NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

**Executive Summary**

**Report to the Board of Directors**

**Being Held on 26 July 2022**

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|---|---|
| **Subject** | CQC Action Plan 2022 – Update Report June 2022 |
| **Supporting TEG Member** | Jennifer Hill, Medical Director (Operations) |
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| **Status**[1] | Discuss |

**PURPOSE OF THE REPORT**

To provide the Board of Directors with an update on progress against the CQC action plan (as at 28 June 2022) following the S29A warning notice and publication of the CQC Inspection Report.

**KEY POINTS**

The Trust CQC Action Plan was approved by the Trust Executive Group on 4 May 2022 and submitted to CQC on 5 May 2022. This report provides an overview of progress against each outcome to the Trust Executive Group, Quality Committee and Board of Directors.

The report details an update for each outcome, which consists of:

- an overview of progress with actions during June.
- a summary of performance against outcome metrics with baseline data and monthly trajectories where available.
- an overview of findings for each outcome. This includes the RAG rated level of assurance from Ward Quality Support Visits, which commenced on 17 May.

Progress has been made against the majority of actions. To provide assurance on the impact of these actions, an analysis of the impact of the actions incorporating data from the Quality Support Visits has been used to RAG rate each of the 17 outcomes. At present 1 is rated Red and 10 Amber from Quality Support Visits (QSV). 14 are rated Amber from action metrics. The remaining outcomes are rated Green. In order to ensure progress:

- Metrics have been further refined by the relevant Operational Leads where possible to monitor each action to ensure that they measure performance against the action and are auditable.
- A CQC Compliance Oversight Group has been established to ensure that there is check and challenge with regard to progress and the addition of new actions as required, to ensure that key actions are communicated throughout the organisation and to ensure that outcome leads receive timely support to overcome barriers. The first meeting took place on the 21 June.
- A weekly meeting has been initiated to share the themes and agree actions arising from the Ward Quality Support Visits with Sisters, Matron, Deputy Nurse Directors and Nurse Directors.
- Progress on the two priority Trust-wide workstreams, Safety Huddles and Ward Boards, are presented in Appendix 1. Progress with Ward Boards is rated as Green and Safety Huddles are rated as Amber. It is clear that it will take time to embed safety huddles consistently, and it has been agreed that the quality improvement work will initially focus on 12 priority, higher risk wards where we believe safety huddles will have greatest impact. The team, with support from organisational development, will support ward teams to establish and embed safety huddles before spreading learning more widely.

**IMPLICATIONS**[2]

| | Aim of the STHFT Corporate Strategy | ✓ 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 progress with the CQC Action Plan and areas of future work proposed. |
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**APPROVAL PROCESS**

| Meeting | Date | Approved Y/N |
|---|---|---|
| Trust Executive Group | 13 Jul 2022 | Y |
| Quality Committee | 18 Jul 2022 | Y |
| Board of Directors | 26 Jul 2022 | |

**Summary Position**

| Outcome | | Metrics RAG | QSV RAG |
|---|---|---|---|
| Outcome 1: Mental Health needs are identified and actioned | Evidence shows a positive position in relation to completion of daily mental health risk assessments on AMU and within the ED and whilst there is no audit data for inpatient areas, audit is now commencing across the 12 priority wards and Neurology and Osborne wards as areas with higher numbers of patients with mental health needs. In the meantime, the quality support visits provide a degree of assurance. However, there have been delays with regard to training. | | |
| Outcome 2: We are assured that our staff are competent in assessing mental capacity and lawfully deprive patients of liberty | Actions are progressing well, with the exception of the introduction of an E-whiteboard icon due to the reliance on an external developer. Both audit data and quality support visits demonstrate assurance with regard to completion of MCA and staff knowledge. | | |
| Outcome 3: We know that we appropriately restrain and tranquillise patients as required | Datix completion for restraint and rapid tranquilisation is becoming part of routine practice and in future will be reflected on a Datix Dashboard. However, there are concerns relating to training. | | N/A |
| Outcome 4: We have embedded evidence-based interventions to reduce falls | Data relating to completion of initial falls risk assessments and feedback from quality support visits is positive, however actions in relation to walking aids are at risk of delay and data on other metrics is not available. | | |
| Outcome 5: We recognise and escalate patient deterioration promptly | Positive assurance received via quality support visits and most metrics are positive, however there remain gaps in relation to safety huddles. | | |
| Outcome 6: We ensure we individualise and meet the needs and preferences of patients | Work is ongoing with 12 priority wards to embed "what matters to you" and whilst there have been delays to the implementation of intentional rounding document, roll out to 12 priority wards is complete, all areas have an identified dignity champion and assurance from quality support visits is positive. | | |
| Outcome 7: We are assured that we manage medicines safely | Quality Support Visits demonstrate that three quarters of wards are compliant with standards for safe storage and metrics, where available, suggest that there is scope for improvement. | | |
| Outcome 8: We are assured that we manage hazardous substances safely in clinical areas | Quality support visits have shown that there is good knowledge of how chemical products should be stored and used, 87% have secure storage and all wards have lockable domestic trolleys. However, the process of undertaking a meaningful COSHH assessment and implementing the actions is not embedded. | | |
| Outcome 9: We are assured that we have adequate nurse staffing levels | Whilst actions are on track or progressing, there is no data available as yet and Quality Support Visits have found significant gaps in assurance. | | |
| Outcome 10: We are assured that staff are trained to do their jobs | Mandatory and Job Specific Essential Training performance improving in line with targets. System in place to agree new and ratify existing subjects, however plans for restraint and learning disability training not yet agreed. | | |
| Outcome 11: We keep patient records up to date, secure, confidential and accurate | All actions are complete or on track, however there is no data available as yet and quality support visits have found significant gaps in assurance. | | |

| Outcome | | Metrics RAG | QSV RAG |
|---|---|---|---|
| Outcome 12: We are assured that our staff adhere to best IPC practice to minimise hospital acquired infection | The transfer of IPC accreditation to QUEST is at risk of delay and compliance with hand hygiene audit is less than 50%. However, feedback from quality support visits is positive. | | |
| Outcome 13: We are assured that incidents are consistently reported and harm accurately assessed | All actions are complete and performance against metrics is positive, however there is limited evidence from Quality Support Visits. | | |
| Outcome 14: We are assured that staff learn from incidents to prevent them happening again | Progress to complete this action is delayed and monitoring the effectiveness is difficult, however the ward quality boards, will provide a consistent approach to the display of learning. | | |
| Outcome 15: We know and take action in response to our immediate performance and risks | Progress has been made in relation to actions. Spot audits need to be undertaken to provide assurance. | | N/A |
| Outcome 16: We have effective systems to ensure adherence to the fit and proper persons requirements and regulation | Work is progressing in line with agreed timeline with all key milestones for actions met to date. Metrics will be measured through audit work by 360 Assurance. | | N/A |
| Outcome 17: We have effective systems to ensure Board oversight of the management of risk | Work is progressing in line with agreed timeline with all key milestones for actions met to date. | | N/A |
| Priority workstream - Safety Huddles | All areas have been visited by the implementation team to discuss safety huddle process and have received the support resources. Work is ongoing to support areas, with a particular focus on the 12 priority wards. | | N/A |
| Priority workstream - Ward Boards | Installation of boards has commenced and a SOP for completion of board content has been developed. | | N/A |

## Outcome 1: Mental Health needs are identified and actioned

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 17/07/2022 | At risk of delay | Spot checks have shown an improvement in the documentation of actions within ED and AMU. Although this work has progressed within ED and AMU there is currently no evidence available for practice across the Trust. The MHRA audit is therefore being rolled out from w/c 4 July across the 12 priority wards and Neurology and Osborne wards, as areas with high numbers of patients with mental health needs.<br><br>Education continuing across the Trust with specific training and communication for ED and AMU. | % of patients referred on to liaison mental health or reason not referred documented | 100% (in ED and AMU during May 2022) | Target: 100%<br>Actual: 100% | Target: 100%<br>Actual: 100% | Target: 100% |
| | | | | % of relevant patients for whom decision-making is documented regarding need for 1-1 care and observation. | 60% (in ED and AMU during May 2022) | Target: 60%<br>Actual: 60% | Target: 65%<br>Actual: 75% | Target: 75% |
| | | | | % fully completed daily mental health risk assessments | 50% (in ED and AMU during May 2022) | Target: 50%<br>Actual: 50% | Target: 60%<br>Actual: 70% | Target: 75% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 1.2 - Introduce training in how to use the daily mental health risk assessment and actions to take. | 17/07/2022 | At risk of delay | Training is on PALMS and dates for face to face teaching have been released. There has been agreement that this will be a JSET.<br><br>Once JSET established compliance will be provided. | % staff completed training | Training not commenced | N/A | N/A | Target: 80% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 17/07/2022 | At risk of delay | Training package is complete and JSET completed. Clinical staff now notified of the requirement to complete the training.<br><br>Ligature risk assessment and plan completed.<br><br>Information on number of ligature incidents will be part of DATIX dashboard to ensure oversight on number of episodes each month. | Reduction in episodes of attempted ligature use | Appropriate improvement targets being identified using historic data | Ligature incidents<br>Actual: 2 (April)<br><br>Self-harm incidents:<br>1 overdose<br>2 self-injury | Ligature incidents<br>Actual: 1 (May)<br><br>Self harm incidents:<br>1 overdose<br>1 self-injury | Target: N/A |

### Quality support visits (as at 1 July 2022)

To date, 6 wards have been assessed against Outcome 1 through Quality Support Visits. Of these, 4 have been graded as 'green' in terms of assurance, 2 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Ward | Grade | Explanation |
|---|---|---|
| Norfolk, Whirlow | | Wards are in the process of implementing Safety Huddles, which need time to embed. |

### Summary of progress against outcome

We have made good progress on improving the completion of daily mental health risk assessment on AMU and in the ED. Staff capacity has limited progress. The training package is available on PALMS and JSET audience is being confirmed. The ligature training package is in development.

