1-1 care and observation. Increase in % fully completed daily mental health risk assessments	• Spot checks • Monthly audit	17/07/2022	
		(1.2) Introduce training in how to use the daily mental health risk assessment and actions to take	% staff completed training	• PALMS dashboard	17/07/2022	
		(1.3) Implement training on the need to provide ligature free areas and one to one observation for patients where the Mental Health Risk Assessment indicates this.	Reduction in episodes of attempted ligature use	• Spot checks for ligature points • Monitor ligature incidents on Datix monthly	17/07/2022	

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Outcome 2: We are assured that our staff are competent in assessing mental capacity and lawfully deprive patients of liberty	**Executive Lead:** Medical Director (Development) **Operational Lead:** Head of Safeguarding and Prevent Lead **Oversight Committee:** Mental Health Steering Group	(2.1) Implement a colour coded record of MCA assessment and best interest documentation to be easily identifiable in the patient's records. Paper MCA assessment forms will be printed on coloured paper and filed behind a coloured divider in the paper records. An MCA/Best Interest assessment template will be added to the Forms section in Lorenzo. Add icon to the EWhiteboard to enable staff to denote that a patient is being deprived of their liberty/cannot consent to being in hospital for care and treatment.	Clearly documented capacity assessments will be evidenced in the records of patients who lack capacity to consent to their care and treatment Patients who lack capacity will be identifiable via the Whiteboard.	• Spot checks of patient records • Audit	30/06/2022 30/06/2022	
		(2.2) The Trust MCA/DOLS team will implement bespoke face to face support for wards identified by the CQC, this will include attendance at Board rounds, MDT meetings and safety huddles to provide on the spot training and support embedding of best practice	MCA Team will demonstrate evidence of and frequency of support visits to the in- patient areas highlighted by CQC. Patients who lack capacity to consent to care and treatment will have documented timely and decision specific capacity assessments.	• Spot checks of patient records • Audit • MCA Team records of support visits	30/06/2022	

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Outcome 3: We know that we appropriately restrain and tranquillise patients as required	**Executive Lead:** Medical Director (Development) **Operational Lead:** Associate Medical Director for Mental Health, Learning Disability and Autism **Oversight Committee:** Mental Health Steering Group	(3.1) Ensure that all episodes of restrictive interventions are documented and investigated. Guideline to be provided to clinical governance leads on how to review.	Datix completion and investigations Themes and areas identified for increased training through review of data	• Compare the EPMA data with Datix submissions to ensure that all episodes are investigated • Record of additional training delivered as a result of themes identified through data analysis	17/06/2022	
		(3.2) Restraint reduction network approved training completed by security staff and key staff in acute areas with highest rates of restrictive practice.	Completion of training once procured	• Via PALMS and from the datix reviews (which will ask whether those carrying out restraint have had training and when)	17/07/2022	
		(3.3) Monthly reports on data relating to the use of restrictive interventions to be included in directorate data and be part of the monthly report to MBB and the Board	Data from Datix and learning from these to be collated and routinely discussed each month	• Spot checks of directorate Quality Governance Group meetings, review of MMB and Board	17/07/2022	

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Outcome 4: We have embedded evidence-based interventions to reduce falls	**Executive Lead:** Medical Director (Operations) **Operational Lead:** Nurse Director for Combined Community and Acute Medicine **Oversight Committee:** Falls Strategy Group	(4.1) Review and improve the falls risk assessment documents used within ED and inpatient areas, and then increase compliance of its completion.	Sustained improvement in completion of weekly risk assessment reviews Improved falls risk assessment documents to be in consistent use in ED	• Clinical indicator audit of weekly falls risk assessment • Audit of use of updated falls risk assessment in ED	17/07/2022	
		(4.2) Ensure walking aids available 24 hours a day 7 days a week within the main assessment units, Acute Medical Unit, Frailty Unit, Surgical Assessment Centre and Hyper Acute Stroke Unit.	Walking aid availability on assessment unit Staff training on supplying and fitting walking aids to be available and part of local induction Consistent improvement in the numbers of staff trained	• Weekly spot checks on each area • Training records • Dedicated Storage area identified • Audit of documentation	17/07/2022	
		(4.3) Ensure patients at risk of falls have lying and standing blood pressure documented	Consistent improvement in the % of patients who have lying and standing blood pressure monitored	• Audit	17/07/2022	

