Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 27 September 2022

Subject	CQC Action Plan 2022 – Update Report August 2022
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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 31 August 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 August.
- 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 remaining 15 outcomes. At present 13 are rated Amber and 2 are rated Green. In order to ensure progress:

- The CQC Compliance Oversight Group continues to meet 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 weekly meeting to share the themes and agree actions arising from the Ward Quality Support Visits with Sisters, Matron, Deputy Nurse Directors and Nurse Directors continues.
- Progress on the two priority Trust-wide workstreams, Safety Huddles and Ward Boards, are presented in Appendix 1. Progress with Ward Boards is rated Amber and Safety Huddles are rated 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 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.
- Where actions are complete, ongoing oversight of performance has been identified and these actions will be not be included in future updates.

In conclusion, there is evidence of progress against all outcomes. The QSVs demonstrate that further work is required to ensure consistency around the secure storage of records and the correct storage and management of medicines in inpatient areas.

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 progress with the CQC Action Plan and the focus of further work.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	14 Sep 2022	
Board of Directors	27 Sep 2022	
Quality Committee	3 Oct 2022	

Summary Position

Outcome	Position	Actions/ Metrics	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 in the A and E department, although we not yet have audit data for inpatient areas. A Trustwide audit will be done in October. The quality support visits provide significant assurance in all areas except Maternity. There has been a significant uptake and completion of all training, but JSET compliance data are not yet available.		
Outcome 2: We are assured that our staff are competent in assessing mental capacity and lawfully deprive patients of liberty	Actions are complete. Audit data demonstrate compliance with MCA in relation to DoLS referrals, but there are no compliance data in relation to other types of decision. Quality support visits demonstrate assurance in most areas regarding 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 increasing and reviews have found that the majority of those with MH concerns have had appropriate attempts at de-escalation prior to the use of restrictive practice. The overarching training plan has been approved and there is a clear timescale for implementation.		N/A
Outcome 4: We have embedded evidence-based interventions to reduce falls	New risk assessment has been launched in all areas. Although we do not yet have audit data to show impact on compliance, quality support visits show positive assurance in most areas. For wards with the highest falls, documentation of lying and standing blood pressures has improved but plateaued at around 65%. Actions in relation to walking aids are delayed.		
Outcome 5: We recognise and escalate patient deterioration promptly	Positive assurance received via quality support visits and the majority of wards are now displaying deteriorating patient bleep holder information, although there remain some gaps in relation to safety huddles. Audits of compliance have commenced.		
Outcome 6: We ensure we individualise and meet the needs and preferences of patients	Dignity champions are in place on all wards and the standardised intentional rounding document has been rolled out to 12 priority wards. A "What matters to you" training video has been produced and training completion on 12 priority wards is almost 50%. Assurance from quality support visits is positive.		
Outcome 7: We are assured that we manage medicines safely	Actions are delayed and where available, metrics are not showing improvement. Quality Support Visits demonstrate that two-thirds are rated amber or red.		
Outcome 8: We are assured that we manage hazardous substances safely in clinical areas	Quality support visits have shown that there have been improvements in storage of chemical products however COSHH risk assessments are out of date in some areas.		
Outcome 9: We are assured that we have adequate nurse staffing levels	All initial actions are complete and Registered Nurse Care Hours per Patient Day (CHPPD) are now routinely reported to TEG and HR&OD. Progress continues with improving compliance with embedding daily staffing board completion across the organisation.		
Outcome 10: We are assured that staff are trained to do their jobs	Mandatory and Job Specific Essential Training performance is over 90% at Trust level and quality support visits are providing high levels of assurance. Systems are in place to agree new and ratify existing subjects, and work is underway and on target to identify and agree local JSET subjects.		

Outcome	Position	Actions/ Metrics	QSV RAG
Outcome 11: We keep patient records up to date, secure, confidential and accurate	All initial actions are complete and staff training is ahead of target. Quality support visits have found significant gaps in assurance suggesting that secure management of patient records is not fully embedded.		
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 delayed. Compliance with hand hygiene audit and submission of commode audits have improved but are below target. Quality support visits for the 12 priority wards provide some assurance.		
Outcome 13: We are assured that incidents are consistently reported and harm accurately assessed	All initial actions are complete and performance against metrics is positive with a significant and sustained improvement in incident uploading times to NRLS. Quality support visits suggest a mixed picture.		
Outcome 14: We are assured that staff learn from incidents to prevent them happening again	Initial actions are now complete and information is now available via the intranet. Further work is required to embed this. Findings from Quality Support Visits have been varied.		
Outcome 15: We know and take action in response to our immediate performance and risks	All actions are now complete with clear oversight for ongoing assurance.		N/A
Priority workstream - Safety Huddles	Feedback from clinical areas remains generally positive and revisits to phase 2 wards have shown good progress. Engagement from nursing staff is excellent, although engagement of other staff is variable.		N/A
Priority workstream - Ward Boards	Quality Boards fully installed on 12 priority wards & Jessop Wing with Trust-wide roll out near completion. Feedback via Quality Support Visits suggests further work is required to fully embed these processes.		N/A

Outcome 1: Mental Health needs are identified and actioned

Progress against actions

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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- revised date of 31 Oct 2022 The target date will not change as the audit is not planned until October. Audits within AED will continue weekly.	On track	Focus on DMHRA at breakfast clubs for nursing staff and DMHRA training- one to one feedback given by senior nursing staff given to those staff members with incomplete documentation/risk assessment. Continuing improvement seen.	% of patients referred on to liaison mental health or reason not referred documented	100% (in ED and AMU during May 2022)	Target: 100% Actual: 100%	Target: 100% ED 100% AMU 100%	Target: 100% Actual: 100% AMU 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: 65% Actual: 75%	Target: 75% ED 80% AMU 100%	Target: 85% Actual: ED 88% AMU 82%
				% fully completed daily mental health risk assessments	50% (in ED and AMU during May 2022)	Target: 60% Actual: 70%	Target: 75% ED 80% AMU 90%	Target: 85% Actual: ED 88% AMU 82% * If not fully completed its usually absence of clear plan

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
1.2 - Introduce training in how to use the daily mental health risk assessment (DMHRA) and actions to take.	17/07/2022 - revised date of 30 Sept 2022	On track	Priority services for wave 1 • ED • AMU • Frailty • Osborn • SAC	% staff completed training	Training commenced June reporting not possible until end August.	N/A	N/A	Target: 50% Actual: Compliance against JSET not available. 362 staff have undertaken the training across all care groups at 31 August.

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Complete	JSET audience agreed on 5.8.2022 as B7 and 8 in- patient nurses and duty Matrons. Reporting against compliance will be available 30.9.2022.	Reduction in episodes of attempted ligature use	Appropriate improvement targets being identified using historic data	Ligature incidents Actual: 1 (May)	Ligature incidents Actual: 2 attempted ligature (June)	Ligature incidents Actual: 5 attempted ligature (August)

Quality support visits (as at 2 September 2022)

To date, 61 wards have been assessed against Outcome 1 through Quality Support Visits. Of these, 56 have been graded as 'green' in terms of assurance, 5 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

Wards	Grade	Explanation
JW - Labour Ward, JW - Norfolk Ward, JW – Whirlow, WPH - Ward 2, WPH - Ward 3		Wards are in the process of implementing Safety Huddles, which need time to embed.

Summary of progress against outcome

There has been a significant uptake and completion of all training. This has been achieved by a flexible approach. Weekly training on site to frailty staff, 2 bespoke sessions to Osborn staff plus 1-1 training to ED, AMU, SAC and Osborn to increase awareness and compliance with the DMHRA and clinical risk assessment and management. Work is being done with Maternity leads, perinatal MH team and STH MH Team to agree amendments to the form and training for the maternity pathway.