**Outcome 2: We are assured that our staff are competent in assessing mental capacity and lawfully deprive patients of liberty**

## Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 10/07/2022 | At risk of delay | PID number available for MC Form, and will be added to Lorenzo by 06.07.2022. The new documentation will be shared with wards during ward visits.<br><br>Medical Records Team progressing procurement for a coloured 'legal' divider<br><br>E-whiteboard icon for DOLS to be installed as part of upgrade on 06.07.2022 | % of relevant patients with clearly documented capacity assessment. | Between 01 April 2022 and 24 May 2022 162 DOLS referrals were made. 76% (123) had a completed Mental Capacity Act Assessments and 24% (39) did not at the point of initial referral. | Target: 76%<br>Actual: 76% | Target: 100%<br>Actual: 100% | Target: 100% |
| | | | | % of patients who lack capacity will be identifiable via the Whiteboard. | Once DOLS icon established on E-Whiteboard, 100% of patients with DOLS in place will have this | N/A | N/A | Target: 100% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 17/07/2022 | On track | All 12 priority wards visited – safety huddles attended. Bespoke training provided.<br><br>By 20.06.22, 40 of 67 wards (59.7%) visited by CQC Inspection team have received support visits by the MC Team. This includes attendance at board rounds, safety huddles and face to face discussion with ward staff re DOLS. The MC Team has scheduled visits for all of the remaining wards by 17.07.2022 | MCA Team will demonstrate evidence of and frequency of support visits to the in- patient areas highlighted by CQC. | Between 01 April 2022 and 24 May 2022, the Mental Capacity Team has provided support to 28 wards across 64 visits. The Mental Capacity Team will continue to visit relevant wards. | N/A | Actual: 59.7% | Target: 100% |
| | | | | % of patients who lack capacity to consent to care and treatment will have documented timely and decision specific capacity assessments. | Data available June 2022 | N/A | Target: 100%<br>Actual: 100%<br>100% of DOLS referrals sent to the relevant Local Authority had MCA recorded | Target: 100% |

## Quality support visits (as at 1 July 2022)

To date, 6 wards have been assessed against Outcome 2 through Quality Support Visits. Of these, 6 have been graded as 'green' in terms of assurance, 0 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

## Summary of progress against outcome

| Progress against actions is progressing well. Quality Support Visits demonstrate assurance with staff being reported as being very knowledgeable regarding MCA/ safeguarding/ DOLs matters. |
|---|

**Outcome 3: We know that we appropriately restrain and tranquillise patients as required**

## Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 17/06/2022 | Complete | Datix has been changed and Trust wide communication shared on 6th June regarding changes.<br><br>Now apparent that significant number of lorazepam prescriptions previously thought to be rapid tranquilisation are not eg. treatment for agitation in patients emerging from anaesthetic and reviewing EPMA data may not be helpful<br><br>Governance teams have provided guidance on how to review incidents and the Associate Medical Director for Mental Health, Learning Difficulties and Autism has attended medical governance leads meetings to reinforce the message about restraint and tranquilisation. | Number of Datix and associated investigations completed | N/A | N/A | Actual: 8 | N/A |
| | | | | Themes and areas identified for increased training through review of data | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 3.2 - Restraint reduction network approved training completed by security staff and key staff in acute areas with highest rates of restrictive practice. | 17/07/2022 | On track for security staff trainers | The Security staff doing train the trainers will have completed, the Security staff themselves will then be scheduled to do the training programme likely to be through to September minimum. | % of relevant staff who have completed training | Training commenced, final session taking place 5, 6, and 7 July | N/A | N/A | Target: 100% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 17/07/2022 | At risk of delay | Datix dashboard is being built by the Trust Risk and Governance Support Officer and will receive its first data at the end of June 2022. By Friday 17/6 there were 8 Datix regarding restraint/ rapid tranquilisation.<br><br>Governance leads aware of need to understand how often restraint/ rapid tranquilisation occurs in their areas. | Data from Datix and learning from these to be collated and routinely discussed each month | N/A | N/A | N/A | N/A |

## Summary of progress against outcome

Datix completion for restraint and rapid tranquilisation is becoming part of routine practice. Guidance for governance teams has been circulated.
The Datix dashboard for restraint and rapid tranquilisation is in progress.
Concern over training – security will have completed trainer training, which will then be rolled out to other security staff, but a plan for how Restraint Reduction Network approved training can be rolled out to acute areas needs to be agreed.

**Outcome 4: We have embedded evidence-based interventions to reduce falls**

**Progress against actions**

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 4.1 - Review and improve the falls risk assessment documents used within ED and inpatient areas, and then increase compliance of its completion. | 17/07/2022 | On track | Risk assessment has been reviewed, and form which is much more user friendly created which will support compliance and appropriateness of patient assessment for both ED and wards<br>Audit is based on data for the 9 wards with the highest number of falls (18.5.22 – 17.6.22) 527 admissions in total, 459 have falls RA in place – 87%. No data available to confirm if updated weekly. | % completion of weekly risk assessment reviews | No data available | N/A | Target: 65%<br>Actual: 87% | Target: 80% |
| | | | | % completion of falls risk assessment in ED | No data available | N/A | Target: 65%<br>Actual: No data available as yet | Target: 80% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 17/07/2022 | At risk of delay | Good engagement between ATS, SAC and NFU although it has taken time to identify the training needed and the staff groups | % of relevant patients with walking aid available on assessment units | No data available | N/A | Target: 50%<br>Actual: no data as yet | Target: 65% |
| | | | | % of staff trained on supplying and fitting walking aids | No data available | N/A | Target: 45%<br>Actual: no data as yet | Target: 60% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 4.3 - Ensure patients at risk of falls have lying and standing blood pressure documented. | 17/07/2022 | On track | Audit of lying and standing BP being focussed on the 9 wards with the most falls in the last 12 months along with a screen cast education tool.<br>Weeks of data collected – 40 patients audited in week 1, 83 in week 2. Audit is ongoing weekly in these focused areas. | % of patients who have lying and standing blood pressure monitored | No data available | N/A | Target: 50%<br>Actual: 58% | Target: 65% |

**Quality support visits (as at 1 July 2022)**

To date, 10 wards have been assessed against Outcome 4 through Quality Support Visits. Of these, 9 have been graded as 'green' in terms of assurance, 0 amber, and 1 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Ward | Grading | Explanation |
|---|---|---|
| CIU (P1) | (red) | No huddles in place on this ward, it was recommended that careful consideration should be given to how they could implement them.<br>No falls observed, however, staff that were asked did not know about the falls pack. |

**Summary of progress against outcome**

Good progress is being made to improve care and assessment of patients at risk of falling, although taking longer than anticipated.
The following has been shared
Wards F1, F2, P2, G2, Q1, Q2 visited last week (w/c 21 June).

Outcome 4 (Falls) - Good overall. No specific issues highlighted.

**Outcome 5: We recognise and escalate patient deterioration promptly**

**Progress against actions**

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 5.1 - Introduce a deteriorating patient bleep holder on all inpatient wards to ensure a first point of escalation is identified. | 31/05/2022 | Delayed – revised date 30 June 2022 | Information services to produce fortnightly report to monitor number of wards compliance, no directorates have escalated concerns regarding process of displaying bleep number on the eWhiteborad. Data from 29/06/2022 30 wards displaying bleep holder information | % of wards with deteriorating patient bleep number visible | 1 ward had deteriorating patient bleep number visible | Target: 1.4% | Target: 60 wards Actual: 30 Wards | Target: 60 wards |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 5.2 - Include deteriorating patient check and challenge in safety huddles. | 31/05/2022 | Complete | Safety huddles in process of being embedded across all in patient areas, assisted by nightingale project team aiding implantation and evaluation.<br>All safety huddles to include deteriorating patient- standardised approach across all inpatient areas via crib sheet<br>Quality assurance and QUEST visits monitoring compliance across inpatient areas- feedback given directly to NDs<br>CEU audits to determine appropriate escalation and response times | Evidence of early identification and escalation of deteriorating patient | No data available | N/A | Target: all inpatient wards Actual: 27 | Target: all inpatient wards |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 30/06/2022 | On track | Pilot effective in identifying change in process required, digital team refining escalation and response documentation<br>Further resource required to assist extension of roll out, phased plan to roll out across other wards in place, | % of relevant patients with documented evidence of early identification and escalation. | Trial on 2 wards in May 2022 | N/A | N/A | N/A |

**Quality support visits (as at 1 July 2022)**

To date, 40 wards have been assessed against Outcome 5 through Quality Support Visits. Of these, 36 have been graded as 'green' in terms of assurance, 4 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Ward | Grading | Explanation |
|---|---|---|
| Firth 7, Huntsman 5, Palliative Care Unit, CIU (P1) | | In general, observations were consistently recorded on the whiteboard. However, one patient who had been admitted and a problem of postural hypotension identified had not had their lying and standing BP recorded (Firth 7)<br>Safety huddle does not currently include deteriorating patients/NEWS 2 triggering patients. The current structure safety huddle is currently only once daily (Huntsman 5)<br>Huddles not yet established (Palliative Care Unit) |

**Summary of progress against outcome**

We have seen from the Weekly / fortnightly Deteriorating patient bleep data from May 17 the numbers have increased from 1 to 12 to 29 to 30 wards this week, we will continue to monitor (noting that the number of inpatient wards may change as wards open and close due to activity and demand) via information services..
From this week, the quality assurance visits will focus on the 12 priority wards, covering all outcomes to establish a baseline across the board and feedback to relevant ND.

| Of the 6 wards visited WC 20 June one ward was identified as not undertaking a safety huddle. There is ongoing support from the safety huddle working group to prepare and support wards with introducing safety huddles.<br>The eWhiteboard trial continues as planned with a plan to extend to the 6 wards with higher number of deteriorating patients once the digital team have addressed the issues identified during the trial (eg. Of 300 escalations only 22 required Dr/ACP review). |
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## Outcome 6: We ensure we individualise and meet the needs and preferences of patients

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 6.1 - Embed the use of "What Matters to you" and the individualisation of nurse care planning in the top 12 priority wards | 17/07/2022 | On track | Working with information services and Digital team on reporting, which is not yet fit for purpose. Limited evidence provided of individualisation of care plans.<br>Digital team has commenced working with the top 12 wards to embed the What matters to you completion at ward level. | % completion of "What matters to you" in the Electronic patient record | Awaiting audit data | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 6.2 - Implement the role of dignity champion across the Trust with the first priority focus "privacy and dignity". | 01/06/2022 | Complete | Introductory session held on 9th June with over 70 champions in attendance. All inpatient areas have provided a name for a champion there are >120 identified champions<br>Role and responsibilities outlined and further session with champions planned early July | Dignity champions in place throughout the inpatient wards (in the first instance)<br><br>100% inpatient wards have an identified champion | N/A | N/A | 100% | 100% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 6.3 - Implement the new standardised intentional rounding document across the Trust. | 01/06/2022 | Delayed – revised date 18 July 2022 | Live wards are:<br>W/C 23/5 – I1, Q1, Firth 2<br>W/C 20 June – Brearley 4, 5, and 7<br>W/C 27 June – Hunstman 6, 7 and Frailty Unit, plus re-visit to Firth 2<br><br>Forward plan for July:<br>W/C 4 July – AMU and SAC<br>W/C 11 July – Brearley 6, G2, plus re-visit to Q1/I1 | % completion of intentional rounding document | Awaiting audit data | N/A | Roll out to 12 priority wards completed | N/A |

### Quality support visits (as at 1 July 2022)

To date, 39 wards have been assessed against Outcome 6 through Quality Support Visits. Of these, 35 have been graded as 'green' in terms of assurance, 4 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Wards | Grading | Explanation |
|---|---|---|
| Accident and Emergency, Chesterman 3, Huntsman 5, I1 | | Call buttons observed to be out of reach for some patients (A&E and Chesterman 3)<br>Staff were not aware of the 'what matters to you' section of the care plan in Lorenzo (Huntsman 5 and I1) |

### Summary of progress against outcome

Work progressing. Implementation delayed for action 6.3 due to "infrastructure" issues, e.g. smart card access for relevant staff members/hardware requirements for electronic input. Focus shifted to top 12 wards, and an implementation date will be given to the wider organisation with a list of requirements that need to be in place for that date. Date for full organisational "switch on" is 18 July 2022.