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Outcome 5: We recognise and escalate patient deterioration promptly	**Executive Lead:** Medical Director (Operations) **Operational Lead:** Nurse Director, OSCCA **Oversight Committee:** Deteriorating Patient Committee	(5.1) Introduce a deteriorating patient bleep holder on all inpatient wards to ensure a first point of escalation is identified	Timely response to escalation of deteriorating patient as per escalation policy	• Audit of response times in 6 areas known to have highest numbers of deteriorating patients • Assurance checks of all inpatient areas to ensure deteriorating patient bleep holder information is displayed and all staff aware	31/05/2022	
		(5.2) Include deteriorating patient check and challenge in safety huddles	Evidence of early identification and escalation of deteriorating patient	• Matron spot checks- how healthy is your ward • Observation • Audit	31/05/2022	
		(5.3) Test and trial deteriorating patient alert in e-whiteboard to highlight those patients with a NEWS2 score that require escalation, providing a form to document escalation and response	Documented evidence of early identification and escalation of deteriorating patient	• Audit of documented escalation all patients with a NEWS2 score that require escalation, initially in 6 areas known to have highest numbers of deteriorating patients and time of response	30/06/2022	

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Outcome 6: We ensure we individualise and meet the needs and preferences of patients	**Executive Lead:** Chief Nurse **Operational Lead:** Deputy Chief Nurse **Oversight Committee:** Nurse Executive Group	(6.1) Embed the use of "What Matters to you" and the individualisation of nurse care planning	Consistent improvement in the completion of these elements in the Electronic patient record	• Audit	01/06/2022	
		(6.2) Implement the role of dignity champion across the Trust with the first priority focus "privacy and dignity"	Dignity champions in place throughout the inpatient wards (in the first instance) Clear roles and responsibilities for the role and first priority established	• Observations • Walkabouts	01/06/2022	
		(6.3) Implement the new standardised intentional rounding document across the Trust	New document in use Consistent improvement in completion	• Audit • Observation/walkabouts	01/06/2022	

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Outcome 7: We are assured that we manage medicines safely	**Executive Lead:** Medical Director (Operations) **Operational Lead:** Chief Pharmacist **Oversight Committee:** Medicines Safety Committee	**(7.1) Ensure Safe Storage of medicines and medical gases** Improve compliance with Medicines Management Checklist (MMC) including gases, crash trolley & associated kits expiry dates.	Medicines Management Checklist (MMC) completion – compliance and actions.	• Audit MMC compliance rates & non-conformance action plans. • Monthly spot-checks of gas storage locations by pharmacy gas operatives to include check that a fire risk assessment is in place. • Weekly checks of crash trolleys and associated kits (via MMC). • Trial report generation from Emergency Box tracking software and interrogation.	01/06/2022 01/06/2022 01/06/2022 30/06/2022	
		(7.2) Medicines Reconciliation Undertake a deep dive into the current data to refine the methodology and identify areas for improvement, understanding of patient flow/demand and agree service-level KPIs.	Consistent improvement in medicines reconciliation rates	• Medicines reconciliation report utilising data from EWhiteboard.	1/6/2022	
		(7.3) Medicines Administration - Eliminate all gaps in recording administration/ reason for omission on EPMA. - Collate and review current missed doses data relating to 'drug not available' (DNA) - review stock holding (range and quantity) of medicines and adjust ward top-up lists accordingly for areas with high	% of "not recorded" doses % missed doses due to DNA by ward % missed critical medicines doses Proportion of supplies provided as stock outside of core top-up dates	• Safety Risk and Quality Dashboard/Weekly MMC. • Develop/expand Info services reports from EPMA • Track % missed doses by ward. • Monitor and actively manage stock requests via the dispensary.	tbc	

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		DNA rates and/or high stock requests - Further develop the Safety and Risk Dashboard to include details of missed doses related to critical medicines.				
Outcome 8: We are assured that we manage hazardous substances safely in clinical areas	**Executive Lead:** Medical Director (Operations) **Operational Lead:** Occupational Health and Safety Manager **Oversight Committee:** Safety and Risk Committee	(8.1) Ensure domestic staff use and store cleaning chemicals safely	Evidence that cleaning chemicals are used and stored appropriately.	• Training records for ward based domestic staff in the safe use and storage of cleaning chemicals • Ward based domestic staff have access to secure lockable trolleys • Spot check by domestic supervisors on compliance • Efficacy of Cleanliness audit score sheet as per national cleaning standards – includes questions relating to chemical storage	Complete Complete Ongoing 09/05/2022	31/03/2022 31/03/2022
		(8.2) Provide safe system of working in relation to frequently used chemical cleaning products within the inpatient area.	Evidence that cleaning chemicals are used appropriately	• Audit of compliance via the IPC accreditation programme • Spot checks	17/07/2022	
		(8.3) Provide safe storage solutions for chemical products in the clinical areas	Rolling programme in place to fit electronic access to chemical storage rooms on in-patient wards. All wards without secure door access to chemical cleaning products have a lockable COSHH cupboard for storing concentrated cleaning solution	• Report to Safety and Risk Committee of progress against the rolling programme for updating the high-risk areas. • H&S checklist audit question responses to safe chemical storage • Walkabout/ spot checks.	17/07/2022 Monthly Ongoing	
Outcome 9: We are assured that we have	**Executive Lead:** Chief Nurse	(9.1) Implement a twice (7 days a week) daily staffing meeting Trust wide	Meeting minutes with actions evident	• Observation of staffing meetings	01/06/2022	