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	Jun progress	Jul progress	Aug Progress
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 E-Whiteboard 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	Complete	All STHFT Mental Capacity Team Actions completed	% 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: 100% Actual: 100%	Target: 100% Actual: 100% of DOLS forms submitted to the relevant Local Authority have an MCA.	Target: 100% Actual: 100% Ongoing oversight of metrics provided by: STHFT Mental Capacity Team
				% 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	Target: 100% Actual: 100% of appropriate DOLS authorisations have the DOLS icon selected	Target: 100% Actual:100% Ongoing oversight of metrics by STHFT Mental Capacity Team

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Complete	The STHFT Mental Capacity Team has visited 63 of the 67 wards inspected by CQC. The remaining 4 wards (all Jessop Wing Wards) will be visited by the Mental Capacity Team once safety huddle sare established.	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.	Actual: 59.7%	Target: 100% Actual: 89.55%	Target: 100% Actual: 94% Ongoing oversight of metrics by STHFT Mental Capacity Team
				% of patients who lack capacity to consent to care and treatment will have documented timely and decision specific capacity assessments.	Data available June 2022	Target: 100% Actual: 100% 100% of DOLS referrals sent to the relevant Local Authority had MCA recorded	Target: 100% Actual: 100% of DOLS referrals sent to the relevant Local Authority had MCA recorded	Target: 100% Actual: 100% Ongoing oversight of metrics by STHFT Mental Capacity Team

Quality support visits (as at 2 September 2022)

To date, 60 wards have been assessed against Outcome 2 through Quality Support Visits. Of these, 54 have been graded as 'green' in terms of assurance, 4 amber, and 2 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

Ward	Grading	Explanation
JW - Labour Ward, RHH - O1, RHH - P3, RHH - Q2		No safety huddles implemented. Nursing staff do not undertake care capacity assessments (done by medical staff) Observed DOL's icons e-whiteboard for patients without DOL's in place
NGH - BREARLEY 4, SPARC (Beech Hill)		Out of date DOL's in place and no documentary evidence of best interests meeting DOLS paperwork not scanned into System One.

Summary of progress against outcome

The Mental Capacity Team has developed Action Cards for Mental Capacity Assessment and updated the Action Card for Deprivation of Liberty Safeguards and circulated to Senior Sisters and Charge Nurses, All Matrons and All Nurse Directors on 26.08.2022.
The Mental Capacity Team has developed a Deprivation of Liberty Safeguards Process / Standard Operating Procedure setting out the responsibilities for processing and monitoring Authorised Deprivations of Liberty, including the need to review a DOLS request to extend the duration of the urgent authorisation for a maximum of a further seven days when it expires.

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

Progress against actions

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Original actions completed Further actions underway to embed into practice	Increasing numbers of reports submitted regarding restrictive practices. STH MH team has access to Datix and are providing feedback and supporting learning to teams.	Number of Datix and associated investigations completed	N/A	Actual: 8	39 completed	45 completed Ongoing oversight of metrics provided by: MHSG
				Themes and areas identified for increased training through review of data	N/A	N/A	N/A	Ongoing oversight of metrics provided by: MHSG

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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 – revised date 4 October 2022 (for security staff)	Delayed – revised date of 4 October 2022 with a clear plan in place	Training plan approved by TEG and Learning and Development leading on implementation.	% of relevant staff who have completed traning	Training commenced, final session taking place 5, 6, and 7 July	N/A	N/A	100% security staff have completed day 1 of training. Day 2 (restraint/clinical holding) will be completed by 4th October

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress

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 – revised date 27 September 2022 (Sept Board meeting)	Data for IQSR on track	Informatics team processing information from Datix for ISQR, and use of restrictive interventions will be routinely discussed in clinical governance meetings.	Data from Datix and learning from these to be collated and routinely discussed each quarter	N/A	N/A	N/A	N/A

Summary of progress against outcome

Increasing numbers of Datix being completed for episodes of restrictive practice. STH MH team are discussing each incident at AMU and ED clinical governance huddles. The MH team has found that the majority of patients with MH concerns have had appropriate attempts at de-escalation prior to the use of restrictive practice.
A plan for Restraint Reduction Network Approved training has been approved for senior nursing staff in the highest risk areas in the trust using a key trainer model. Learning and development are leading on implementing this and will employ a band 8 and band 6 staff member to become key trainers and to oversee the training plan.
Data already available from Datix for IQSR and review of clinical governance meetings will be carried out.

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

Progress against actions

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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– revised date 12 September 2022	Complete – updated FRA At risk of delay	Falls risk assessment form launched across STH including ED and inpatient areas, in the process of being added to metavison and System 1 for SPARC. Assessment area data (AMU/SFU) for risk assessment within 6 hours of admission was over 80% Completion of assessment on transfer within 6 hours is 30%	% completion of weekly risk assessment reviews	No data available	Target: 65% Actual: 87%	Target: 80% Actual: not yet audited since new document launch	Target: 80% Actual: no data
				% completion of falls risk assessment in ED	No data available	Target: 65% Actual: No data available as yet	Target: 80% Actual: No data available as awaiting launch	Target: 80% Actual: no data as yet as only been live since 15 August

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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– revised date 12 September 2022	At risk of delay	New Falls Risk Assessment rolled out, however awaiting IS to confirm if this data is able to be obtained from the RA. Training on supply and fit of walking aids is ongoing on SFU led by FDRT SAC is awaiting support of new falls educator as ATS are unable to release PTs to provide training	% of relevant patients with walking aid available on assessment units	No data available	Target: 50% Actual: no data as yet	Target: 65% Actual: no data as yet	Target: 65% Actual: no data as yet
				% of staff trained on supplying and fitting walking aids	No data available	Target: 45% Actual: no data as yet	Target: 60% Actual: no data as yet	Target: 60% Actual: no data as yet

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress

4.3 - Ensure patients at risk of falls have lying and standing blood pressure documented.	17/07/2022– revised date 12 September 2022	On track	Weekly audit and sharing of educational video ongoing average completion rate for August is 64% Actual data: • Audit starting 3.8.22 – 62% • Audit starting 10.8.22 – 68% • Audit starting 17.8.22 – 62%	% of patients who have lying and standing blood pressure monitored	No data available	Target: 50% Actual: 58%	Target: 65% Actual: w/c 20 July data = 70%	Target: 65% Actual: 64%

Quality support visits (as at 2 September 2022)

To date, 62 wards have been assessed against Outcome 4 through Quality Support Visits. Of these, 56 have been graded as 'green' in terms of assurance, 4 amber, and 2 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

JW - Labour Ward, NGH - ACCIDENT AND EMERGENCY, NGH - SAC / HUNTSMAN 8, WPH - Ward 2	Amber	Safety huddles not yet implemented. Confused patient deemed to be a falls risk being nursed on a trolley with a cotside in situ. Not a 7 steps safety huddle - fedback to Sister and Matron
NGH - HUNTMAN 3, RHH - CIU (P1)	Red	No huddles in place No falls observed, however, staff that were asked did not know about the falls pack on ward CIU (P1)

Summary of progress against outcome

Good progress has been made with the update of the Falls Risk Assessment with excellent engagement from clinicians and digital team. Work is in progress with information services to extract compliance data and remove need for clinical teams to undertake audits. The walking aid action is a priority although stalled in august due to operational pressure and leave. Compliance with lying and standing blood pressure has plateaued at mid-60%. Interviewing for a falls educator 5th September. Feedback from the QSVs to be fed back at the next operational falls meeting with the local falls leads.

Outcome 5: We recognise and escalate patient deterioration promptly

Progress against actions

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
5.1 - Introduce a deteriorating patient bleep holder on all inpatient wards to ensure a first point of escalation is identified.	31/05/2022 revised date 30/06/2022 revised date of 30/09/2022	On track	56 wards displayed deteriorating bleep number on e-whiteboard	% of wards with deteriorating patient bleep number visible	1 ward had deteriorating patient bleep number visible	Target: 60 wards Actual: 30 Wards	Target: all inpatient wards 60 wards Actual: 43	Target: all inpatient wards 60 Actual: 56

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
5.2 - Include deteriorating patient check and challenge in safety huddles.	31/05/2022	Complete	4 wards partial (amber) compliance, 52 fully compliant	Evidence of early identification and escalation of deteriorating patient	No data available	Target: all inpatient wards Actual: 27	Target: all inpatient wards Actual: 44	Target: all inpatient Actual: 56

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Complete	ID wards included in pilot	% of relevant patients with documented evidence of early identification and escalation.	Trial on 2 wards in May 2022 3 wards currently involved in pilot	N/A	N/A	ID wards included in pilot Ongoing oversight of metrics provided by: DPC

Quality support visits (as at 2 September 2022)

To date, 64 wards have been assessed against Outcome 5 through Quality Support Visits. Of these, 58 have been graded as 'green' in terms of assurance, 6 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

Wards	Grading	Explanation
NGH - HUNTMAN 3, NGH - HUNTSMAN 4, NGH - ROBERT HADFIELD 1, RHH - CIU (P1), WPH - Ward 2, WPH - Ward 3		Observations consistently recorded on the whiteboard, although, one patient admitted with postural hypotension had not had their lying and standing BP recorded (Firth 7) Safety huddle does not currently include deteriorating patients/NEWS 2 triggering patients (Huntsman 5) Huddles not established (Palliative Care Unit) Mini ward round; not a bespoke safety huddle dedicated to the 7 domains in WPH

Summary of progress against outcome

- Audit of compliance with NEWS2 score commenced on 6 wards with the highest number of deteriorating patients. Findings from the audit presented and will form baseline for future audits in Sep/Oct 22 with results evaluated from the baseline data of this first audit.
- E- whiteboard deteriorating patient alert pilot extended to ID wards to provide a better understanding of how task management system is being used and establish standardised process.
- Safety huddle - roll out is progressing, including the 12 high risk wards. Over the next 3 weeks the operational delivery team will focus on ensuring that safety huddles are standardised and address the key risk factors.