## Outcome 7: We are assured that we manage medicines safely

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 7.1 - Ensure Safe Storage of medicines and medical gases<br>• Improve compliance with Medicines Management Checklist (MMC) including gases, controlled drugs, crash trolley & associated kits expiry dates. | 30/06/2022 | Delayed – revised date 15 Jul 2022 | Connexica given assurance that compliance reports will be available from QUEST by mid-July. All clinical areas with gases checked; 77% have appropriate signage, and signage ordered for non-compliant areas. Report of emergency kit expiries to be reviewed monthly on track from 30/06/22. Inspection of controlled drug security completed on 12 designated wards. Actions being followed up and re-audit planned in 2 weeks. | • % of areas completing Medicines Management Checklist (MMC)<br>• % of areas showing 95% or over– compliance | Aug-Nov 2021 Manual audit (72% areas completing MMC, 86% of those reached 95% target). | Target: 95%<br>Actual: N/A | Target: 95%<br>Actual: not available | Target: 95% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 7.2 - Medicines Reconciliation<br>• 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. | 01/06/2022 | Complete | Executive agreement obtained to remove day cases and patients admitted for less than 24 hours from denominator to bring in line with methodology used by regional/national peers. Review of improvement strategies for outlying wards on track. Risk register updated. | % medicines reconciliation rates (< and > 24 hours) | Overall Med Rec Rate 65%<br>Med Rec <24hrs = 37%<br>Med Rec > 24hrs = 28%<br><br>Data from May 2021 – April 2022 (12months) | N/A | Target: no longer defined nationally<br><br>Actual:<br>Overall = 76%<br><24hrs = 39%<br>> 24hrs = 37%<br><br>Data from May 2022 | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 7.3 - Medicines Administration<br>• Eliminate all gaps in recording administration/ reason for omission on EPMA.<br>• Collate and review current missed doses data relating to 'drug not available' (DNA)<br>• Review stock holding (range and quantity) of medicines and adjust ward top-up lists accordingly for areas with high DNA rates and/or high stock requests<br>• Further develop the Safety and Risk Dashboard to include details of missed doses related to critical medicines. | 17/07/2022 | On track | Missed critical medication (retrospective) report available in Safety, Risk and Quality Dashboard. Live report of missed doses requested from Dedalus/Information Services. Report of stock supplied outside core top-ups on track to be available by 30/06/22 and review of stock lists will follow. | % of "not recorded" doses | From Quest Apr-Jun 2020 = 3%<br>Jun 2020 – May 2022 = 2% | N/A | Target: 0%<br>Actual: 2% | N/A |
| | | | | % missed doses due to DNA by ward | 9.66% (Jan 2022) | Actual: 9.47% (April 2022) | Actual: 9.16% (May 2022) | N/A |
| | | | | % missed critical medicines doses | 14% (Jan 2022) | N/A | Actual: 11% (May 2022) | N/A |
| | | | | Proportion of supplies provided as stock outside of core top-up dates | Pending JAC data report build | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 7.4 Medication incidents<br>• Identify the most common causes and trends<br>• Produce a single action plan to address these with oversight from MSC | 03/08/2022 | On track | MSC reviewed quarterly reports. In line with other Trusts, medication incidents are the 2nd or 3rd most common type of incident reported. Over 99% of medication incidents are graded no / minor harm. Only 2 drug related Never events since 01/04/19 and none since 08/04/2020. A high level of reporting and low level of severity is considered an indicator of safety. 60% of incidents involve high risk drugs (anticoagulants, antimicrobials, diabetic medications and analgesics) due to a lower threshold for reporting incidents for high risk drugs. Action plans in place for these drug groups with relevant committees/teams/working parties, but plans to collate into a single plan with oversight from MSC. | % of medication incidents graded moderate of above | N/A | N/A | Target: < 1%<br>Actual: 0.5%<br><br>(Jan – March 2022 data finally approved and quality checked) | N/A |

**Quality support visits (as at 1 July 2022)**

To date, 40 wards have been assessed against Outcome 7 through Quality Support Visits. Of these, 31 have been graded as 'green' in terms of assurance, 5 amber, and 4 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| | | |
|---|---|---|
| Brearley 7, Huntsman 5, Osborne 4, Robert Hadfield 1, SAC/Huntsman 8 | | Drugs cupboards left unlocked and intravenous drugs being part reconstructed and left unattended<br>Delays noted in the checking of crash trolley and medicines fridge |
| Brearley 1, Brearley 4, Chesterman 3, Robert Hadfield 1 | | Drugs fridge and resuscitation trolley not checked consistently on a daily basis and embedded into the ward routine.<br>Controlled Drugs keys were observed in a cupboard that could be accessed within the main drugs room.<br>Drugs room/s could be accessed from the treatment room which does not have swipe access.<br>No swipe access for the room with IV fluids, planned and awaited for 10 months. Estates are aware. |

**Summary of progress against outcome**

Quality Support Visits demonstrate that 77% wards are compliant with standards for safe storage. Pharmacy staff continue to encourage good practice and will benefit from Nurse Directors support. Availability of compliance reports on QUEST is delayed. The medicine reconciliation action is complete and improvement strategies are being implemented but will be limited by pharmacy staff resource. Work on missed doses is showing slight improvement. Medicines Safety Committee reviews incidents reporting which suggests a healthy reporting culture with a low level of harm.

## Outcome 8: We are assured that we manage hazardous substances safely in clinical areas

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 8.1 - Ensure domestic staff use and store cleaning chemicals safely. | 09/05/2022 Revised date: 10/06/2022 | Complete | All clinical inpatient areas now have lockable trolleys with staff receiving training in their use and the importance of storing chemicals safely. Good practice has been observed in most ward areas during visits. | % of areas where cleaning chemicals stored appropriately. | N/A | N/A | All clinical inpatient areas now have lockable trolleys. | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 8.2 - Provide safe system of working in relation to frequently used chemical cleaning products within the inpatient area. | 17/07/2022 | Complete | All tier 1 wards have been visited and safe storage of chemicals discussed. All wards reported having received training in the preparation and use of Tristel Cleaning products. Staff report being aware of the need to use and store chemicals safely. The guidance document for safe storage of chemicals has been updated. Updated COSHH template has been circulated for staff to use when COSHH risk assessments are due for review. Training records available. | % of areas where cleaning chemicals are used appropriately | N/A | N/A | All 60 wards reported that some staff have had training in preparation and use of Tristel cleaning solution. | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 8.3 - Provide safe storage solutions for chemical products in the clinical areas. | 17/07/2022 | On track | Of the 59 Tier 1 wards visited 8 had no means of securing chemicals by a locked room or cabinet. Discussions ongoing to clarify if there are any ‘shared’ secure spaces or if a COSHH cabinet is required. | % of wards as identified as high risk which have electronic access to chemical storage rooms. | N/A | N/A | 29 of the 59 wards had rooms that were securely locked (either sluice or domestic store) | N/A |
| | | | | % of wards without secure door access to chemical cleaning products have a lockable COSHH cupboard for storing concentrated cleaning solution | N/A | N/A | 23 of the 59 wards had COSHH cupboards. Total secure storage = 52/59 = 88%<br><br>Target is 100% | N/A |

### Quality support visits (as at 1 July 2022)

To date, 59 wards have been assessed against Outcome 8 through Quality Support Visits. Of these, 14 have been graded as ‘green’ in terms of assurance, 40 amber, and 4 red. The wards graded as amber or red are detailed below:

| | | |
|---|---|---|
| Accident and Emergency, Brearley 3, CCU, CF Unit, Chesterman 1, Chesterman 2, Chesterman 4, F1, F2, Firth 4, Firth 5, Firth 6, Firth 7, Frailty Unit, G1, I1, Labour Ward, Norfolk Ward, Rivelin, Whirlow, L1, L2, N1, O1, Osborne 1, Osborne 4, P3, P4, Robert Hadfield 5, Sac / Huntsman 8, Vickers 2, Firth 8, Firth 9, Huntsman 2, Huntsman 4, Huntsman 5, Huntsman 6, Huntsman 7, Robert Hadfield 2, Robert Hadfield 3 | | COSHH risk assessments past review date.<br>Ward requires a COSHH cupboard.<br>Cleaning products not able to be stored correctly.<br>Chemicals stored in a room that cannot be locked currently.<br>Some changes to trollies still to be made but most Tristel stored in locked room. |
| Brearley 1, Brearley 4, Chesterman 3, Robert Hadfield 1, Robert Hadfield 6 | | No COSHH cupboard available, some chemicals stored in sluice which can't be secured. No COSHH risk assessments available or are out of date. Old style domestic trolly still in use. |

**Summary of progress against outcome**

Quality support visits have shown that there is good knowledge of how chemical products should be stored. Several wards have been proactive and installed ACT or keypad access on their sluices and domestic stores, and many are using COSHH cupboards.
The process of undertaking a meaningful COSHH assessment and implementing the actions is not embedded. Ward managers and matrons are being provided with an updated COSHH template and a partially completed example to improve practice.

## Outcome 9: We are assured that we have adequate nurse staffing levels

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 9.1 - Implement a twice (7 days a week) daily staffing meeting Trust wide incorporating a skill mix review for any staff movements. | 01/06/2022 | Complete | Twice Daily staffing meetings embedded<br>Risk assessment guidance for staff movement provided for bleep holders and Matrons, Duty Matron logs reviewed and evidencing consideration of Acuity/dependency in staff movement | Meeting minutes with actions evident | Twice daily staffing meetings commenced 9th May 2022.<br>Central Nursing keeping weekly risk assessment log | Twice daily meeting commenced | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 9.2 - Implement centralised prospective monthly roster review for inpatient areas – aligned to roster approval and publication dates. | 07/07/2022 | On track | Organisational refresh of rostering practices almost complete, and ACN meeting with all Senior nursing teams<br>Roster KPI review undertaken to align with national E-rostering Levels of attainment guidance<br>Prospective roster reviews piloted in maternity commenced in early June 2022. Process agreed with E-rostering team, and go-live across Trust planned for September 2022 | Staff on shift (assignment count) equally distributed across shift and day of the week in published rotas | >90% RN CHPPD (each site) | N/A | Commence monthly meetings with e-roster lead | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 9.3 - Review and Refresh the planned/actual nurse staffing information boards and standardise completion across all clinical areas. | 30/06/2022 | Delayed – revised date 5 July 2022 | Boards for areas that did not have them have been delivered<br>Completion SOP to be developed and shared with all ward leaders by July 1st 2022<br>Spot check audits on board completion across sites planned for July | Boards in place and completed on a shift/shift basis | >90% RN CHPPD (each site) | N/A | Review ward compliance | N/A |

### Quality support visits (as at 1 July 2022)

To date, 40 wards have been assessed against Outcome 9 through Quality Support Visits. Of these, 19 have been graded as 'green' in terms of assurance, 11 amber, and 10 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Wards | Grade | Explanation |
|---|---|---|
| Accident and Emergency, Brearley 7, CF Unit, Chesterman 3, Frailty Unit, Huntsman 5, Huntsman 6, Huntsman 7, G2, Rivelin, Q2 | (amber) | Staff board in display, but not updated on day of visit. |
| Brearley 1, Brearley 1, Brearley 2, Brearley 4, Brearley 5, Brearley 6, Firth 5, Robert Hadfield 1, Robert Hadfield 2, Robert Hadfield 5 | (red) | Currently no staffing board on display and this does not appear to be part of the ward culture. |

### Summary of progress against outcome

Work is progressing to achieve outcome. There has been a slight delay with the review and refresh of the nursing staffing information boards but this is now nearing completion.