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adequate nurse staffing levels	**Operational Lead:** Deputy Chief Nurse **Oversight Committee:** Nurse Executive Group	incorporating a skill mix review for any staff movements		• Monthly review of action log		
		(9.2) Implement centralised prospective monthly roster review for inpatient areas – aligned to roster approval and publication dates	Staff on shift (assignment count) equally distributed across shift and day of the week in published rotas	• Roster KPIs • Targeted support via confirm, coach and challenge meetings with action log for evidence	07/07/2022	
		(9.3) Review and Refresh the planned/actual nurse staffing information boards and standardise completion across all clinical areas	Boards in place and completed on a shift/shift basis	• Spot checks • Observation/walkrounds	30/06/2022	
Outcome 10: We are assured that staff are trained to do their jobs	**Executive Lead:** Director of HR and Staff Development **Operational Lead:** Director of Education **Oversight Committee**: People Strategy Programme Board	(10.1) Complete a review of the current JSET provision to ratify core subjects to include: • MCA Level 2a • MCA Level 2b (DOLS) • Oxygen Cylinder Training • NEWS 2 • Safer use of Insulin • React to Red Develop a plan to agree directorate (local) and additional JSET requirements including: • Physical Restraint • Falls • Dementia • Learning Disabilities	Progress against plan for ratifying core JSET subjects with sign off process complete. Progress against plan to identify local (directorate) JSET.	• Project plan updates every two weeks.	17/06/22	
		(10.2) Monitor compliance rates across mandatory training and JSET performance by subject, directorate and staff group with a focus on non-compliant subjects:	Performance data by: • Subject • Directorate Staff group	• Performance reports generated from PALMs.	10/06/22	

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		• Moving & Handling • Safeguarding Children • Safeguarding Adults • Prevent				
		(10.3) Evaluate the current corporate and local induction to ensure new starters complete mandatory and JSET appropriate for their role.	New starters compliant with mandatory training and JSET.	• Performance reports generated from PALMs	10/06/22	
Outcome 11: We keep patient records up to date, secure, confidential and accurate	**Executive Lead:** Medical Director (Development) **Operational Lead:** Performance and Information Director **Oversight Committee:** Healthcare Records Committee	(11.1) Develop Health Records Policy that includes 'definition of Trust Health Record'.	Approved policy	• Minutes of HealthCare Records Committee approving policy	31/05/2022	
		(11.2) Commence role-based education and training for staff to reflect policy standards.	*Target staff groups by role *Training packages in place for each staff group	• 20% clinical staff trained by roles	17/07/2022	
		(11.3) Audit effectiveness of training	Assess record keeping quality by role	• Audit of records (sample selected by role) • Audit to include security of notes on wards and ED • Feedback to users following audit output and additional education/ training as required.	17/07/2022	
Outcome 12: We are assured that our staff adhere to best IPC practice to minimise	**Executive Lead:** Chief Nurse **Operational Lead:**	(12.1) Transfer the IPC Accreditation Programme on to the Quest platform – aim to provide transparency of data and ease of monitoring of compliance	Meetings between IPC Team, LB and Quest developers to determine what is required, layout etc	• Accreditation audits gradually being uploaded onto Quest	At least one audit being on Quest 01/07/2022	