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	Jun progress	Jul progress	Aug Progress
6.1 - Embed the use of "What Matters to you" and the individualisation of nurse care planning in the top 12 priority wards	12/09/2022	Action revised – on track for 12 September	Progress has been made with overall compliance for the 12 wards at 47.9%	To achieve 90% compliance with training completion for each RN responsible for care planning in the top 12 priority wards	(see ward table below)	N/A	N/A	Actual: 47.9%

Ward Name	Site	Compliance with individualised care plan training as at w/c 8 August 2022
Frailty Unit	NGH	34% ↑37%
G2	RHH	47% ↑100%
Q1 (now on H1)	RHH	60% ↔
AMU	NGH	0%
I1	RHH	100%
SAC	NGH	24%↑91%
Brearley 5	NGH	48%↑76%
Brearley 6	NGH	28% ↑57%
Brearley 7	NGH	24%↑100%
HU6	NGH	0%
HU7	NGH	0%

					Firth 2	NGH	54.5%			

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
6.2 - Implement the role of dignity champion across the Trust with the first priority focus "privacy and dignity".	01/06/2022	Complete	Champions in place across the Trust and now business as usual. Action to be removed from CQC Action Plan.	Dignity champions in place throughout the inpatient wards (in the first instance) 100% inpatient wards have an identified champion	N/A	100%	100%	100%

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
6.3 - Implement the new standardised intentional rounding document across the Trust.	18/07/2022	Complete	Action will be monitored via QUEST and the Ward Accreditation Framework. Action to be removed from CQC Action Plan.	% completion of intentional rounding document	Awaiting audit data	Roll out to 12 priority wards completed	N/A	N/A

Quality support visits (as at 2 September 2022)

To date, 64 wards have been assessed against Outcome 6 through Quality Support Visits. Of these, 61 have been graded as 'green' in terms of assurance, 3 amber, and 0 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

NGH - ACCIDENT AND EMERGENCY, NGH - CHESTERMAN 3, NGH - HUNTSMAN 4, NGH - HUNTSMAN 5, NGH - HUNTSMAN 7, RHH - G1		Call buttons out of reach for some patients Staff were not aware of the 'what matters to you' section of the care plan in Lorenzo Some inconsistencies around intentional rounding. Some patients observed did not have IR forms. Patients described significant delays with Nurse call buzzers being answered (up to 20 minutes in one instance), largely an issue during the night.

Summary of progress against outcome

Progress has been made across 7 of the 12 wards with 2 achieving 100%. Intentional Rounding is electronic throughout the entire organisation (except Beech Hill SPARC) and practice is monitored via an eWhiteboard report reviewed by the ward manager.
Dignity Champion role is now 'business as usual' and the new standardised intentional rounding document will be monitored via QUEST and the Ward Accreditation Framework.

Outcome 7: We are assured that we manage medicines safely

Progress against actions

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
7.1 - Ensure Safe Storage of medicines and medical gases • Improve compliance with Medicines Management Checklist (MMC) including gases, controlled drugs, crash trolley & associated kits expiry dates.	30/06/2022	Delayed – Revised date 31 August 2022	MMC compliance reports now available via QUEST although identified that N/A answers are being counted as non-compliant. Being investigated by Connexica. Medical gases: 91% clinical areas have been checked. 61% of areas are compliant with signage recommendations.	• % of areas completing Medicines Management Checklist (MMC) • % of areas showing 95% or over– compliance	Aug-Nov 2021 Manual audit (72% areas completing MMC, 86% of those reached 95% target).	Target: 95% Actual: not available	Target: 95% Actual: not available	Target: 95% Actual: not available

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
7.2 - Medicines Reconciliation • Undertake a deep dive into the current data to refine the methodology and identify areas for improvement, understanding of patient flow/demand and agree service-level KPIs.	01/06/2022	Complete	Ongoing monitoring of performance	% medicines reconciliation rates (< and > 24 hours)	Overall Med Rec Rate 65% Med Rec <24hrs = 37% Med Rec > 24hrs = 28% Data from May 2021 – April 2022 (12months)	Target: no longer defined nationally Actual: Overall = 74% <24hrs = 34% > 24hrs = 40%	Target: no longer defined nationally Actual: Overall = 75% <24hrs = 34% > 24hrs = 41%	Target: no longer defined nationally Actual: Overall = 74% <24hrs = 34% > 24hrs = 40%

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
7.3 - Medicines Administration • Eliminate all gaps in recording administration/ reason for omission on EPMA. • Collate and review current missed doses data relating to 'drug not available' (DNA) • Review stock holding (range and quantity) of medicines and adjust ward top-up lists accordingly for areas with high DNA rates and/or high stock requests • Further develop the Safety and Risk Dashboard to include details of missed doses related to critical medicines.	17/07/2022	Delayed – Revised date 31 August 2022	Stock review SOP to be launched w/c 12th September. Ongoing work on report from Information services as medication form does not display. Pharmacy to launch daily missed doses report once tested by information services (after 23rd August). Pharmacy continues to work with Information services to develop the 'medicines unavailable' dashboard.	% of "not recorded" doses	From Quest Apr-Jun 2020 = 3% Jun 2020 – May 2022 = 2%	Target: 0% Actual: 1.9%	Target: 0% Actual: 2%	Target: 0% Actual: 2%
				% of all prescribed regular doses omitted with recorded reason	Jan 2022 = 14.9%	Actual: June 2022 = 14.0%	Actual: July 2022 = 14.2%	Actual: 15%
				% of all prescribed regular doses omitted due to DNA	Jan 2022 = 1.4%	Actual: June 2022 = 1.4%	Actual: July 2022 = 1.4%	Actual: 1.3%
				% of prescribed regular doses of critical medicines omitted with recorded reason	Jan 2022 = 14%	Actual: June = 11%	Actual: July = 12%	Actual: 12%
				Proportion of supplies provided as stock outside of core top-up dates	Pending JAC data report build	N/A	N/A	N/A
7.4 Medication incidents • Identify the most common causes and trends • Produce a single action plan to address these with oversight from MSC	~~03/08/2022~~ 07/09/2022	On track	Draft strategy going to MSC 07/09/22	% of approved medication incidents graded moderate of above		Target: < 1% Actual: 0.45% (April - May 2022 data finally approved)	N/A	Next quarterly report due Oct 2022

Quality support visits (as at 2 September 2022)

To date, 64 wards have been assessed against Outcome 7 through Quality Support Visits. Of these, 22 have been graded as 'green' in terms of assurance, 18 amber, and 24 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