## Outcome 10: We are assured that staff are trained to do their jobs

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 10.1 - Complete a review of the current JSET provision to ratify core subjects to include:<br>• MCA Level 2a, MCA Level 2b (DOLS), Oxygen Cylinder Training, NEWS 2, Safer use of Insulin, React to Red<br>Develop a plan to agree directorate (local) and additional JSET requirements including:<br>• Physical Restraint, Falls, Dementia, Learning Disabilities | 17/06/2022 | Delayed – revised date 31 August 2022 | JSET Review Panel established. Additional JSETs launched are:<br>• Deteriorating Patient<br>• Patient Safety<br>• Blood Transfusion<br>Existing 13 JSET subjects ratified at panel meeting on 6/6/22<br>Project plan in place for agreeing local JSET.<br>Physical Restraint Training (Level 3 in violence & Aggression training plan) being led by the Associate Medical Director for Mental Health, Learning Difficulties and Autism.<br>Falls training has been incorporated into Moving and Handling training.<br>Dementia training plan developed and launched. JSET proposal going to panel 20/7.<br>Plans still to be finalised for Learning Disabilities training | • Progress against plan for ratifying core JSET subjects with sign off process complete.<br>• Progress against plan to identify local (directorate) JSET. | No JSET reviews signed off at 17/5/22<br>Project plan developed 24/5/22 | N/A | Target: 100%<br>Actual: 100% | Target: 100% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 10.2 - Monitor compliance rates across mandatory training and JSET performance by subject, directorate and staff group with a focus on non-compliant subjects:<br>• Moving & Handling, Safeguarding Children, Safeguarding Adults, Prevent | 10/06/2022 | On track | Prevent training incorporated into Safeguarding Adults training. Mandatory and JSET performance being sent to all Care Groups every two weeks supplementing MBB reports. | Performance data by:<br>• Subject<br>• Directorate<br>• Staff group | Mandatory Training: 91% | Target: 90%<br>Actual: 91% | Target: 90%<br>Actual: 92% | Target: 90% |
| | | | | | JSET: 88% | Target: 88%<br>Actual: 88% | Target: 89%<br>Actual: 89% | Target: 90% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 10.3 - Evaluate the current corporate and local induction to ensure new starters complete mandatory and JSET appropriate for their role. | 10/06/2022 | Complete | Core curriculum agreed for all induction programmes. All new starters have a training profile which includes all required mandatory and JSET necessary for their role.<br>Mandatory and JSET compliance for new starters included in monitoring reports. | New starters compliant with mandatory training and JSET. | Mandatory Training: 91% | Target: 90%<br>Actual: 91% | Target: 90%<br>Actual: 92% | Target: 90% |
| | | | | | JSET: 88% | Target: 88%<br>Actual: 88% | Target: 89%<br>Actual: 89% | Target: 90% |

### Quality support visits (as at 1 July 2022)

To date, 40 wards have been assessed against Outcome 10 through Quality Support Visits. Of these, 33 have been graded as 'green' in terms of assurance, 5 amber, and 2 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Ward | Grade | Explanation |
|---|---|---|
| Brearley 1, Brearley 2, Brearley 3, Brearley 6, Firth 5 | | Not enough computers or designated space for training purposes. |
| Huntsman 5, Huntsman 6 | | A number of staff reported not being up to date with all mandatory training topics. There is currently no allocation of time designated for staff to complete their mandatory training. No promotional material for staff observed on the ward. |

### Summary of progress against outcome

Mandatory and Job Specific Essential Training performance improving. System in place to agree new and ratify existing subjects. Work underway to identify and agree local JSET subjects.

### Outcome 11: We keep patient records up to date, secure, confidential and accurate

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 11.1 - Develop Health Records Policy that includes 'definition of Trust Health Record'. | 31/05/2022 | Complete | Policy approved by Health Records Committee | Approved policy | N/A | Policy scheduled for approval at HRC meeting on 30 May 22 | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 11.2 - Commence role-based education and training for staff to reflect policy standards. | 17/07/2022 | On track | Initial material approved and working on routes for dissemination.<br>List of staff identified by role for training | Target staff groups by role | N/A | Training Needs analysis commenced | Developed the training | Trained 20% of clinical Staff |
| | | | | Training packages in place for each staff group<br>- As work progresses we can monitor PALMs training | N/A | Training Needs analysis commenced | Plan for training | Develop training for Admin & Clerical staff |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 11.3 - Audit effectiveness of training. | 17/07/2022 | On track | A range of material being developed to support audit. | Assess record keeping quality by role | N/A | Review the records audit outcome at Healthcare Records Meeting | Refined the audit methodology | Cross sample of audits from ED and Wards on record keeping standards |

### Quality support visits (as at 1 July 2022)

To date, 40 wards have been assessed against Outcome 11 through Quality Support Visits. Of these, 15 have been graded as 'green' in terms of assurance, 13 amber, and 12 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Wards | Grading | Explanation |
|---|---|---|
| Brearley 6, CF Unit, Chesterman 1, CIU (P1), F1, Firth 4, Firth 7, Firth 8, Frailty Unit, G2, Osborne 4, Q1, Q2 | Amber | Loose sheets slotted into patient records<br>Notes kept in a side room without a door |
| Brearley 1, Chesterman 3, Chesterman 4, Huntsman 5, Huntsman 6, Huntsman 7 | Red | No lockable notes trollies available or designated lockable room for patient records to be stored.<br>Laptops left unattended whilst logged in<br>The current patient record is stored in ring binders separately to the Trusts standard buff notes folder. |

### Summary of progress against outcome

Initial focus on training and audit material to support safe and secure records, and is progressing well.
Once in place work will be undertaken on documentation in the record.

The quality visits feedback will be used to refine the training and education material with regards to filing in the notes.

## Outcome 12: We are assured that our staff adhere to best IPC practice to minimise hospital acquired infection

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 12.1 - Transfer the IPC Accreditation Programme on to the Quest platform – aim to provide transparency of data and ease of monitoring of compliance. | At least one audit being on Quest 17/07/2022 | At risk of delay | One module (Cleaning and Decontamination) of the Accreditation Programme has been updated and has been sent to Quest Team to progress uploading to Quest.<br>Report of % of wards on schedule for submitting commode audits is being developed | % of wards on schedule for submitting commode audits | Report being developed | N/A | N/A | N/A |
| | | | | % of wards who are on schedule with submitting their Hand Hygiene audit | N/A | N/A | Target: 100%<br>Actual: 47% | Target: 100% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 12.2 - Evaluate the scoring systems for all IPC Accreditation audits and implement a quantitative and transparent approach to scoring. | 01/07/2022 | On track | Hand Hygiene audit reviewed and updated and changes notified to users. | Review the Accreditation audit templates and update these with appropriate metrics (PH) | N/A | N/A | Completed for Hand Hygiene audit | N/A |
| | | | | Update templates uploaded onto the Accreditation database and advertised to users (PH) | N/A | N/A | Templates uploaded onto the Accreditation database and advertised to users | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 01/07/2022 | On track | Lead Nurse for Quality and Practice Development has developed a schedule for peer review and all areas should have completed at least one peer review audit by July 17th | Review the Accreditation audit list and determine which audits should be part of the peer review programme (PH) | N/A | N/A | Accreditation audits review complete | N/A |
| | | | | CN office to develop a programme of matron peer review audits (LB) | N/A | N/A | Programme of Matron Peer Review audits developed | N/A |
| | | | | Programme taken to NDs for implementation (LB & KJ) | N/A | N/A | Programme taken to NDs | N/A |
| | | | | Peer reviews being undertaken as per the programme developed by CN's office | N/A | N/A | All areas to have one peer review before 17 July | N/A |
| | | | | System developed for identifying which submitted IPC Accreditation audits were undertaken by peer review (PH) | N/A | N/A | System developed | N/A |

### Quality support visits (as at 1 July 2022)

To date, 10 wards have been assessed against Outcome 12 through Quality Support Visits. Of these, 8 have been graded as 'green' in terms of assurance, 1 amber, and 1 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Ward | Grading | Explanation |
|---|---|---|
| SAC | | A number of staff were seen wearing masks under/on chin. One doctor seen wearing a wrist watch |
| Frailty Unit | | A number of staff were seen wearing masks under/on chin. Two pharmacists seen wearing wrist watches.<br>1 side room had a makeshift sign advising gloves & aprons, other 2 side rooms did not have any signage. |

**Summary of progress against outcome**

| 12.1 - Transfer IPC Accreditation Scheme onto Quest: Capacity within the IPC and Quest teams has meant that one audit has been prioritised to be a pilot for transferring the scheme onto Quest. The Cleaning and Decontamination module has been updated and progress from the Quest team is awaited.<br>Proposed matrices:<br>Metric 1 – IPC audit to be replaced by commode audits and report being developed by IPC team analyst<br>Metric 2 – Information provided - IPC Team following up areas with poor compliance<br>Matrices 3 to 5 – removed as already part of another piece of assurance work<br>12.2 - Progress against updating the Accreditation audits: Capacity has only allowed for one of the Accreditation audits to be updated and uploaded to date. The Hand Hygiene audit has been prioritised and is now available for use. Later in the year other audits will be reviewed.<br>12.3 Introducing peer review audit to the IPC Accreditation scheme: A rota has been developed by CN office, and the Accreditation database has been updated to allow those undertaking the audits to log that it is a peer review audit. Lead Nurse for Quality and Practice Development has asked all areas to undertake at least one peer reviewed audit by Jul 17th. |
|---|

**Outcome 13: We are assured that incidents are consistently reported and harm accurately assessed**

**Progress against actions**

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 13.1 - Introduce new and simplified harm grading descriptors and revised guidance to support this. | 23/05/2022 Revised date: 01/06/2022 | Complete | Harm grade descriptors have been 'simplified' and are 'live' and in use on Datix and the associated guidance launched. | % of audited incidents with accurate harm grading. | N/A | N/A | Audit completed | TBC |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 13.2 - Implement a revised process to reduce time between incidents being logged on Datix and reported to NRLS. | 01/06/2022 | Complete | Revised process in place and incidents now uploaded to NRLS 'earlier' in the review process. Early evidence suggests that time between incident being reported and uploaded to NRLS has reduced from average of 23 days in week commencing 04/05/2022 to an average of 10 days week commencing 22/06/2022 | % of incidents reported to NRLS within the target timeframe. | N/A | N/A | Target: <21 Actual: 10 days | Target: < June |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 13.3 - Monitor incident reporting rates (per 1000 bed nights for inpatient areas) by directorate including the subject categories of incidents reported. | 03/05/2022 | Complete | Work to review inpatient areas' incident reporting rates per 1000 bed nights was completed on 03 May and data was published on the Safety, Risk and Quality Dashboard on 20 June. | Incident reporting rates | N/A | N/A | Target: >13.8 Actual: 14.4 | Target >June |

**Quality support visits (as at 1 July 2022)**

To date, 3 wards have been assessed against Outcome 13 through Quality Support Visits. Of these, 1 have been graded as 'green' in terms of assurance, 2 amber, and 0 red. There are plans to undertake Quality Support Visits to assess this outcome on the 12 priority wards in the coming weeks. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| Ward | Grading | Explanation |
|---|---|---|
| Brearley 7, Firth 3 | | Incident identified to be recorded in the patient record, but this was not recorded on Datix. This has been escalated to the governance team.<br>In addition, on Brearley 7, clerical staff spoken to on the ward had never reported an incident, was not aware they could and described incidents of mis-filing that could have been reported. |

**Summary of progress against outcome**

All of the required actions have been completed, and monitoring of the effectiveness of these actions continues. This will continue to be monitored using audit data form the ongoing severity grading audits, data from NRLS uploads and by data from quality assurance visits.