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hospital acquired infection	Consultant Microbiologist and Lead for Infection Control **Oversight Committee:** IPC Committee	(12.2) Evaluate the scoring systems for all IPC Accreditation audits and implement a quantitative and transparent approach to scoring.	a) Review the Accreditation audit templates and updated these with appropriate metrics (PH) b) Update templates uploaded onto the Accreditation database and advertised to users (PH)	• Review and Update audit templates • Published and advertise updated templates • Update templates increasingly being used by staff when undertaking the rolling programme of audits	15/05/22 01/06/22 01/07/22	
		(12.3) Introduce peer review audit within the IPC Accreditation Programme - to be undertaken by matrons – aim is to provide the Trust with increased confidence in the current IPC Accreditation process and allow the sharing of good practice	a) Review the Accreditation audit list and determine which audits should be part of the peer review programme (PH) b) CN office to develop a programme of matron peer review audits (LB) c) Programme taken to NDs for implementation (LB & KJ) d) Peer reviews being undertaken as per the programme developed by CN's office e) System developed for identifying which submitted IPC Accreditation audits were undertaken by peer review (PH)	• ND meeting notes indicated that the CN office has developed the peer review programme and taken this to NDs meeting • Review of IPC Accreditation audit submissions shows Matrons undertaken peer review audits as per plan	01/05/22 01/07/22	
Outcome 13: We are assured that incidents are consistently	**Executive Lead:** Medical Director (Operations)	(13.1) Introduce new and simplified harm grading descriptors and revised guidance to support this.	Consistent improvement in harm grading audit scores.	• Incident grading audits.	23/05/2022	

Outcome	Oversight	Top 3 high level actions (deliverable by 17 July)	Metrics (to measure delivery of the actions)	How will you measure delivery of actions (e.g. audit, spot checks, observation/walkabout)	Target date (for delivery of action)	Completion date (date action was completed)
reported and harm accurately assessed	**Operational Lead:** Head of Patient and Healthcare Governance **Oversight Committee:** Safety and Risk Committee	(13.2) Implement a revised process to reduce time between incidents being logged on Datix and reported to NRLS.	Incidents are reported to NRLS within the target timeframe.	• Regular report of time taken to report incidents to NRLS.	01/06/2022	
		(13.3) Monitor incident reporting rates (per 1000 bed nights for inpatient areas) by directorate including the subject categories of incidents reported.	Incident reporting rates show consistent improvement and remain within or above target range.	• Regular report of performance by directorate • Review with comparable data for other similar Trusts when national data published.	03/05/2022	
Outcome 14: We are assured that staff learn from incidents to prevent them happening again	**Executive Lead:** Medical Director (Operations) **Operational Lead:** Head of Patient and Healthcare Governance **Oversight Committee:** Safety and Risk Committee	(14.1) Provide current accessible information via the intranet for sharing of learning from incidents, including never events.	Information evident on intranet and on ward Quality Boards.	• Spot check ward Quality Boards • Walk/about / talking to staff	01/06/2022	
		(14.2) Pilot five minute briefings in clinical areas to share learning.	Briefings delivered to clinical areas.	• Log of wards and departments visited where briefings have been delivered.	06/05/2022	
Outcome 15: We know and take action in response to our immediate performance and risks	**Executive Lead:** Chief Operating Officer **Operational Lead:** Deputy Chief Operating Officer	(15.1) Escalation process from Jessops Wing services, through Clinical Ops, to First and TEG on-call agreed	1. Twice daily information flow from directorate to Clinical Ops 2. Review of on-call escalations from Jessops Matron to Clinical Ops/FOC	1. Audit 2. Audit	01/06/2022	
		(15.2) Directorate Operational Leads flag immediate operational risks to Virtual Operational Support	Clear record of risks identified and mitigating actions described	• Audit	01/07/2022	

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	Oversight Committee: Performance and Caseload Overview Group	Room/Clinical Ops Lead and/or daily huddle				
		(15.3) Triangulation of risks raised at monthly Performance Management meetings with directorate risk registers and organisational performance	Corroboration of risks discussed at PMF with risk registers with incidents reported	• Audit	01/07/2022	
Outcome 16: We have effective systems to ensure adherence to the fit and proper persons requirements and regulation	**Executive Lead:** Assistant Chief Executive/Executive Director of Human Resources and Staff Development **Operational Lead:** Corporate Governance Manager / HR Business Partner **Oversight Committee:** Trust Executive Group	(16.1) To update and implement a revised Fit and Proper Persons Policy additions include • Three yearly DBS checks for the Board of Directors and Council of Governors, • Annual cross reference against the disqualified directors and insolvency list. • Removal of the reference to an assessment of values during interview as this is implicit in the interview approach rather than explicit (and therefore difficult to evidence). • Annual review of professional registration status for relevant Board members.	• Implementation of updated approved policy (April 2022) • Three yearly DBS checks in place for all relevant individuals (May 2022) • Annual cross reference against the disqualified directors and insolvency list (May 2022) • Annual review of professional registration status for relevant Board members (May 2022)	• Audit of records against an internal checklist	31/05/2022	
		(16.2) To introduce and promote improved standards of record keeping for the relevant personnel files to enable monitoring of adherence to the fit and proper persons regulations.	• Checklist to be completed to align with the requirements of the fit and proper persons policy. For example, all records must be dated.	• Audit of records against an internal checklist	31/05/2022	