Wards	Grading	Explanation
JW - Neonatal Unit (NNU), NGH - CHESTERMAN 1, NGH - CHESTERMAN 2, NGH - CHESTERMAN 4, NGH - FIRTH 2, NGH - FIRTH 9, NGH - HUNTSMAN 4, NGH - HUNTSMAN 7, NGH - PALLATIVE CARE UNIT, NGH - ROBERT HADFIELD 3, NGH - ROBERT HADFIELD 5, RHH - E1/E2, RHH - G2, RHH - M2, RHH - N2, RHH - Q1, RHH - Q2, WPH - Ward 2	Amber	Keys hanging in drug cupboard door and room despite having key pad entry. Medication left on the side and staff that are not authorised to handle drugs accessing the medicines storage room. Drugs trolleys were observed unattended and unlocked. Drug cupboards unlocked. Drug fridge had not been locked. Crash trolleys not checked on a daily basis
JW - Labour Ward, JW – Rivelin, NGH - Acute Medical Unit (AMU), NGH - BREARLEY 1, NGH - BREARLEY 3, NGH - BREARLEY 5, NGH - CHESTERMAN 3, NGH - FIRTH 4, NGH - FIRTH 7, NGH - FIRTH 8, NGH - HUNTMAN 3, NGH - HUNTSMAN 5, NGH - HUNTSMAN 6, NGH - OSBORNE 1, NGH - RENAL UNIT E, NGH - RENAL UNIT F, NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 2, NGH - ROBERT HADFIELD 4, NGH - ROBERT HADFIELD 6, NGH - SAC / HUNTSMAN 8, NGH - VICKERS 2, RHH - F1, RHH - I1	Red	Inconsistencies in checking drug fridges and crash trolleys. No swipe access for room with IV fluids. Drugs cupboard unlocked, doors open and unattended. Fridge temperature not consistency recorded. Drug and injection cupboards unlocked and open. Drugs found on surfaces. Observed staff not authorised to handle medicines entering the room. Pharmacy returns box not locked. CD order book not secured

Summary of progress against outcome

Promotion of use of the medicine management checklists is key to improving compliance and providing assurance. Ongoing issues with Connexica being able to access STHFT server to correct glitch in compliance reports, logged with IT.

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

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
8.1 - Ensure domestic staff use and store cleaning chemicals safely.	09/05/2022 Revised date: 10/06/2022	Complete	Action complete	% of areas where cleaning chemicals stored appropriately.	N/A	All clinical inpatient areas now have lockable trolleys.	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
8.2 - Provide safe system of working in relation to frequently used chemical cleaning products within the inpatient area.	17/07/2022	Complete	Action complete	% of areas where cleaning chemicals are used appropriately	N/A	All 60 wards reported that some staff have had training in preparation and use of Tristel cleaning solution.	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
8.3 - Provide safe storage solutions for chemical products in the clinical areas.	17/07/2022	Complete	All wards that have been Identified as requiring a COSHH cabinet have been asked to purchase one and provided with the information and support to do so. Support visits are ongoing.	% of wards as identified as high risk which have electronic access to chemical storage rooms.	N/A	29 of the 59 wards had rooms that were securely locked (either sluice or domestic store)	N/A	N/A
				% of wards without secure door access to chemical cleaning products have a lockable COSHH cupboard for storing concentrated cleaning solution	N/A	23 of the 59 wards had COSHH cupboards. Total secure storage = 52/59 = 88% Target is 100%	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
8.4 – Undertake on-site audit visits of the clinical areas to ensure safe and effective use of Tristel. Outpatient areas to be included. Audit to be undertaken with decontamination colleagues and representative from Tristel with advise and guidance provided on safe use at each visit.	30/09/2022	On track	Audits commenced.	% areas visited	0%	N/A	N/A	N/A
				% compliance rate with audit outcomes	Not available yet	N/A	N/A	N/A

Quality support visits (as at 2 September 2022)

To date, 69 wards have been assessed against Outcome 8 through Quality Support Visits. Of these, 43 have been graded as 'green' in terms of assurance, 24 amber, and 2 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

Wards	Grading	Explanation
NGH - ACUTE MEDICAL UNIT, NGH - FRAILTY UNIT, NGH - BREARLEY 4, NGH - ROBERT HADFIELD 2, NGH - ROBERT HADFIELD 6, RHH - E1/E2, WPH - WARD 3, NGH - CCU, NGH - CF UNIT, NGH - FIRTH 7, NGH - HUNTSMAN 4, NGH - OSBORNE 4, RHH - L1, RHH - L2, RHH - O1, RHH - P3/P4, FIRTH 8, NGH - HUNTSMAN 2, NGH - HUNTSMAN 5, SPARC (Beech Hill), JW - NEONATAL UNIT (NNU), NGH - OSBORNE 3, NGH - CCU GITU, NGH - CC HDU		COSHH risk assessments out of date for review. No COSHH cupboard to store chemicals.
NGH - OSBORNE 2, JW – NORFOLK WARD		Some chemicals stored in locked domestic room, some stored in sluice which can't be locked, no COSHH cupboard available. COSHH risk assessments not available. COSHH risk assessments need updating. COSHH cupboard needs padlock

Summary of progress against outcome

Feedback from the quality support visits has been positive. There has been evidence of improvement in chemical storage practices in areas that have been revisited.

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

Progress against actions

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Practice now business as usual. Action to be removed from CQC Action Plan.	Meeting minutes with actions evident	Twice daily staffing meetings commenced 9th May 2022.	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
9.2 – Implement centralised prospective monthly roster review for inpatient areas – aligned to roster approval and publication dates.	07/07/2022	Complete	Metric reported monthly to TEG and HR&OD. Action to be removed from CQC Action Plan.	Staff on shift (assignment count) equally distributed across shift and day of the week in published rotas	>90% RN CHPPD (each site)	Commence monthly meetings with e-roster lead	RN Shift fill for CHPPD (June 2022): NGH: 91.47% RHH: 93.24% JW: 90.54% WPH: 87.05% Trust: 91.63%	Metric reported monthly to TEG and HR&OD

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
9.3 – Review and Refresh the planned/actual nurse staffing information boards and standardise completion across all clinical areas.	30/06/2022 – revised date 05/07/2022	Complete	Work to emend practice covered in action 9.4. Action to be removed from CQC Action Plan.	Boards in place and completed on a shift/shift basis	Phase 1 – 42% Phase 2 = 55%	Review ward compliance	As per baseline (audit complete 28th July)	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
9.4 – Embed consistent completion of Planned/actual staffing information boards across Phase 1 and Phase 2 wards, achieving >95% compliance in each area (utilising same baseline data)	14/09/2022	On track	Compliance of completion by site : • RHH – 75% • NGH – 80% • JW – 100% .	Achieving >95% compliance in completion of planned/actual staffing information boards across each area (utilising same baseline data)	Phase 1 – 42% Phase 2 = 55%			Target: 95% Phase 1-75% Phase 2 – 79%

Quality support visits (as at 2 September 2022)

To date, 62 wards have been assessed against Outcome 9 through Quality Support Visits. Of these, 47 have been graded as 'green' in terms of assurance, 11 amber, and 4 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

Wards	Grade	Explanation
JW – Rivelin, NGH - ACCIDENT AND EMERGENCY, NGH - CF UNIT, NGH - HUNTSMAN 4, NGH - HUNTSMAN 6, NGH - HUNTSMAN 7, NGH - ROBERT HADFIELD 2, NGH - VICKERS 2, RHH - L1, RHH - L2, RHH - M2		The Nurse staffing board not completed on day of visit Unable to find Nurse Staffing board at entrance to department.
NGH – AMU, NGH - BREARLEY 2, NGH - BREARLEY 5, NGH - SAC / HUNTSMAN 8		No staffing board on display and this does not appear to be part of the ward culture. There is still no designated Nurse staffing board. The board describing staff allocations for today did not include planned v actual staffing numbers as is required.