**Outcome 14: We are assured that staff learn from incidents to prevent them happening again**

**Progress against actions**

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 14.1 - Provide current accessible information via the intranet for sharing of learning from incidents, including never events. | 01/06/2022 | Delayed – revised date 08 July 2022 | The getting back on track intranet page went live on 28/06/2022. Information relating to shared learning from incidents will be made available by 08/07/2022. | % of staff who are aware of learning from recent incidents | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 14.2 - Pilot five-minute briefings in clinical areas to share learning. | 06/05/2022 | Complete | Agreement reached at Safety and Risk Committee 23 May that information in relation to learning from recent incidents should be 'scripted' and provided for safety huddles and ward quality boards.<br><br>Consideration is being given to the development of a newsletter, however resource to achieve this would be required. | Briefings delivered to clinical areas. | N/A | N/A | N/A | N/A |

**Quality support visits (as at 1 July 2022)**

To date, 3 wards have been assessed against Outcome 14 through Quality Support Visits. Of these, 1 have been graded as 'green' in terms of assurance, 2 amber, and 0 red. There are plans to undertake Quality Support Visits to assess this outcome on the 12 priority wards in the coming weeks. The wards graded as amber or red are detailed below, along with an explanation of the grading:

| | | |
|---|---|---|
| Brearley 7, Firth 3 | | Incident identified for recording in the patient record, but this was not recorded on Datix. This has been escalated to the governance team.<br>On Brearley 7, clerical staff had never reported an incident, were not aware they could and described incidents of misfiling that could have been reported. |

**Summary of progress against outcome**

Monitoring effectiveness of this action is difficult but will be helped to by the introduction of ward quality boards which are currently being installed, and information displayed. Additional assurance will be sought by the ward quality assurance visits, however the limitations of assurance obtained by this route should be noted.

**Outcome 15: We know and take action in response to our immediate performance and risks**

## Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 15.1 - Escalation process from Jessops Wing services, through Clinical Ops, to First and TEG on-call agreed. | 01/06/2022 | Complete | Training Session has taken place with Jessops Matrons. Audit undertaken w/e 19/06/2022 of sitreps to ensure MAT level completed and escalation process being followed. This will be repeated in July to ensure new process is being embedded. | % compliance with twice daily information flow from directorate to Clinical Ops | No evidence of regular escalation prior to April 2022 | Target: 50%<br>Actual: 50% | Target: 75%<br>Actual: 80.6% | Target: 100% |
| | | | | Review of on-call escalations from Jessops Matron to Clinical Ops/FOC | No formal record in place | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 15.2 - Directorate Operational Leads flag immediate operational risks to Virtual Operational Support Room/Clinical Ops Lead and/or daily huddle. | 01/07/2022 | On track | Process of escalation to VOSR embedded. Standard template used to handover risks raised and mitigating actions to on call colleagues daily. | Clear record of risks identified and mitigating actions described | Issues and mitigating actions recorded FOC handover on a daily basis | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 15.3 - Triangulation of risks raised at monthly Performance Management meetings with directorate risk registers and organisational performance. | 01/07/2022 | On Track | PMF meetings are held monthly. Risks raised at Level 3 PMF meetings are being clearly identified in meeting notes. Plan to confirm that all risks raised in level 3 PMF meetings in June are recorded on relevant Directorate risk registers in early July. | Corroboration of risks discussed at PMF with risk registers with incidents reported | Risks raised in Level 3 PMF meetings recorded in meeting notes | N/A | N/A | N/A |

## Summary of progress against outcome

Progress has been made in relation to all three actions. Spot audits need to be undertaken to ensure processes are embedded and that records accurately capture risks and any mitigating actions that are being undertaken

## Outcome 16: We have effective systems to ensure adherence to the fit and proper persons requirements and regulation

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 16.1 - To update and implement a revised Fit and Proper Persons Policy additions include:<br>• Three yearly DBS checks for the Board of Directors and Council of Governors,<br>• Annual cross reference against the disqualified directors and insolvency list.<br>• 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).<br>• Annual review of professional registration status for relevant Board members. | 31/05/2022 | Complete | Completed: Approved policy implemented | Implementation of updated approved policy (April 2022) | N/A | N/A | N/A | N/A |
| | | | | % of records which include three yearly DBS checks in place for all relevant individuals (May 2022) | N/A | N/A | N/A | N/A |
| | | | | % of records with annual cross reference against the disqualified directors and insolvency list (May 2022) | N/A | N/A | N/A | N/A |
| | | | | % of records which include annual review of professional registration status for relevant Board members (May 2022) | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 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. | 31/05/2022 | Complete | NED records audited by CEO Office and verified as complete Executive Director records reviewed and revised checklists in place.<br><br>Terms of reference for audit by 360 Assurance agreed and audit work to commence across all Exec and NED files. | % compliance with FFP checklist | N/A | N/A | N/A | N/A |

### Summary of progress against outcome

Work is progressing in line with agreed timeline with all key milestones for actions met to date.
Metrics will be tested / measured through audit work by 360 Assurance.

## Outcome 17: We have effective systems to ensure Board oversight of the management of risk

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 17.1 - Refresh the Trust's Framework for Risk Management (Risk Management Policy). | 28/06/2022 | On track | Ontrack for completion by the June deadline – submitted to BoD for approval at its meeting to be held 28 June 2022 | Board approved Framework for Risk Management | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 17.2 - Implement revised reporting / oversight arrangements for the management of risk. | 17/07/2022 | On track | Work progressing in line with timeline agreed by TEG on 1 June 2022 | Meeting agendas / minutes | N/A | N/A | N/A | N/A |
| | | | | Reports | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| 17.3 - Deliver a Communication and Engagement Plan for oversight arrangements for the management of risk. | 17/07/2022 | On track | Work progressing in line with agreed timeline action will be completed by the deadline. | Training attendance / compliance | N/A | N/A | N/A | N/A |
| | | | | Educational resources | N/A | N/A | N/A | N/A |

### Summary of progress against outcome

| Work is progressing in line with agreed timeline with all key milestones for actions met to date. |
|---|

## Community Inpatients Outcome 1: To improve the safety of patient care delivered at SPARC

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| C1.1 - To ensure patients dietary requirement information is consistent with current recommendations and accurately documented.<br><br>To ensure SLT embed new principles of working to include nutrition documentation review. | 01/07/2022 | On track | SOP for communication of IDSI texture recommendations implemented 16.05.22- for sign off at SPARC governance 27.06.22.<br>Since implementation no reported incidents relating to incorrect texture administrated to pt.<br>At weekly MDT 100% compliance with nutrition information being accurate on 3 identified communication points | % of patients for whom nutrition information is documented on SPARC communication tools | Initial audit due w/c 23 May 22 | N/A | Target: 85%<br>Actual: 100% | Target: 85% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| C1.2 - To ensure SPARC are compliant with STH fire safety recommendations. | 01/07/2022 | On track | Achieved 70% staff evacuation equipment training (target 90%)- further sessions booked<br>Completed fire evacuation simulation session 21.06.22<br>SPARC fire risk assessment review to be completed 12.07.22 | SPARC fire risk assessment updated including the completion of an annual fire drill | N/A | N/A | N/A | N/A |
| | | | | Fire wardens to be identified and trained | N/A | N/A | Target: 8<br>Actual: 8 | Target: 8 |
| | | | | % of staff who have completed evacuation equipment training | 0% | Target: 10%<br>Actual: 10% | Target: 50%<br>Actual: 70% | Target: 50% |

| Action | Target completion | Status | Update | Metrics | Baseline data | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| C1.3 - Skin integrity will be consistently assessed and managed using evidence-based practice. | 01/07/2022 | On track with potential for delay | React to red mandatory training for SPARC at 95%<br>Weekly audit of pressure areas RA being completed – 100% for Waterlow<br>Care plan completion remains inconsistent – care plan will be amended to include time to turn – will be added by end of June<br>Care plan training is underway to address inconsistency of daily pressure care plan completion - target date for completion mid July 2022<br>Paula McDonald has sent purpose T details for SPARC as potential trial site – awaiting details of implementation plan | % of patients who have skin integrity assessment and management (purpose T trial site) | No data available | N/A | Target: 50%<br>Actual: 100% for assessment completion<br>Care plan still being updated | Target: 50% |

### Quality support visits (as at 20 June 2022)

No Quality Support Visits for Community Inpatients undertaken to date.

### Summary of progress against outcome

Outcome Lead: Good progress being made across actions 1 and 2. Good improvements with Waterlow RA and care plan update on track although there is a plan for SPARC to be ‘purpose T’ trial site.

## Urgent and Emergency Care Outcome 1: (Trust outcome 1) Mental Health needs are identified and actioned

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC1.1- 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. | 17/07/2022 | On track | Adapted Daily Assurance Checklist approved at Governance meeting on 14/06/22 to pilot on 17/06/2022 for two weeks. This aligns with the Trust improvement work on the Nightingale Process – improving patient safety, outcomes and experience.<br>Data from pilot will be analysed and update provided in July.<br>Importance of documenting safety huddles and Daily Departmental Checklist shared.<br>Discussed with senior sister and nurses and at weekly Breakfast club.<br>Established baseline in June and plan for 10% improvement monthly.<br>Electronic MH risk assessment form available in ED to make it easier to document the risk management plan at triage and any subsequent updates to this | Evidence of best practice with escalation to provide observers | Audit of 3 hourly safety huddle documentation shows 52% are fully documented | N/A | Target: N/A<br>Actual: 52% | Target: 62% |
| | | | | | Audit of notes for the completion of Mental Health Risk Assessments shows, on average, 53% of MH Risk Assessments are being fully completed | N/A | Target: N/A<br>Actual: 53% | Target: 63% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC1.2- Inclusion of reviewing all alerts in Lorenzo in induction and acting on them to ensure safety of patient. | 17/07/2022 | On track | Initial baseline audit of 10 patient notes identified that care plans were acted on 30% of the time. Data will be fed back to staff and a focus group will be established to include staff involved in the mental health audit (e.g MHLT) and members of staff in ED to clarify actions and subsequent audits.<br>Plan for 10% improvement on Monthly | % compliance with review and acting on alert notices | 30% | N/A | Target: N/A<br>Actual: 30% | Target: 40% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC1.3- Monitor PLAN room Q shift & after patient use for ligature anchor points. | 17/07/2022 | On track | Audit indicated Yellow Bay room 17 (PLAN room) checked 71% of the time in the audited week.<br>Yellow Bay checklist did not include PLAN standards and specific ligature points to check for. Checklist has been updated and now includes Psychiatry Liaison Accreditation Network (PLAN) standards and an area to document repairs to Y17.<br>ED matron has reminded all nursing staff of PLAN standards.<br>SOP being written for stripping a cubicle ready to receive Mental Health patients. – Spot audit before and after implementation of the SOP to see improvement. Data available in July update. | Evidence of a safe environment | 71% compliance with documentation of Yellow Bay Room 17 (PLAN room) | N/A | Target: N/A<br>Actual: 71% | Target: 81% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC1.4- Ensure that all areas looking after patients with mental health risks understand the need for ligature free areas or one to one observation. | 17/07/2022 | On track | Datix report on ligature episodes for May has been undertaken, with one incident being identified (10/05/2022).<br><br>Trust MH lead and Director of Estates have reviewed ligature free areas and a report is awaited. | Number of episodes of attempted ligature use | 1 incident of ligature episode in May 2022 | N/A | Actual: 1 | Target: 0 |