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Outcome 17: We have effective systems to ensure Board oversight of the management of risk	**Executive Lead:** Assistant Chief Executive **Operational Lead:** Corporate Governance Manager **Oversight Committee**: Trust Executive Group	(17.1) Refresh the Trust's Framework for Risk Management (Risk Management Policy)	• Board approved Framework for Risk Management	• Commission an external review of risk management arrangements	28/06/2022	
		(17.2) Implement revised reporting / oversight arrangements for the management of risk.	• Meeting agendas / minutes • Reports	• Commission an external review of risk management arrangements	July 2022	
		(17.3) Deliver a Communication and Engagement Plan for oversight arrangements for the management of risk	Training attendance / compliance Educational resources	• Knowledge test / survey results	July 2022	

Core Services Action Plans

Community Inpatients

Outcome	Oversight	Top 3 high level actions (deliverable by 17 July)	Metrics (to measure delivery of the actions)	How will you measure delivery of actions (e.g. audit, spot checks, observation/walkabout)	Target date (for delivery of action)	Completion date (date action was completed)
Community Inpatients Outcome 1: To improve the safety of patient care delivered at SPARC	**Executive Lead:** Chief Nurse **Operational Lead:** Nurse Director for Combined Community and Acute Medicine **Oversight Committee**: CCA Care Group Executive	(17.1) To ensure patients dietary requirement information is consistent with current recommendations and accurately documented. To ensure SLT embed new principles of working to include nutrition documentation review	To consistently improve the documentation of nutrition information on SPARC communication tools	To complete a weekly review of compliance	01/07/2022	
		(17.2) To ensure SPARC are compliant with STH fire safety recommendations	SPARC fire risk assessment updated including the completion of an annual fire drill Fire wardens to be identified and trained All staff receive evacuation equipment training	Documentation of completed actions at local governance meeting Evidence of staff training	01/07/2022	
		(17.3) Skin integrity will be consistently assessed and managed using evidence based practice	To consistently improve documentation of skin integrity assessment and management (purpose T trial site)	Staff training log Review of care plan completion and compliance weekly	01/07/2022	

Urgent and Emergency Care

Outcome	**Oversight**	**Top 3 high level actions** (deliverable by 17 July)	**Metrics** (to measure delivery of the actions)	**How will you measure delivery of actions** (e.g. audit, spot checks, observation/walkabout)	**Target date** (for delivery of action)	**Completion date** (date action was completed)
UEC Outcome 1: (Trust outcome 1) Mental Health needs are identified and actioned	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	Implement that all patients assessed at risk/high risk are in sight of nurse's station and/or a one-to-one constant observer is allocated by group/trust	Evidence of best practice with escalation to provide observers	• Safety Huddles • Observation/walk around • Spot checks	17/7/2022	
		Inclusion of reviewing all alerts in Lorenzo in induction and acting on them to ensure safety of patient	Consistent improvement in % increase of acting on alert notices	• Safety Huddle • Records Audit	17/7/2022	
		Monitor PLAN room Q shift & after patient use for ligature anchor points	Evidence of a safe environment	• Safety Huddle • Observation/walk around • Spot checks	17/7/2022	
		Ensure that all areas looking after patients with mental health risks understand the need for ligature free areas or one to one observation	Reduction in % in episodes of attempted ligature use	• Spot checks for ligature points • Reduction in ligature episodes in UEC , as recorded on Datix	17/7/2022	
UEC Outcome 3: (Trust outcome 4) We have embedded evidence-based interventions to minimise the risk of falls.	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**:	Monitor completion of risk assessments for all patients at risk of falls: check that paper assessment aligns with electronic assessment and includes verifying history of falls Monitor that staff escalate if staffing is inadequate for good observation	Falls risk assessment audit scores remain within or above target range Audit to include escalation of staffing issues, as required.	• Records audit	17/7/2022	
		Review falls risk assessment to ensure inclusion of "Postural Drop" to ED Electronic Falls Risk Assessment Ensure patients identified at risk of postural drop on paper notes are included in the electronic	Consistent improvement in % patients who have lying and standing blood pressure documented	• Records audit • Observation/walkabout • E-whiteboard review	17/7/2022	