Summary of progress against outcome

Progress continues with improving compliance with daily staffing board completeness across the organisation. Further weekly visits and audits are planned in September

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 Jun Progress	31 Jul Progress	Aug Progress
10.1 - Complete a review of the current JSET provision to ratify core subjects to include: • MCA Level 2a, MCA Level 2b (DOLS), Oxygen Cylinder Training, NEWS 2, Safer use of Insulin, React to Red Develop a plan to agree directorate (local) and additional JSET requirements including: • Physical Restraint, Falls, Dementia, Learning Disabilities	31/08/2022	Complete	JSET Review Panel reviewed and signed off • Dementia • Self-harm (Ligature) Restrictive Interventions (Restraint) training plan agreed – 2 permanent posts to coordinate training across Trust with 16 train the trainer places in 2022 and 4 in 2023. ICB regional approach to Learning Disabilities to be introduced late 2022/early 2023. Completed JSET discussion with 21 of 38 Directorates. Action to be removed from CQC Action Plan.	• Progress against plan for ratifying core JSET subjects with sign off process complete. • Progress against plan to identify local (directorate) JSET.	No JSET reviews signed off at 17/5/22 Project plan developed 24/5/22	Target: 100% Actual: 100%	Target: 100% Actual 100%	Target: 100% Actual: 100%

Action	Target completion	Status	Update	Metrics	Baseline data	17 Jun Progress	31 Jul Progress	Aug Progress
10.2 - Monitor compliance rates across mandatory training and JSET performance by subject, directorate and staff group with a focus on non-compliant subjects: • Moving & Handling, Safeguarding Children, Safeguarding Adults, Prevent	10/06/2022	Complete	PREVENT level 2 national standard training evaluated and materials to be released October 2022. MT/JSET non-compliance reports provided to all directorates. Action to be removed from CQC Action Plan.	Performance data by: • Subject • Directorate • Staff group	Mandatory Training: 91%	Target: 90% Actual: 92%	Target: 90% Actual: 92%	Target: 90% Actual: 94%
					JSET: 88%	Target: 89% Actual: 89%	Target: 90% Actual: 90%	Target: 90% Actual: 93%

Action	Target completion	Status	Update	Metrics	Baseline data	17 Jun Progress	31 Jul Progress	Aug Progress
10.3 - Evaluate the current corporate and local induction to	10/06/2022	Complete	Fortnightly non-compliance reports incorporate new starters.	New starters compliant with	Mandatory Training: 91%	Target: 90% Actual: 92%	Target: 90% Actual: 90%	Target: 90% Actual: 95%

ensure new starters complete mandatory and JSET appropriate for their role.			Action to be removed from CQC Action Plan.	mandatory training and JSET.	JSET: 88%	Target: 89% Actual: 89%	Target: 90% Actual: 90%	Target: 90% Actual: 90%

Quality support visits (as at 2 September 2022)

To date, 64 wards have been assessed against Outcome 10 through Quality Support Visits. Of these, 57 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:

Wards	Grade	Explanation
NGH – AMU, NGH - BREARLEY 2, NGH - BREARLEY 5, NGH - HUNTMAN 3, NGH - HUNTSMAN 5		Limited computers on ward. Ward is very busy and short staffed, so difficult to release staff for training. It was reported that some staff are out of date with some MT topics. Some staff reported not having completed some mandatory training and job specific topics.
NGH - BREARLEY 1, NGH - HUNTSMAN 6		Three RN's on duty had been released from other clinical areas to support the ward. The Ward Manager did not hold a contemporaneous record of staff training nor could she access PALMS. Asked several staff if they were up to date with their MT topics and all reported that they weren't (apart from new staff nurse who had recently completed induction).

Summary of progress against outcome

Mandatory and Job Specific Essential Training performance at 90% or above. Systems in place to agree new and ratify existing subjects. Work underway and on target 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	Jun progress	Jul progress	Aug Progress
11.1 - Develop Health Records Policy that includes 'definition of Trust Health Record'.	31/05/2022	Complete	Policy approved by Health Records Committee. Action to be removed from CQC Action Plan.	Approved policy	N/A	N/A	N/A	No further action

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
11.2 - Commence role-based education and training for staff to reflect policy standards.	17/07/2022	Complete	Training available on Palms – compliance will be managed through JSET proposal (Action 11.4). Action to be removed from CQC Action Plan.	Target staff groups by role	N/A	Training developed	Trained 42% of clinical Staff, against a target of 20%	Target: 50% Actual: 50% Ongoing oversight of metrics provided by: Health Records Committee
				Training packages in place for each staff group and will be monitored on PALMS	N/A	Plan for training developed	Training for Admin & Clerical staff developed	Target: 50% Actual: 52%

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
11.3 - Audit effectiveness of training.	17/07/2022	Complete	Reviewed audit outputs agreeing re-training for targeted areas (Action 11.5).	Assess record keeping quality by role	N/A	Refined the audit methodology	Cross sample of audits from ED and	No formal target – Ward assurance

			Action to be removed from CQC Action Plan.				Wards on record keeping standards	visits provide enough feedback Ongoing oversight of metrics provided by: Unsure

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
11.4 - Develop health records training as a JSET	30/09/2022	On track	In discussion with Learning and development re: JSET process	JSET approved	N/A	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
11.5 - Review ward assurance audits and identify any further training themes	31/08/2022	Complete	No new themes identified. Targeted training underway. Visit to all red/ amber areas to be completed by the end of September	Training to clinical teams	N/A	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
11.6 - Review audit outcomes and feedback to clinical areas on record keeping standards	30/09/2022	Complete	Review complete. No modifications to training material.	Clinical areas to sign off feedback received and understood		N/A	N/A	N/A

Quality support visits (as at 2 September 2022)

To date, 64 wards have been assessed against Outcome 11 through Quality Support Visits. Of these, 28 have been graded as 'green' in terms of assurance, 22 amber, and 14 red. The wards graded as amber or red are detailed below, along with an explanation of the grading:

NGH - Acute Medical Unit (AMU), NGH - BREARLEY 3, NGH - BREARLEY 6, NGH - CF UNIT, NGH - CHESTERMAN 1, NGH - CHESTERMAN 4, NGH - FIRTH 3, NGH - FIRTH 4, NGH - PALLATIVE CARE UNIT, NGH - RENAL UNIT F, NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 3, NGH - ROBERT HADFIELD 5, NGH - ROBERT HADFIELD 6, RHH - CIU (P1), RHH - F2, RHH - G1, RHH - M2, RHH - O1, RHH - P3, RHH - Q1, SPARC (Beech Hill)		Loose sheets slotted in patient records. Notes kept in a side room without a door. Unsecure notes trollies. No appropriate arrangements for securing notes. Nursing records e.g. NEWS charts, intentional rounding forms hanging in corridors outside rooms
NGH - BREARLEY 1, NGH - FIRTH 2, NGH - FIRTH 8, NGH - FIRTH 9, NGH - HUNTMAN 3, NGH - HUNTSMAN 5, NGH - HUNTSMAN 6, NGH - HUNTSMAN 7, NGH - OSBORNE 1, NGH - ROBERT HADFIELD 2, NGH - ROBERT HADFIELD 4, NGH - SAC/HUNTSMAN 8, NGH - VICKERS 2, RHH - I1		No lockable notes trollies or designated lockable room for patient records to be stored. Laptops left unattended whilst logged in. Patient record stored in ring binders separate to notes folder. Notes left unattended on Nurse station. Observed patient identifiable data on a handwritten white board in public view and suggested this is moved.

Summary of progress against outcome

Training material developed and shared with staff. The practice of securely managing patient records is not embedded and further work is underway to target areas where compliance is low. Main issues are paper notes left accessible and smartcards left in unattended machines.

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	Jun progress	Jul progress	Aug Progress
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– revised date dependent on capacity of QUEST team.	Delayed	Awaiting QUEST capacity to upload the IPC Accreditation programme onto QUEST. Commode audit report developed. Hand Hygiene report developed	% of wards on schedule for submitting commode audits	Report being developed	N/A	N/A	Target: 100% Actual: 78.6%
				% of wards who are on schedule with submitting their Hand Hygiene audit	N/A	Target: 100% Actual: 47%	Target: 100% Actual: 59.6%	Target: 100% Actual: 67.9%

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
12.2 - Evaluate the scoring systems for all IPC Accreditation audits and implement a quantitative and transparent approach to scoring.	01/07/2022– revised date 30 November 2023	On track	Accreditation module has been updated and is available on the Accreditation platform. Changes communicated to ward staff and IPC Team. Plan for updated modules to move to QUEST is outlined in 12.1.	Review the Accreditation audit templates and update these with appropriate metrics (PH)	N/A	Completed for Hand Hygiene audit	N/A	N/A
				Update templates uploaded onto the Accreditation database and advertised to users (PH)	N/A	Templates uploaded onto the Accreditation database and advertised to users	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Complete	Peer review audits continuing.	Review the Accreditation audit list and determine which audits should be part of the peer review programme (PH)	N/A	Accreditation audits review complete	N/A	N/A
				CN office to develop a programme of matron peer review audits (LB)	N/A	Programme of Matron Peer Review audits developed	N/A	N/A
				Programme taken to NDs for implementation (LB & KJ)	N/A	Programme taken to NDs	N/A	N/A
				Peer reviews being undertaken as per the programme developed by CN's office	N/A	All areas to have one peer review before 17 July	52% of wards had review audit between 20 Jun and 17 Jul	75% of priority wards have had a peer review; 25% had IPC Team review
				System developed for identifying which submitted IPC Accreditation audits were undertaken by peer review (PH)	N/A	System developed	N/A	N/A

Quality support visits (as at 2 September 2022)

To date, 11 wards have been assessed against Outcome 12 through Quality Support Visits. Of these, 9 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
NGH - SAC / HUNTSMAN 8		Staff seen wearing masks under/on chin. One doctor wearing a wristwatch
NGH - FRAILTY UNIT		Staff seen wearing masks under/on chin. Two pharmacists seen wearing wristwatches. 1 side room had a makeshift sign advising gloves & aprons. 2 side rooms did not have any signage.