**Urgent and Emergency Care Outcome 3: (Trust outcome 4) We have embedded evidence-based interventions to minimise the risk of falls.**

**Progress against actions**

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC3.1- 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.<br><br>Monitor that staff escalate if staffing is inadequate for good observation. | 17/07/2022 | On track | Audit data have indicated there is work to be done to improve completion rate of Falls assessments in ED:<br>• 61% of Falls Risk assessments are completed<br>• the most common missing items are dementia/mental health medication.<br>• 86% had access to a call buzzer<br>Falls Focus Group will be established to design interventions, implemented and audit completed.<br><br>Plan for 10% increase monthly<br>% compliance with appropriate escalation of staffing issues No escalation has been required this Month (June). Safe Staffing can be accessed centrally (monthly staffing return). | % compliance with Falls risk assessment audit | 61% of Falls Risk assessments are completed | N/A | Target: N/A<br>Actual: 61% | Target: 71% |
| | | | | % compliance with appropriate escalation of staffing issues | N/A | N/A | Target: N/A<br>Actual: 100% | Target: 10% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC3.2- 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 falls assessment and have lying and standing blood pressure documented. | 17/07/2022 | Complete | We have removed L&S BP in ED after discussion with trust falls lead | % patients who have lying and standing blood pressure documented | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC3.3- Implement Falls Prevention Packs across ED & AMU – increase awareness by messaging "Yellow to Red Socks" initiative. | 17/07/2022 | On track | Falls Prevention packs implemented and actioned on AMU – Falls packs not implemented on ED after discussion with trust wide falls group.<br>Audits of Falls Risk "Red" Socks in ED commenced w/c 06/06/22 indicated further improvement work is needed to ensure proper documentation of red socks. A focus group will be formed and actions discussed, implemented, and audits will be re-commenced for 4 weeks to measure impact.<br>Plan for 10% improvement monthly. | % compliance with falls prevention packs & "Red Socks being used appropriately | In ED – 40% compliance with documentation of Red Socks | N/A | Target: N/A<br>Actual: 40% | Target: 50% |

## Urgent and Emergency Care Outcome 4: (Trust outcome 5) We recognise and escalate patient deterioration promptly.

## Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC4.1- Reiteration of Triage Nurse induction to ensure visual check of waiting area each time they call a patient.<br><br>Improve communication to remind patients to alert staff if feeling unwell, through triage, posters and 'ticker-tape-messaging'. | 17/07/2022 | At risk of delay | From the patient satisfaction pareport run for May, A&E had a 71% positive rating (19% response rate). To address low response rates, business cards with QR codes have been ordered and will be given to patients by housekeepers to encourage uptake<br><br>Thematic analysis planned by Patient experience co-ordinator for next month. Status at risk due to reliance on doctor waits, capacity in department and overcrowding<br><br>No Datixes relating to waiting room were identified for May.<br><br>Posters have been ordered. Waiting room signage delayed – awaiting comms to review waiting room presentation. | % patient satisfaction scores related to experience of waiting and environment | 71% positive rating | N/A | Target: N/A<br>Actual: 71% | Target: 75% |
| | | | | Appropriate signage and patient information available 24/7 | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC4.2- Proactive 07:30 – 19:30 waiting room monitoring by Streaming Sister stationed at Reception (June 2022-evaluation)<br><br>Receptionist 'floor walker' to be stationed in waiting area as a point of information. | 17/07/2022 | At risk of delay | Deep dive into streaming sister benefits to patient safety showed comparable levels with receptionist in streaming patients to urgent waiting room. Receptionist follow a process to speak with Nurse (streaming sister or NIC) before streaming to urgent waiting room. A case note audit will be established to understand the benefits of streaming sister to specific patient cases and results will be shared by 05/07/2022.<br><br>Audit of recognition and escalation of deteriorating patients undertaken w/c 13/06/22. Initial findings indicate that 50% of the time patients with NEWS of 3 or more have observations checked on time. Documentation of appropriate escalation was low at 20%<br><br>Audit results will be shared with staff and a focus group will be established to clarify actions to be implemented before a subsequent round of audits to assess improvement.<br><br>At risk due to funding for Streaming Sisters not being available after August 2022 | Evidence of early recognition of patient deterioration and prompt escalation | 50% of the time, patients with NEWS >3 have observations on time Escalation documented 20% of the time | N/A | Target: N/A<br>Actual: 50% / 20% | Target: 60% / 30% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC4.3- Ensure ED escalation cards are adhered to and visible implementation of checklist for Purple Escalation procedure. | 17/07/2022 | On track | Patients with bed ready to transfer in 15 minutes was 62% in June<br>Median number of lodged patients is 23<br><br>Morning Operation Group discusses previous days performance and risks to patient and staff safety.<br><br>Further guidance will be provided to Nurse Team Leaders around expectations of transfer of patients within 15 minutes<br><br>ED Matron has reiterated the importance of ensuring patients are moved within 15 minutes of bed ready to all nursing staff on 14/06/22.<br><br>10% increase monthly. | % exit flow | 62% of patients with bed ready to exit from department in 15 minutes | N/A | Target: N/A<br><br>Actual: 62% bed ready to transfer within 15 minutes / median is 23 pts lodged per hour | Target: 72% |

**Urgent and Emergency Care Outcome 5: (Trust outcome 6) We ensure we individualise and meet the needs and preferences of patients**

## Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC5.1- Ensure timely documentation and individualised nursing assessments following implementation of the Named Nursing process. | 17/07/2022 | On track | Audit of Named Nursing process has been undertaken, showing only 47% of the front sheet completed. Patient observations were completed at regular intervals in 73% of patient notes audited. Only 27% of patient notes had intentional rounding completed at appropriate intervals.<br><br>Results are being shared with staff and a focus group will be set up to work through improvements, and will be re-audited following this to demonstrate improvement.<br><br>Survey has been sent to Nursing staff around feedback on the impact and benefits of named nursing. This has been reviewed and shared with staff. | % compliance with individualised patient care standards | Nursing Front Sheet completion is 47%<br>Patient observations completed at regular intervals is 73%<br>Intentional rounding is recorded 27% of the time | N/A | Target: N/A<br><br>Actual:<br>Nursing Front Sheet completion is 47%<br>Patient observations completed at regular intervals is 73%<br>Intentional rounding is recorded 27% of the time | Target: 10% increase |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC5.2- Ensure that refreshment and food is provided to patients at regular intervals 24/7, especially if they are waiting for inpatient admission. | 17/07/2022 | On track | Initial baseline data has been collected and indicates that around 44% of patients had no documentation of drink offered and 59% had no documentation of food offered, indicating improvement required for documentation of nutritional status.<br><br>These results will be fed back to staff by 30/06/22 and a focus group established to identify improvements. Improvements will be implemented as part of a PDSA cycle and audits will commence to review improvements made.<br><br>Additional housekeepers to commence in post on the 20 June and 2000-0400 shift implemented.<br>Following a review of food and drink provision, and supply increased after discussion with catering dietician (27/05/22)<br>Nutritional steering group in ED with champions has been implemented and monthly meetings arranged with housekeepers, ND, Matron, catering and Trust Nutritional Lead. | Evidence of nutritional guidance being used appropriately | 44% of patients had no documentation of food drink offered<br>59% of patients had no documentation of food offered | N/A | Target: N/A<br><br>Actual:<br>44% of patients had no documentation of food drink offered<br>59% of patients had no documentation of food offered | Target:<br>10% increase |

**Urgent and Emergency Care Outcome 6: (Trust outcome 10) We are assured that staff are trained to do their jobs deliverable 24/7**

**Progress against actions**

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC6.1- 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. | 17/07/2022 | On track | Triage courses are running in June, July, August and training sessions have been allocated to staff on Roster.<br>100% of nurses undertaking triage in practice have completed the triage training<br><br>By the end of 2022, 100% of eligible staff will be triage trained<br>64% of ED nurses Triage trained by 2023 | % of relevant staff who have completed triage course | 100% of those undertaking triage in practice have completed training | N/A | Target:<br>Actual: 100% | Target: 100% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC6.2- Complete a second cycle of the Safer Nursing Care Tool to identify the appropriate nursing-staff volume and skill mix for ED | ~~17/07/2022~~<br><br>24/07/2022 | Delayed- revised date 24 Jul 2022 | Second cycle of Safer Nursing Care Tool to be undertaken with confirmed dates of 12th – 24th July. | % staff completing mandatory training | 90.38% staff completed Mandatory Training as of June 2022 | N/A | Target: 90%<br>Actual: 90.4% | Target: 90% |
| | | | | % staff skill mix as per national guidelines | N/A | N/A | Target:<br>Actual: | Target: Outcome of the SNCT |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC6.3- Ensure staff are able to undertake both mandatory and job specific training to reach at least 90% coverage.<br><br>Professional development training is now available for staff 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. | 17/07/2022 | On track | On track for 90% compliance. Areas of concern are Information Governance and all staff have been emailed and line managers notified to encourage compliance. Safeguarding Level 3 F2F training is commencing in June (no f2f training available during covid)<br><br>Courses booked for staff, including TNCC<br>Courses will be held in Newcastle and Edinburgh as only 1 course in Yorkshire (also booked).<br><br>Leadership courses staff have been added to mentorship courses and professional nurse advocate course (identified staff are undergoing training)<br>• Increase in MH, Sepsis, TILS, TNCC places<br>• AEM staff do not have ALS/ILS mandated, therefore bespoke BLS (Basic Life Support) is planned with sim sessions to recommence once a week. This aim is to still release development for ALS places later in the year. The number of places on offer will depend on mandatory uptake through the summer.<br>• Places are expected to be available again in October 2022<br><br>Plan for appraisals to be 100% by September. | % compliance with appraisals and supervision | N/A | N/A | Target: 75%<br>Actual: 75% | Target: 80% |
| | | | | % staff acquiring national recognised qualifications | N/A | N/A | Actual: 6 TNCC | N/A |

## Urgent and Emergency Care Outcome 7: (Trust outcome 11) We are assured we maintain accurate, secure, complete and contemporaneous record in respect of each service user securely