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	AEM Delivery Group	falls assessment and have lying and standing blood pressure documented.				
		Implement Falls Prevention Packs across ED & AMU – increase awareness by messaging "Yellow to Red Socks" initiative.	Evidence of falls prevention packs & "Red Socks being used appropriately	• Observation/walkabout • Spot checks	17/7/2022	
UEC Outcome 4: (Trust outcome 5) We recognise and escalate patient deterioration promptly.	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	Reiteration of Triage Nurse induction to ensure visual check of waiting area each time they call a patient Improve communication to remind patients to alert staff if feeling unwell, through triage, posters and 'ticker-tape-messaging'.	Consistent improvement in % patient satisfaction scores related to experience of waiting and environment Consistent improvement in appropriate signage and patient information available 24/7	• Friends and Family feedback • Reduction in waiting room complaints/Datix • Observation/walkabout	17/7/2022	
		Proactive 07:30 – 19:30 waiting room monitoring by Streaming Sister stationed at Reception (June 2022- evaluation) Receptionist 'floor walker' to be stationed in waiting area as a point of information.	Evidence of early recognition of patient deterioration and prompt escalation	• Records Audit • E-whiteboard review	17/7/2022	
		Ensure ED escalation cards are adhered to and visible implementation of checklist for Purple Escalation procedure	Consistent improvement in % exit flow	• Daily Observation/walkabout by STH Ops Team	17/7/2022	
UEC Outcome 5: (Trust outcome 6) We ensure we individualise and meet the needs	**Executive Lead:** Jennifer Hill, Medical Director (Operations)	Ensure timely documentation and individualised nursing assessments following implementation of the Named Nursing process	Consistent increase in evidence of individualised patient care	• Records Audit • Friends and family feedback • Reduced number of Complaints • Observation/walk around • Spot checks	17/7/2022	

Outcome	**Oversight**	**Top 3 high level actions** (deliverable by 17 July)	**Metrics** (to measure delivery of the actions)	**How will you measure delivery of actions** (e.g. audit, spot checks, observation/walkabout)	**Target date** (for delivery of action)	**Completion date** (date action was completed)
and preferences of patients	**Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	Ensure that refreshment and food is provided to patients at regular intervals 24/7, especially if they are waiting for inpatient admission	Evidence of nutritional guidance being used appropriately	• Observation/Walk around • Friends and family feedback • Reduced number of Complaints	17/7/2022	
UEC Outcome 6: (Trust outcome 10) We are assured that staff are trained to do their jobs deliverable 24/7	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	All Nurses providing triage and streaming to have completed triage training and be deemed competent and ensure all patients identified as suitable for streaming by a suitably trained clinician, thereby removing accountability from the non-clinical reception team.	Evidence of completed triage course	• Audit of training records • Records audit	17/7/2022	
		Complete a second cycle of the Safer Nursing Care Tool to identify the appropriate nursing-staff volume and skill mix for ED.	Consistent improvement in % staff skill mix as per national guidelines Consistent improvement in % staff completing mandatory training	• Audit of training records	17/7/2022	
		Ensure staff are able to undertake both mandatory and job specific training to reach at least 90% coverage. Professional development training is now available for staff	Consistent improvement in % staff acquiring national recognised qualifications Consistent improvement in % appraisals/supervision	• Audit	17/7/2022	

Outcome	Oversight	Top 3 high level actions (deliverable by 17 July)	Metrics (to measure delivery of the actions)	How will you measure delivery of actions (e.g. audit, spot checks, observation/walkabout)	Target date (for delivery of action)	Completion date (date action was completed)
		to enroll in e.g. Sheffield Hallam University Mentorship Course, Trauma Nursing Core Course (TNCC), and Advanced Life Support (ALS). All courses are promoted by posters/emails /social media				
UEC Outcome 7: (Trust outcome 11) We are assured we maintain accurate, secure, complete and contemporaneous record in respect of each service user securely	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	Move to a Clinical Data Capture (CDC) card which will facilitate the further development of the Single Assessment project to use a single set of clinical notes in ED and remove the printing of notes for admissions to AMU by August 2022.	Consistent improvement in % accurate and contemporaneous record	• Audit	August 2022	
		Continued improvement against delivery of the latest iteration of the Emergency Care Dataset (ECDS)'	Evidence from NHSE ECDS Dashboard measures performance against completeness and validity for each ECDS data field.	• Audit	17/7/2022	
		Yorkshire Ambulance Service (YAS) Transfer of Care Project – YAS data for conveyed patients is both scanned and manually entered into the STH ED EPR. This project will enable the direct electronic transfer of this patient information between the YAS and STH ED EPR.	Consistent improvement in % ability to review pre-hospital care in near time	• Audit	17/7/2022	
		Improve the use of Smartcards within ED, ensuring that patient information is only accessed on an individualised basis. Ensure staff compete Information Governance training	Consistent improvement % of staff compliance with IG training	• Audit	17/7/2022	