Summary of progress against outcome

All actions are on-going.

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	Jun progress	Jul progress	Aug Progress
13.1 - Introduce new and simplified harm grading descriptors and revised guidance to support this.	23/05/2022	Complete	Ongoing monitoring of metrics being overseen by Safety and Risk Committee (SRC)	% of audited incidents with accurate harm grading.	N/A	Audit completed	Base line data – 88% compliance	Target: >88%

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
13.2 - Implement a revised process to reduce time between incidents being logged on Datix and reported to NRLS.	01/06/2022	Complete	Ongoing monitoring of metrics being overseen by Safety and Risk Committee (SRC)	% of incidents reported to NRLS within the target timeframe.	N/A	Target: <21 Actual: 10 days	Target: <10 Actual: 8 days	Target: <10 days Actual: 8 days

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
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	Data now reflects minimal difference between June and July data. Data to be monitored one month in retrospect to allow for data lags, and overseen by Safety and Risk Committee (SRC)	Incident reporting rates	N/A	Target: >13.8 Actual: 14.4	Target >June Actual: 11.8	Target: > June Actual: 15.7

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
13.4 - Complete a rolling audit of 50 incident records per month to monitor compliance with the revised severity grading descriptors., and take any action as identified depending on the ongoing results	July 2023	On track	Audit ongoing, but is delayed due to capacity	% of audited incidents with accurate harm grading.	88%	N/A	N/A	Target: 95% Actual: TBC

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
13.5 - Monitor incident reporting rates (per 1000 bed nights for inpatient areas)	July 2023	On track	As per update in action 13.3	Incident reporting rates	13.8	N/A	N/A	Target:>June Actual: 15.7

Quality support visits (as at 2 September 2022)

42 wards have been assessed against Outcome 13 through Quality Support Visits. 26 have been graded as 'green', 14 amber, and 2 red. The wards graded as amber or red are detailed below:

Wards	Grade	Findings
NGH – AMU, NGH - BREARLEY 3, NGH - BREARLEY 7, NGH - CHESTERMAN 3, NGH - FIRTH 7, NGH - FRAILTY UNIT, NGH - HUNTSMAN 6, NGH - HUNTSMAN 7, NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 5, RHH - G2, RHH - Q1, RHH - Q2, WPH - Ward 2		Incident noted in patient record but not recorded on Datix - escalated to governance team. Brearley 7 clerical staff spoken to had never reported an incident, were not aware they could and described incidents of misfiling that could have been reported. Staff knew that the quality board was in situ on the ward but had not had opportunity to review information. Staff (other than senior staff) could not evidence learning from incidents without prompting. Some information on Quality Board was missing. Some staff did not know top three risks for the ward. Further development of the Safety Huddles required - needs a multi-professional approach
NGH - BREARLEY 4, NGH - CCU		The quality board had not been updated and there did not seem to be any system in place to support this. Top three risks were not displayed on the Quality Board. The staff, including Sisters, were not familiar with their top three risks or any action/s to mitigate them. The "you said we did" information was not displayed on the board.

Summary of progress against outcome

Progress with this outcome is on track and positive, with significant and sustained improvement in incident uploading times to NRLS.

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	Jun progress	Jul progress	Aug Progress
14.1 - Provide current accessible information via the intranet for sharing of learning from incidents, including never events.	01/06/2022 revised date 08/07/2022	Complete	Action complete and to be monitored via action 14.3	% 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	Jun progress	Jul progress	Aug Progress
14.2 - Pilot five-minute briefings in clinical areas to share learning.	06/05/2022	Complete	No update as action closed and superseded by action 14.4	Briefings delivered to clinical areas.	N/A	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
14.3 – Provide and promote current accessible information via the intranet for sharing of learning from incidents, including never events., and ensure it remains current	Dec 2022	On track	Information available on the 'Getting back on Track page' and this remains current and up to date	N/A	N/A	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
14.4 - Develop a central newsletter sharing information Trust wide	Feb 2023	On track	Bid for additional resource for PHCG agreed at TEG. Plan to develop a central newsletter by Feb 2023.	N/A	N/A	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
14.5 - Review the ward quality boards to consider how these can be developed to included Trust wide shared learning e.g. from Never Events	Dec 2022	On track	Further discussion to take place regarding potential for further changes.	N/A	N/A	N/A	N/A	N/A

Quality support visits (as at 2 September 2022)

42 wards have been assessed against Outcome 14 through Quality Support Visits. 26 have been graded as 'green', 14 amber, and 2 red. The wards graded as amber or red are detailed below:

Wards	Grade	Findings
NGH – AMU, NGH - BREARLEY 3, NGH - BREARLEY 7, NGH - CHESTERMAN 3, NGH - FIRTH 7, NGH - FRAILTY UNIT, NGH - HUNTSMAN 6, NGH - HUNTSMAN 7, NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 5, RHH - G2, RHH - Q1, RHH - Q2, WPH - Ward 2		Incident identified in patient record, but not recorded on Datix - escalated to governance team. Brearley 7 clerical staff spoken to had never reported an incident, was not aware they could and described incidents of misfiling that could have been reported. Staff knew that the quality board was in situ on the ward but had not had chance to review the information. Staff (other than senior staff) could not evidence learning from incidents. Information on the Quality Board was missing. Staff did not know top three risks for the ward. Further development of the Safety Huddles required - needs a multi-professional approach
NGH - BREARLEY 4, NGH - CCU		The quality board had not been updated and there did not seem to be any system in place to support this. The top three risks were not displayed on the Quality Board. Staff, including Sisters, were not familiar with top three risks or any action/s to mitigate them. The "you said we did" information was not displayed on the board.

Summary of progress against outcome

Ongoing work required to promote information on boards and have assurance that staff learn from incidents, which is a cultural change. The adoption of the Patent Safety Incident Framework will support going forward.

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	Jun progress	Jul progress	Aug Progress
15.1 - Escalation process from Jessops Wing services, through Clinical Ops, to First and TEG on-call agreed.	01/06/2022	Complete	Compliance has improved for August, with only one afternoon sitrep not circulated. No further audits undertaken. Ongoing oversight of compliance will be at the monthly Directorate Oversight Group where it will be a standing agenda item from 06/09/2022.	% compliance with twice daily information flow from directorate to Clinical Ops	No evidence of regular escalation prior to April 2022	Target: 75% Actual: 80.6%	Target: 100% Actual: 93.5%	Target: 100% Actual: 98.38%
				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	Jun progress	Jul progress	Aug Progress
15.2 - Directorate Operational Leads flag immediate operational risks to Virtual Operational Support Room/Clinical Ops Lead and/or daily huddle.	01/07/2022	Complete	Virtual Operational Support Room and associated sitreps is part of core business of Clinical Operations. Practice will be regularly reviewed, and any changes to process/ learning shared at Operational Management Group (OMG) Meetings held with representatives from Care Groups on a weekly basis.	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	Jun progress	Jul progress	Aug Progress
15.3 - Triangulation of risks raised at monthly Performance Management meetings with directorate risk registers and organisational performance.	01/07/2022	Complete	Any risks that are raised at PMF meetings will continue to be recorded in the notes and escalated via Performance and Caseload Oversight Group (PCOG)	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

All actions are now complete with clear oversight for ongoing assurance.