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC7.1- 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. | 31/08/2022 | On track | Spot checks reveals compliance with observation checklist of 52%. Consistent non-compliance with unattended computers logged in and smartcards left out. Consistent compliance with IPC standards.<br><br>10% increase monthly. | % compliance with accurate and contemporaneous record keeping standards | 52% compliance | N/A | Target: N/A<br>Actual: 52% | Target: 62% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC7.2- Continued improvement against delivery of the latest iteration of the Emergency Care Dataset (ECDS)'. | 17/07/2022 | On track | Currently behind schedule for Transfer of Care project due to a gap in the technical support for the project whilst someone was off long term sick, but they have now returned to support. Implementation likely October 2022<br>Snapshot of the ECDS Data Power BI Dashboard for data up to 29th May - Shows ECDS performance against completion (fields filled in) and validity (how well they're filled in). STH has gaps on some data items but are consistent with almost all other providers. Moreover, overall performance against both measures is well above average | Evidence from NHSE ECDS Dashboard measures performance against completeness and validity for each ECDS data field. | N/A | N/A | Target: Above average<br>Actual: Above average | Target: Above average |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC7.3- 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. | 17/07/2022 | Delayed- revised date Oct 2022 | Currently behind schedule for Transfer of Care project due to a gap in the technical support for the project due to long term sickness. Implementation likely October 2022 | % ability to review pre-hospital care in near time | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC7.4- Improve the use of Smartcards within ED, ensuring that patient information is only accessed on an individualised basis. Ensure staff compete Information Governance training. | 17/07/2022 | On track | Central visit to ED to audit record keeping undertaken on 24th May.<br>Overall comments:<br>*Overall, it was a really positive visit to see how a department is working using electronic documentation. The department was clean and tidy, and staff approached were helpful. There was no evidence of sharing of smartcards and additional screens in the corridors were all logged on ready for single sign on.* | % of staff compliant with IG training | 83.13 %<br>(April 2022) | Target<br>Actual:<br>83.82% | Target:<br><br>Actual:<br>85.22% | Target: 90% |

## Urgent and Emergency Care Outcome 8: (Trust outcome 12) We are assured that our staff adhere to best IPC practice to minimise hospital acquired infection

## Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC8.1- Equipment is cleaned in line with trust and national guideline: i.e. in-between patient use & paediatric resus trolley/tabards. | 17/07/2022 | On track | Cleaning schedules checked and signed – resus<br>BAU Spotchecks are being undertaken by NIC/ND/Matron and findings shared with IPC Team resulting in consistent AEM IPC accreditation<br>Findings from audit show consistent improvement in cleaning | % of equipment that is cleaned and checklist signed | N/A | N/A | Target:N/A<br>Actual: | Target: 90% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC8.2- 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. | 17/07/2022 | On track | Spot checks audit week commencing 20/06 indicate a baseline of compliance of correct PPE wearing in accordance with Trust policy of 75%<br>ED matron newsletter w/c 01/07 reissuing guidance and policies and notifying of spot checks. | % in all staff wearing correct PPE in line with ED SharePoint PPE Guidelines | N/A | N/A | Target:<br>Actual: 75% | Target: 90% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC8.3- Reminder at clinical and nursing handovers basic IPC: Bare below elbows, changing gloves and washing hands. | 17/07/2022 | On track | Baseline audit for May data complete, and findings being reviewed. An IPC focus group will be established to identify improvements. Improvements will be implemented and measured with subsequent audits to identify improvement. | % compliance with basic personal IPC | N/A | N/A | N/A | Target: 90% |

## Urgent and Emergency Care Outcome 9: (Trust outcome 13) We are assured that incidents are consistently reported and harm accurately assessed

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC9.1- Monthly feedback to teams of incident trends, top five risks and lessons learned and includes "You Reported – We Acted" Poster. | 17/07/2022 | On track | Monthly Datix themes will be fed back to teams during staff meetings, emails from ND to Matrons as part of QUEST and to education team. Subsequent reports will include Datix by staff group.<br><br>Monthly improvement for lowest reporting staff groups | % staff reporting safety concerns on Datix | N/A | N/A | Target:<br>Actual: | Target: |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC9.2- Encourage all staff to report safety concerns via Datix or a conversation with Clinical Governance Team.<br><br>When over capacity Clinical Governance Coordinator will round and assess in real time for potential harm. | 17/07/2022 | On track | CD update on how to report Datix for June 2022<br>Monthly top 5 themes sent to all staff and all staff receive feedback when reporting Datix<br><br>Monthly improvement for lowest reporting staff groups (as above) | Consistent improvement in MDT reporting safety concerns | N/A | N/A | Target:<br>Actual: | Target: |

## Urgent and Emergency Care Outcome 10: (Trust outcome 15) We know and take action in response to our immediate performance and risks

### Progress against actions

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| UEC10.1- 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. | 17/07/2022 | On track | AEM improvement meeting continued throughout June and shared accountability for improvements across Trust Leadership team and Triumvirate; including Ambulance wait, flow. | Evidence of operational oversight of risk, issues and performance | N/A | N/A | N/A | N/A |

**Maternity Services Outcome 1: (Trust outcome 5) We recognise and escalate maternal and fetal deterioration promptly**

CQC Conditions: 1a, 1b, 3

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 1.1- Ensure fetal monitoring (Antenatal & Intrapartum) is undertaken and recorded consistently reflecting NICE (2017) Intrapartum Care Guidelines (CG190 | 17/07/2022 | On track | May 2022 audit commenced reviewing "Fresh Eyes" compliance including categorisation, escalation and outcomes. Updated audit template also reflecting the Saving Babies Live national toolkit in place.<br>June 2022<br>• Audit data collection completed, and report due to be published in July. Early indications are that 55% of "Fresh Eyes" review completed hourly but 100% of those were correctly classified and 100% of those were appropriately escalated. Month on month audit to provide assurance.<br>• Fetal monitoring training compliance is in line with trajectory<br>• A weekly report is shared with Matrons to highlight staff who are due to be/are overdue for training<br>The aim is to achieve 90% compliance of Fetal monitoring training assessments passed, by the end of June. | > 90% compliance with staff training in relation to fetal monitoring (CTG and intermittent auscultation). | 25/05 – 70% compliance | Target: 70%<br>Actual: 70% | Target: 80%<br>Actual:84.1% | Target: 90% |
| | | | | >90% compliance with fresh eyes assessment. | Audit reviewed – new tool | N/A | N/A | Target: TBC |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 1.2- Ensure maternal monitoring is undertaken consistently and documented. | 17/07/2022 | On track | MEOWS audit complete awaiting final report.<br><br>June 2022<br>• Training compliance for Prompt and Neonatal Life Support is continuing to improve<br>• Matrons are performing focused 1:1s to support Midwives with compliance<br>• Secured support from theatre management team for theatre staff attendance<br>• The Clinical Director is monitoring medical staff booking on courses<br>• This is a prioritised area for training<br>• MEOWS draft audit report was discussed at the Maternity Governance Meeting on the 16.6.22. Further work is being undertaken to validate the results.<br>• NEWTT Report- data has been collected but not yet analysed. | > 90% compliance with staff training in relation to MEOWS and Neonatal Early Warning Track and Trigger (NEWTT) via PROMPT and Newborn Life Support training. | PROMPT – 68.9 % compliance | N/A | Target: 89.9%<br>Actual: 82.56% | Target: 90% |
| | | | | | Neonatal Life Support May 58% | Target: N/A<br>Actual: 58% | Target: 65%<br>Actual: 69.6% | Target: 75% |
| | | | | >90% compliance with recording of MEOWS and NEWTT. | Audits MEOWS and NEWTT complete final reports awaited | N/A | Target: *<br>Actual: * | Target: 90% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 1.3- Ensure the completion of risk assessments for women on arrival via implementation of Birmingham Symptom Specific Obstetrics Triage System (BSOTS). | 17/07/2022 | At risk of delay | Regarding completion of risk assessments for woman on arrival:<br>• Estate issues for 2 additional triage assessment rooms – office moves<br>• Paper based BSOTS pathway absence of MIS solution to support data collection/audit<br>• Focused senior obstetric support for LWAU CD progressing<br>• Midwifery acuity/activity ongoing monitoring using BR+app<br>June<br>• The team is starting to make changes to processes, to bring this in line with BSOTS. For example, changes to data collection are due to be completed by 1/7.<br>• There is progress with interim solutions, with access to 2 clinical rooms<br>• Review of recording of telephone calls to Triage, identifying some additional information to add to data collection to bring this in line with BSOTS. These changes will be put into place by July<br>• BSOTS paperwork and training for staff has commenced<br>• Anticipate full birth rate plus assessment in July | Pace of BSOTS implementation and roll out against action plan (dependent on Maternity specific information system and estate constraints). | At the end of May there were 95.8% of rapid reviews completed. Average time to completion was 32 minutes. We recognise that this is not a BSOTS standard. | Target: ≥ 95% completed<br>Actual: 95.8%<br><br>Target: ≤ 30 mins<br>Actual: 32 minutes | Target: ≥ 95% completed<br>Actual: *<br><br>Target: ≤ 30 mins<br>Actual: *<br><br>** data available after the end of the month* | Target: ≥ 95%<br><br>Target: ≤ 30 mins |

## Maternity Services Outcome 2: (Trust outcome 7) We are assured that we manage medicines safely

CQC Conditions: 1a, 1b

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 2.1- Review of pathway for prescribing and administration of all ongoing medications in labour ward assessment unit (LWAU) (linked to BSOTS) | 17/07/2022 | On track | Operations Director scheduled to meet Chief Pharmacist to review EPMA to support compliance.<br><br>June:<br>• An audit to investigate whether critical medicines are prescribed and administered on time for inpatients in the antenatal ward and to evaluate the reasons for delay or omissions of the drugs has been undertaken and reported to the Maternity Governance group.<br>• The audit focused on the antenatal ward as most admissions will come via labour ward assessment unit (triage). This would therefore provide an insight into prescribing at point of admission. However, it is noted that every in-patient area has patients coming from home, clinic, other outpatient areas as well as labour ward triage.<br>• An action plan has been put in place and reaudit planned for 3 months' time | Improved prescribing and administration of ongoing medications in labour ward triage. | 16/20 (80%) critical medications were prescribed or there was a clinical reason why it was not(3).<br>10/13 (77.3%) critical medicines were administered on time<br>(One was administered late due to patient request, one was unavailable, and one was administered 1h 15 min late) | N/A | N/A | N/A |

**Maternity Services Outcome 3: (Trust outcome 9) We are assured that we have adequate midwifery, nursing and obstetric staffing levels**