Outcome	Oversight	Top 3 high level actions (deliverable by 17 July)	Metrics (to measure delivery of the actions)	How will you measure delivery of actions (e.g. audit, spot checks, observation/walkabout)	Target date (for delivery of action)	Completion date (date action was completed)
UEC Outcome 8: (Trust outcome 12) We are assured that our staff adhere to best IPC practice to minimise hospital acquired infection	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	Equipment is cleaned in line with trust and national guideline: i.e. in-between patient use & paediatric resus trolley/tabards	Consistent improvement in % of equipment that is cleaned and checklist signed	• Once daily commode checks by NIC • Sluice checks Q 4h 24h by ED IPC Team • Weekly Audit with findings forwarded to STH IPC Team • Pilot of 4h internal observation walkabout - audit • QUEST Dashboard updated by ED IPC TL and reported to monthly CG meeting	17/7/2022	
		Correct PPE across all job roles i.e. correct placement of mask and not lowered when talking e.g. by Nurse in Charge and Consultant in Charge	Consistent improvement in % in all staff wearing correct PPE in line with ED SharePoint PPE Guidelines	• Observation/walk around: Check and challenge that appropriate PPE is worn • Audit - Spot-check by CG/3rd party	17/7/2022	
		Reminder at clinical and nursing handovers basic IPC: Bare below elbows, changing gloves and washing hands	Consistent improvement in adherence to basic personal IPC	• Attendance sign-in at Breakfast Club with IPC nurse reviewing basic IPC & PPE • Observation/walk around: check and challenge • Audit - secret observer	17/7/2022	
UEC Outcome 9: (Trust outcome 13) We are assured that incidents are consistently reported and harm accurately assessed	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director	Monthly feedback to teams of incident trends, top five risks and lessons learned and includes "You Reported – We Acted" Poster.	Consistent improvement in % staff reporting safety concerns on Datix	• Audit of Datix • Safety Huddles	17/7/2022	
		Encourage all staff to report safety concerns via Datix or a conversation with Clinical Governance Team When over capacity Clinical Governance Coordinator will	Consistent improvement in MDT reporting safety concerns	• Audit of Datix • Audit of records	17/7/2022	

Outcome	**Oversight**	**Top 3 high level actions** (deliverable by 17 July)	**Metrics** (to measure delivery of the actions)	**How will you measure delivery of actions** (e.g. audit, spot checks, observation/walkabout)	**Target date** (for delivery of action)	**Completion date** (date action was completed)
	Oversight Committee: AEM Delivery Group	round and assess in real time for potential harm.				
UEC Outcome 10: (Trust outcome 15) We know and take action in response to our immediate performance and risks	**Executive Lead:** Jennifer Hill, Medical Director (Operations) **Operational Lead:** Angela Harris, Nurse Director; Ben Cooper, Clinical Director **Oversight Committee**: AEM Delivery Group	Fortnightly meetings between the Acute and Emergency Care Group Triumvirate and the Performance and Information Director, the Deputy Chief Nurse, The Deputy Chief Operating Officer and the Medical Director to review operational oversight of risk, issues and performance.	Evidence of operational oversight of risk, issues and performance	Audit	17/7/2022	