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

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
C1.1 - To ensure patients dietary requirement information is consistent with current recommendations and accurately documented. To ensure SLT embed new principles of working to include nutrition documentation review.	01/07/2022	Complete	Data with SLT and to follow Oversight to be review of incidents and annual review of the SOP via governance meeting	% of patients for whom nutrition information is documented on SPARC communication tools	Initial audit due w/c 23 May 22	Target: 85% Actual: 100%	Target: 85% Actual: 100%	Audit not completed in August. Ongoing oversight of metrics and swallow/nutrition incidents via governance meeting

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
C1.2 - To ensure SPARC are compliant with STH fire safety recommendations.	01/07/2022	Complete	All 3 metrics will be reviewed 6 monthly (triggered via datix to governance meeting): • risk assessment • fire wardens • evacuation equipment training	SPARC fire risk assessment updated including the completion of an annual fire drill	N/A	N/A	N/A	RA added to datix for oversight
				Fire wardens to be identified and trained	N/A	Target: 8 Actual: 8	Target: 8 Actual: 19	Target achieved last month
				% of staff who have completed evacuation equipment training	0%	Target: 50% Actual: 70%	Target: 50% Actual: 90%	% of staff trained in equipment remains at 90%, which is a level we will maintain Ongoing oversight of metrics by adding this to local JSET.

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
C1.3 - Skin integrity will be consistently assessed and managed using evidence-based practice.	01/07/2022– revised date of 31 October 2022	At risk of delay	Training on the updated skin integrity section of the care plan has started but low numbers through August due to annual leave and operational challenges. All staff made aware of changes made. F2F discussion needed to ensure clear understanding of changes and answer queries. Robust plan to deliver this during September	% of patients who have skin integrity assessment and management (purpose T trial site)	No data available	Target: 50% Actual: 100% for assessment completion Care plan still being updated	Target: 50% Actual: no data from July due to awaited transition to purpose T	No data for August

Summary of progress against outcome

Actions 1 and 2 completed and oversight to be built into routine business within governance meetings.
Action 3 has proved more challenging due to operational pressures - revising the care plan and rolling out training will have the biggest impact on patient care and outcomes

UEC Outcome 1: (Trust outcome 1) Mental Health needs are identified and actioned

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	Audit of 3 hourly safety huddle demonstrates that completion of huddles is compromised by busy department (number of patients in the department and lodged patients) and trauma patients in resus when NIC is absent for lenghthy period. New Safety Huddle documentation/daily assurance checklist, following feedback, is being trialled from 30th August. New, one patient per page, mental health rounding document introduced which allows more detailed recording of patient plan as part of safety huddles. This will be scanned onto patient notes.	Evidence of best practice with escalation to provide observers	Audit of 3 hourly safety huddle documentation shows a 68% completion rate	Target: N/A Actual: 68%	Target: 78% Actual: 76%	Target: 78% Actual: 71% Ongoing oversight of metrics provided by Monthly 'spotcheck' audits
			Audits demonstrate marked improvement in MH risk assessment in ED. Mental Health Professional Lead has been undertaking opportunistic training on DMHRA (Daily Mental Health Risk Assessments) with band 6/7s. All band 6/7s to be trained by end September – currently at 45%. Monthly ED Mental Health Improvement groups ongoing.		Audit of notes for completion of Mental Health Risk Assessments shows 48% of Risk Assessments are being fully completed in ED and 80% on AMU (Baseline data of 40 patients >4 weeks in May/June 2022)	Target: N/A Actual: 48% (ED) 80% (AMU)	Target: 63% (ED) 90% AMU Actual: 67% (ED) 92% (AMU)	Target: Actual: 82% for ED / 81% for AMU

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC1.2- Inclusion of reviewing all alerts in Lorenzo in induction and acting on them to ensure safety of patient.	17/07/2022– revised date of 31 Aug 2022	Complete	New Doctors have had training as part of induction. Audit indicates that documentation of acting on alerts remains low, although has reached the target of 10% increase from baseline, despite training at both Drs and Nurses induction and reminders as part of the Nursing and Consultant updates. Latest audit of 15 patient notes in August 2022 indicate that 40% had reference of alerts in notes.	% compliance with review and acting on alert notices	30%	Target: N/A Actual: 30%	Target: 40% Actual: 10%	Target: 40% Actual: 40%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC1.3- Monitor PLAN room Q shift & after patient use for ligature anchor points.	31/08/2022	Delayed – revised date of 31 Aug 2022	Audit for August 2022 indicates 69% compliance with documenting checking of Yellow Bay room 17 (PLAN standards room). All band 6 & 7 nurses who take charge of yellow bay have been made aware of importance of documenting physical check in July. **Action** Discuss with senior nursing team regarding adding room 17 check to morning NIC checklist. Speak with staff members to understand reasons behind not completing. New deadline of October 2022 to allow actions to be embedded with addition to NIC checklist.	Evidence of a safe environment	71% compliance with documentation of Yellow Bay Room 17 (PLAN room)	Target: N/A Actual: 71%	Target: 81% Actual: 71%	Target: 81% Actual: 69%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	Feedback given to staff on two incidents of Datix reports of ligature episodes in August. MHLT present at one safety huddle per day. SOP developed for stripping a cubicle to receive Mental Health patients, which will be taken to Clinical Governance and recorded in minutes during August 2022 to be circulated to staff.	Number of episodes of attempted ligature use	1 incident of ligature episode in May 2022	Actual: 1	Target: 0 Actual: 0	Target: 0 Actual: 2

UEC Outcome 3: (Trust outcome 4) We have embedded evidence-based interventions to minimise the risk of falls.

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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. Monitor that staff escalate if staffing is inadequate for good observation.	17/07/2022	Complete	Falls improvement group established with nursing team Falls Leads to identify improvement areas and implement an action plan. The following improvements have been actioned since last month: • New Falls Risk Assessment embedded in new Nursing Assessment documentation which is shorter and in line with the Trust wide falls risk assessment • Orderlies reminded to provide a call buzzer when transferring patients into teams. • Orderly representative has joined Improvement group • Planning to trial a 'Falls Risk' sign attached to patients' trolley in September Falls improvement group to meet w/c 29/08 August with representation from Orderly staff group. Orderly staff reminded w/c 01/08 that a buzzer is provided when moving patients into a bay. Plan for 10% increase monthly with increase to 80% seen in latest audits. Call buzzers being offered to patients - 66% in May, 83% in July. Meeting 10th August with Fraxinus about eWhiteboard falls status icon roll out in ED.	% compliance with Falls risk assessment audit	61% of Falls Risk assessments are completed	Target: N/A Actual: 61%	Target: 71% Actual: 80%	Target: 71 Actual: 75% Ongoing oversight of metrics provided by: AEM Project Manager

			% compliance with appropriate escalation of staffing issues. Increase in sickness, but adequate cover of the department has been maintained. No escalation required in June. Safe Staffing can be accessed centrally (monthly staffing return). Trust Nurse escalation policy followed when significant sickness absence (due to covid) and additional RN provided in line with policy.	% compliance with appropriate escalation of staffing issues		Target: N/A Actual: 100%	Target: 100% Actual: 100%	Target: 100% Actual:

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Removed L&S BP measurement in ED after discussion with Trust Falls Lead. New Trustwide Falls Risk Assessment implemented in ED in August.	% 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	Jun progress	Jul progress	Aug Progress
UEC3.3- Implement Falls Prevention Packs across ED & AMU – increase awareness by messaging "Yellow to Red Socks" initiative.	17/07/2022	Complete	**August update** Recent data indicates improvement to 78% compliance with red socks. Falls 23 in July 10 in ED 13 in AMU	% compliance with falls prevention packs & "Red Socks being used appropriately	In ED – 23% compliance with documentation of Red Socks	Target: N/A Actual: 23%	Target: 33% Actual: 60%	Target: 43% Actual: 78% Ongoing oversight of metrics provided by Falls Improvement group

UEC Outcome 4: (Trust outcome 5) We recognise and escalate patient deterioration promptly.