CQC Conditions: 2i, 2ii

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 3.1- Complete Birth Rate Plus full assessment for maternity staffing and undertake a review against current maternity establishment. | 30/06/2022 | On track | Trust data for Birth Rate Plus now complete for sign off by Midwifery Director before submitted to Birth Rate Plus. Birth Rate Plus assessment anticipated in July 2022.<br>June:<br>• A full Birthrate Plus assessment is in progress. Trust data submitted on the 30th May.<br>• The full assessment is anticipated in July. | Staffing levels in line with "Safe Midwifery Staffing for Maternity Settings" NICE guideline (NG4) 2015 | Reviewed daily | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 3.2- Implementation of Birth Rate Plus App on Consultant led and Midwifery Led Intrapartum Areas and AN and PN wards. | 30/06/2022 | Complete | Since December 2021, Birth Rate Plus app in place, sustainable 85% data input compliance is achieved and monitored weekly by Matron for Intrapartum.<br>AN/PN wards Birth Rate Plus app launched in April 2022, 85% data input compliance not yet achieved, monitored weekly by Inpatient Matron.<br>June:<br>Monthly reports undertaken by inpatient matron and intrapartum matron using birth rate plus acuity tool app data, to triangulate red flags, with incident and complaints reporting through maternity and directorate governance and reported through to Board Maternity and Neonatal Safety Report. | Staffing levels in line with acuity every 4 hours (intrapartum areas) and every 8 hours other areas. | N/A | N/A | N/A | N/A |
| | | | | Number of red flags by type. | N/A | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 3.3- Recruitment of relevant staff to all vacant posts. | 17/07/2022 | At risk of delay | System led recruitment process for NQM complete, 28 posts offered, 12 IR Midwives.<br>Rolling band 5/6 midwife roles advert updated.<br>June:<br>• First International midwife arrived in JW, now in York for OSCE support. A further 12 to follow (Trust commitment for 7 further 20 IR midwives in total)<br>• Increase in the number of Newly Qualified Midwives requesting to work at JW (28 offered roles)<br>• NHSEI funded recruitment and retention B7 Pastoral support role out to advert (2 years fixed term)<br>• Rolling advert for B5/6 Midwife updated<br>• HEE funded RM shortened course for STH RNs progress continues in collaboration with Sheffield Hallam University, roll out planned for January 2023.<br>• Interim Midwifery Director in discussion with SHU to progress new tender for midwifery apprenticeships.<br>• Vacant medical jobs have been advertised and interview will take place on 30 June 2022 (Consultant) and 4 July 2022 (Speciality Drs)<br>• Consultant Obstetrician interviews scheduled for 30 June 2022 for 2/3 vacant posts. | Staffing levels in line with "Safe Midwifery Staffing for Maternity Settings" NICE guideline (NG4) 2015 | Current establishment B2-B8b is 345.15. Current vacancies are 57.92WTE | N/A | N/A | N/A |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 3.4- Analyse red flag data to identify actions required to reduce reoccurrence and report via governance process for escalation to the Board. | 30/06/2022 | On track | Analysis of red flag data commenced in May being reviewed by Matrons weekly with data triangulated against activity/ acuity/ incidents/ complaints report through Directorate Governance.<br>June:<br>Monthly reports undertaken by inpatient matron and intrapartum matron using birth rate plus acuity tool app data to triangulate red flags with incident complaints reporting through maternity and directorate governance and reported through to Board Maternity and Neonatal Safety Report. | Reduction in number of red flags | Targets to be set once baseline established | N/A | N/A | Target: TBC |

## Maternity Services Outcome 4: (Trust outcome 17) We have effective systems to ensure oversight of the management of risk

CQC Conditions: 2i-vi

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 4.1- Implement the Maternity Governance Toolkit reflecting the Perinatal Quality Surveillance Model. | 17/07/2022 | On track | • Scheduled launch of the Maternity Quality & Safety Toolkit planned for June 2022 supported by external governance support 0.4 wte. Although planned for June the launch may be delayed by a week, this will not affect the completion date.<br>• This will feed into the monthly perinatal quality surveillance report to the Directorate Governance Group and the Board of Directors. | A range of key indicators for the service reflecting the perinatal quality surveillance model. | Monthly board paper | Target: 100%<br>Actual: 100% | Target: 100%<br>Actual: 100% | Target: 100% |

| Action | Target completion | Status | Update | Metrics | Baseline date | 17 May data | 17 Jun data | 17 Jul data |
|---|---|---|---|---|---|---|---|---|
| OGN 4.2- Ensure senior oversight of audit results via the Directorate Quality Governance Group. | 17/07/2022 | On track | 12 month audit plan scheduled for sharing with Triumvirate week commencing 06 June.<br>June:<br>• To ensure senior oversight of audit results, a 12-month audit plan has been shared with the Triumvirate. Ongoing oversight of the plan is through the Directorate Governance group.<br>• The CD has reviewed the audit programme with the Clinical Lead and advised on the plan and on securing the appropriate level of support from Trainees | Audits are completed in a timely manner and robust actions are taken in response to findings | N/A | N/A | N/A | N/A |

**Appendix 1: Progress update for the two priority corporate workstreams**

| Outcome and actions (and target completion date) | Progress to date |
|---|---|
| **Priority Corporate Workstream - Safety Huddles** | All inpatient wards have been visited by the implementation team who have delivered posters and prompt cards and discussed the rationale and process with the nurse in charge at that time. All areas informed of the need to commence MDT huddles, and that support resources are available on the intranet including FAQ's and a video guide. Areas have been assisted to find a place to undertake their huddle and to decide on a suitable time. A standard script has been provided to ensure consistent practice.<br><br>Implementation team plan to return to all inpatient areas in the coming 4 weeks. There will be an initial focus on the top 12 priority ward areas. These will be unscheduled visits so that the MDT safety huddles can be observed in practice. Visits are intended to be supportive and offer constructive feedback. The deputy chief nurse is also undertaking supportive visits to areas to observe their MDT Safety Huddles.<br><br>Overwhelmingly the response from nursing teams has been positive and staff have been very accommodating and willing to get involved in this key safety initiative. Staff have highlighted how they can understand the value of the safety huddle. Some areas have expressed concern about achieving a full MDT safety huddle, and supportive work will be targeted in these areas from the implementation team. |
| **Priority Corporate Workstream - Ward Boards** | Installation of patient and visitor Ward Entrance Boards and staff Quality Boards has commenced. The 12 priority wards and the Jessop Wing have been prioritised.<br><br>Templates for content and Standard Operating Procedure for completion of board content of Boards have been developed. These are due to be presented to all Senior Nurses on Monday 4 July 2022.<br><br>Central Nursing will support the 12 priority wards with compliance in the first instance. |

## Appendix 2: Quality Support Visits - RAG rating by ward and outcome (as at 1 July 2022)

The table provides an overview of the level of assurance for each of the outcomes assessed as part of the Quality Support Visits.

Assured | Partially assured | Not assured | Still to be assessed

| | | | Outcome | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CORE SERVICE | SITE | WARD | 1 | 2 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13<br>14 |
| Medicine | NGH | BREARLEY 1 | | | | | | | | | | | | |
| Medicine | NGH | BREARLEY 2 | | | | | | | | | | | | |
| Medicine | NGH | BREARLEY 3 | | | | | | | | | | | | |
| Medicine | NGH | BREARLEY 4 | | | | | | | | | | | | |
| Medicine | NGH | BREARLEY 5 | | | | | | | | | | | | |
| Medicine | NGH | BREARLEY 6 | | | | | | | | | | | | |
| Medicine | NGH | BREARLEY 7 | | | | | | | | | | | | |
| Medicine | NGH | CCU | | | | | | | | | | | | |
| Medicine | NGH | CF UNIT | | | | | | | | | | | | |
| Medicine | NGH | CHESTERMAN 1 | | | | | | | | | | | | |
| Medicine | NGH | CHESTERMAN 2 | | | | | | | | | | | | |
| Medicine | NGH | FIRTH 7 | | | | | | | | | | | | |
| Medicine | NGH | FRAILTY UNIT | | | | | | | | | | | | |
| Medicine | NGH | HUNTSMAN 4 | | | | | | | | | | | | |
| Medicine | NGH | OSBORNE 1 | | | | | | | | | | | | |
| Medicine | NGH | OSBORNE 4 | | | | | | | | | | | | |
| Medicine | NGH | PALLATIVE CARE UNIT | | | | | | | | | | | | |
| Medicine | NGH | RENAL UNIT E | | | | | | | | | | | | |
| Medicine | NGH | RENAL UNIT F | | | | | | | | | | | | |
| Medicine | NGH | ROBERT HADFIELD 1 | | | | | | | | | | | | |
| Medicine | NGH | ROBERT HADFIELD 2 | | | | | | | | | | | | |
| Medicine | NGH | ROBERT HADFIELD 3 | | | | | | | | | | | | |
| Medicine | NGH | ROBERT HADFIELD 4 | | | | | | | | | | | | |
| Medicine | NGH | ROBERT HADFIELD 5 | | | | | | | | | | | | |
| Medicine | NGH | VICKERS 2 | | | | | | | | | | | | |
| Medicine | RHH | CIU (P2) | | | | | | | | | | | | |
| Medicine | RHH | G2 | | | | | | | | | | | | |
| Medicine | RHH | L1 | | | | | | | | | | | | |
| Medicine | RHH | L2 | | | | | | | | | | | | |
| Medicine | RHH | M2 | | | | | | | | | | | | |
| Medicine | RHH | O1 | | | | | | | | | | | | |
| Medicine | RHH | P3 | | | | | | | | | | | | |
| Medicine | RHH | P4 | | | | | | | | | | | | |
| Medicine | RHH | Q1 | | | | | | | | | | | | |
| Medicine | RHH | Q2 | | | | | | | | | | | | |
| Surgery | NGH | CHESTERMAN 3 | | | | | | | | | | | | |
| Surgery | NGH | CHESTERMAN 4 | | | | | | | | | | | | |
| Surgery | NGH | FIRTH 2 | | | | | | | | | | | | |
| Surgery | NGH | FIRTH 3 | | | | | | | | | | | | |
| Surgery | NGH | FIRTH 4 | | | | | | | | | | | | |
| Surgery | NGH | FIRTH 8 | | | | | | | | | | | | |
| Surgery | NGH | FIRTH 9 | | | | | | | | | | | | |
| Surgery | NGH | HUNTSMAN 2 | | | | | | | | | | | | |
| Surgery | NGH | HUNTSMAN 5 | | | | | | | | | | | | |
| Surgery | NGH | HUNTSMAN 6 | | | | | | | | | | | | |
| Surgery | NGH | HUNTSMAN 7 | | | | | | | | | | | | |
| Surgery | NGH | SAC / HUNTSMAN 8 | | | | | | | | | | | | |
| Surgery | RHH | F1 | | | | | | | | | | | | |
| Surgery | RHH | F2 | | | | | | | | | | | | |
| Surgery | RHH | G1 | | | | | | | | | | | | |
| Surgery | RHH | I1 | | | | | | | | | | | | |
| Surgery | RHH | N1 | | | | | | | | | | | | |
| Surgery | RHH | N2 | | | | | | | | | | | | |
| UEC | NGH | A&E | | | | | | | | | | | | |
| UEC | NGH | FIRTH 5 | | | | | | | | | | | | |
| UEC | NGH | FIRTH 6 | | | | | | | | | | | | |
| Maternity | JW | LABOUR WARD | | | | | | | | | | | | |
| Maternity | JW | NORFOLK WARD | | | | | | | | | | | | |
| Maternity | JW | RIVELIN WARD | | | | | | | | | | | | |
| Maternity | JW | WHIRLOW WARD | | | | | | | | | | | | |