Maternity Services

Outcome	Oversight	Top 3 high level actions (Deliverable by 17th July)	Metrics (To measure delivery of the actions	How will you measure delivery of actions (e.g., audit, spot checks, observation /walkabout0	Target date (for delivery of action)	Completion date (date action was completed)
OGN Outcome 1: (Trust outcome 5) We recognise and escalate maternal and fetal deterioration promptly	**Executive lead:** Chief Nurse **Operational Lead:** Clinical Director/Midwifery Director **Oversight Committee:** Maternity Improvement Board	(OGN 1.1) Ensure fetal monitoring (Antenatal & Intrapartum) is undertaken and recorded consistently reflecting NICE (2017) Intrapartum Care Guidelines (CG190).	> 90% compliance with staff training in relation to fetal monitoring (CTG and intermittent auscultation). >90% compliance with fresh eyes assessment.	• Staff training data for fetal monitoring (CTG and intermittent auscultation) • Weekly audits of documentation of CTG, including the intrapartum review tool sticker (fresh eyes).	17/7/22	
		(OGN 1.2) Ensure maternal monitoring is undertaken consistently and documented	> 90% compliance with staff training in relation to MEOWS and Neonatal Early Warning Track and Trigger (NEWTT) via PROMPT and Newborn Life Support training. >90% compliance with recording of MEOWS and NEWTT.	• Staff training data for PROMPT and NLS • Audit of compliance against MEOWS and NEWTT	17/7/22	
		(OGN 1.3) Ensure the completion of risk assessments for women on arrival via implementation of Birmingham Symptom Specific Obstetrics Triage System (BSOTS).	Safe, BR+ compliant, maternity staffing levels to support delivery of BSOTS standards. Pace of BSOTS implementation and roll out against action plan (dependent on Maternity specific information system and estate constraints).	• Safe staffing to support BSOTS is recorded via BR + acuity app every 4 hours and reported twice daily on the Jessop Wing SiTRep. • Progress with implementation of BSOTS against action plan	17/7/22	
OGN Outcome 2: (Trust outcome 7) We are assured that we manage medicines safely	**Executive Lead:** Chief Nurse **Operational Lead**	(OGN 2.1) Review of pathway for prescribing and administration of all ongoing medications in labour ward assessment	Improved prescribing and administration of ongoing medications in labour ward triage.	• Reaudit of the timeliness of critical medication prescription on admission to maternity services	17/7/22	

Outcome	Oversight	Top 3 high level actions (Deliverable by 17th July)	Metrics (To measure delivery of the actions	How will you measure delivery of actions (e.g., audit, spot checks, observation /walkabout0	Target date (for delivery of action)	Completion date (date action was completed)
	Clinical Director/Midwifery Director **Oversight Committee:** Maternity Improvement Board	unit (LWAU) (linked to BSOTS)				
OGN Outcome 3: (Trust outcome 9) We are assured that we have adequate midwifery, nursing and obstetric staffing levels	**Executive Lead:** Chief Nurse **Operational Lead:** Midwifery Director **Oversight Committee:** Maternity Improvement Board	(OGN 3.1) Complete Birth Rate Plus full assessment for maternity staffing and undertake a review against current maternity establishment.	Staffing levels in line with "Safe Midwifery Staffing for Maternity Settings" NICE guideline (NG4) 2015	• Birth rate plus acuity App	30/06/22	
		(OGN 3.2) Implementation of Birth Rate Plus App on Consultant led and Midwifery Led Intrapartum Areas and AN and PN wards.	Staffing levels in line with acuity every 4 hours (intrapartum areas) and every 8 hours other areas. Number of red flags by type.	• Birth rate plus acuity App	30/06/22	
		(OGN 3.3) Recruitment of relevant staff to all vacant posts	Staffing levels in line with "Safe Midwifery Staffing for Maternity Settings" NICE guideline (NG4) 2015	• Birth rate plus acuity App	17/7/22	
		(OGN 3.4) Analyse red flag data to identify actions required to reduce reoccurrence and report via governance process for escalation to the Board.	Reduction in number of red flags	• Birth rate plus acuity App	30/06/22	
OGN Outcome 4: (Trust outcome 17)	**Executive Lead:** Chief Nurse	(OGN 4.1) Implement the Maternity Governance Toolkit reflecting the	A range of key indicators for the service reflecting the perinatal quality surveillance model.	Monthly Perinatal Quality Surveillance report to Directorate Quality Governance Group and Trust Board	17/7/22	

Outcome	**Oversight**	**Top 3 high level actions** (Deliverable by 17th July)	**Metrics** (To measure delivery of the actions	**How will you measure delivery of actions** (e.g., audit, spot checks, observation /walkabout0	**Target date** (for delivery of action)	**Completion date** (date action was completed)
We have effective systems to ensure oversight of the management of risk	**Operational Lead:** Midwifery Director **Oversight Committee:** Maternity Improvement Board	Perinatal Quality Surveillance Model.				
		(OGN 4.2) Ensure senior oversight of audit results via the Directorate Quality Governance Group	Audits are completed in a timely manner and robust actions are taken in response to findings	• Review of outcomes from a sample of audits		