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC4.1- Reiteration of Triage Nurse induction to ensure visual check of waiting area each time they call a patient. Improve communication to remind patients to alert staff if feeling unwell, through triage, posters and 'ticker-tape-messaging'.	31/08/2022	Delayed – revised date 30 October 2022	Posters in waiting areas informing patients to notify reception if feeling unwell and/or in pain. Waiting room signage is nearly complete. Working to provide live waiting time information from CXAIR to waiting room. Business cards with QR code for patients to complete FFT survey delivered and given out by the Housekeepers. % positive rating increased to 74%.	% patient satisfaction scores related to experience of waiting and environment	71% positive rating	Target: N/A Actual: 71%	Target: 75% Actual: 68%	Target: 75% Actual: 74%
				Appropriate signage and patient information available 24/7	N/A	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC4.2- Proactive 07:30 – 19:30 waiting room monitoring by Streaming Sister stationed at Reception (June 2022- evaluation) Receptionist ‘floor walker’ to be stationed in waiting area as a point of information.	30/09/2022* recruitment of floor walker	At risk of delay	With introduction of streaming sister, proportion of walk-in triages avoided has increased by 25% and the average wait from walk-in to triage has reduced from 1hr 20 minutes in March 2022 to 45 minutes in August 2022. Long term funding for the role is being sought. The percentage of patients with NEWS>3 who have observations on time remains around 60%. Deteriorating Patient audit results shared with Band 6s and 7s and a deteriorating patient improvement group has been established. Improvement actions from this group include: • Deteriorating Training Day to target the most Junior staff • Badges to identify Team Leaders to be handed out by NIC • Simulation Wednesdays to be restarted with expansion of Education team. • Review of the Named Nursing SOP Action at risk if funding for Streaming Sisters is not available after August 2022	Evidence of early recognition of patient deterioration and prompt escalation	47% of the time, patients with NEWS >3 have observations on time / Escalation documented 20% of the time	Target: N/A Actual: 47% / 36%	Target: 60% / 46% Actual: 65% / 90%	Target: Actual: 60% / 80% escalation documented
UEC4.3- Ensure ED escalation cards are adhered to and visible implementation of checklist for Purple Escalation procedure.	17/07/2022	Complete	Patients transferred within 15 minutes from bed ready was 65% in August, a 5% increase from July and 8% increase from baseline. Time spent in purple escalation has increased monthly since November 2021 and highest at 90% in July Morning Operation Group minutes discussion of the previous day’s performance and risks to patient and staff safety, and whether an internal incident was declared.	% exit flow	62% of patients with bed ready to exit from department in 15 minutes	Target: N/A Actual: 62% bed ready to transfer within 15 minutes / median is 23 pts lodged per hour	Target: 72% Actual:60% / median 16 patients lodged for a bed per hour	Target: 72% Actual: 65% Ongoing oversight of metrics provided by: Project Manager, AEM

UEC Outcome 5: (Trust outcome 6) We ensure we individualise and meet the needs and preferences of patients

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC5.1- Ensure timely documentation and individualised nursing assessments following implementation of the Named Nursing process.	17/07/2022	Complete	New Nursing documentation implemented in ED from August 2022 79% of Nursing documentation front sheet fully completed. Increase to 63% of observations completed on time. 45% of intentional rounding forms fully completed. **Action** Survey planned for staff to feed back on new document and will shape the future CDC form.	% compliance with individualised patient care standards	Nursing Front Sheet completion is 47% Patient observations completed at regular intervals is 73% Intentional rounding is recorded 27% of the time	Target: N/A Actual: Nursing Front Sheet completion is 47% Patient observations completed at regular intervals is 73% Intentional rounding is recorded 27% of the time	Target: 10% increase **Actual** Nursing Front Sheet completion is 92% Patient observations completed at regular intervals is 60% Intentional rounding is recorded 40% of the time	Target: 10% increase from baseline Actual: Nursing Front Sheet completion is 79% Patient observations completed at regular intervals is 63% Intentional rounding is recorded 45% of the time

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	Improvement in documentation of food and drink being offered as a result of work by Trust Nutritional Lead at Nursing handovers and inclusion of reminders in the Matron update. Housekeepers are documenting offer on laminated sheet which is added to Lorenzo by nursing staff. Drink offered documentation has increased by 12%. Food offered has decreased by 3% Nutrition and Hydration improvement group meeting monthly to monitor progress. A 3 day of Hydration Stations in areas of department had positive feedback. Poster in waiting room informs patients of nearest vending machines and how to access hot food.	Evidence of nutritional guidance being used appropriately	52% of patients had documentation of drink offered 35% of patients had documentation of food offered	Target: N/A Actual: 52% of patients had documentation of drink offered 35% of patients had documentation of food offered	Target: 10% increase Actual: 67% / 56%	Target: 62% drink / 45% food Actual: 79% drink documentation and 53% food documentation

UEC Outcome 6: (Trust outcome 10) We are assured that staff are trained to do their jobs deliverable 24/7

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	100% of nurses undertaking triage have completed triage training - 12 trained since April, and 7 planned for October once eligible. By the end of 2022, 100% of eligible staff will be triage trained (64% of ED nurses)	% of relevant staff who have completed triage course	% of those eligible are triage trained	Target: Actual: 100%	Target: 100% Actual: 100%	Target: 100% Actual: 100%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC6.2- Complete a second cycle of the Safer Nursing Care Tool to identify the	24/07/2022	Complete	Mandatory training completion levels >90%. Educators to issue monthly update to operational management for	% staff completing mandatory training	90.38% staff completed Mandatory	Target: 90% Actual: 90.4%	Target: 90%	Target: 90% Actual: 90.4%

appropriate nursing-staff volume and skill mix for ED			ongoing oversight.		Training as of June 2022		Actual: 90.4% Mandatory Training	
			Second cycle of Safer Nursing Care Tool undertaken and results expected within 4-6 weeks of 29/7/22.	% staff skill mix as per national guidelines	N/A	Target: Actual:	Target: Outcome of the SNCT	N/A

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC6.3- Ensure staff are able to undertake both mandatory and job specific training to reach at least 90% coverage. Professional development training is now available for staff 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.	30/09/2022	At risk of delay	**August update** On track with Mandatory, JSET training and appraisals. Action plan being developed to increase appraisal rates. Compassionate leadership course available for staff in Autumn 2022. AEM staff are not mandated to have ALS/ILS training; bespoke BLS (Basic Life Support) is planned with weekly simulation sessions.	% compliance with appraisals and supervision	75% appraisal	Target: Actual: 75%	Target: 80% Actual: 79% Appraisals /	Target: 80% Actual: 79% (July)
				% staff acquiring national recognised qualifications	N/A	Target: Actual: 6 TNCC	Target: Actual: 6	Target: Actual: 6

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

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	Spot checks revealed 83% compliance with observation checklist. Most frequent issue is non-compliance with unattended computers logged in. Reiteration in September communications to Nursing and Medical staff of smartcard use and IPC standards.	% compliance with accurate and contemporaneous record keeping standards	52% compliance	Target: Actual: 52%	Target: 62% Actual: 86%	Target: 62% Actual: 83%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC7.2- Continued improvement against delivery of the latest iteration of the Emergency Care Dataset (ECDS)'.	17/07/2022	Complete	Use of new Clinically Ready To Proceed (CRTP) function has increased following ED Matron update and inclusion in Junior Doctors August induction.	Evidence from NHSE ECDS Dashboard measures performance against completeness and validity for each ECDS data field.	N/A	Target: Above average Actual: Above average	Target: Above average Actual: Above average	Target: Above Average Actual: Above average

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	17/07/2022- revised date 31 October 2022	On track	Behind schedule for Transfer of Care project due to a long term sick gap in the technical support for the project - implementation likely October 2022.	% ability to review pre-hospital care in near time	N/A	N/A	N/A	N/A

electronic transfer of this patient information between the YAS and STH ED EPR.								

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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- revised date 30 September 2022	On Track	Increase in compliance with IG training is around 2% each month and predicted deadline for 90% is end of September. Current data for 30th August is 89.7%, 2% increase since July.	% of staff compliant with IG training	83.13 % (April 2022)	Actual: 85.22%	Target: 90% Actual: 87.7%	Target: 90 Actual: 89.7

UEC Outcome 8: (Trust outcome 12) We are assured that our staff adhere to best IPC practice to minimise hospital acquired infection

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	Compliance with Cleaning schedules being checked and signed – 95% in Blue Team, 79% in Green Team, 91% in Yellow Team, 97% in CDU. 100% compliance with commode cleaning checks in August (baseline 75% June 2022) 95% compliance with cleanliness audit in July 2022. BAU Spot-checks being undertaken by NIC/ND/Matron and findings shared with IPC Team resulting in consistent AEM IPC accreditation.	% of equipment that is cleaned and checklist signed	N/A	Target: N/A Actual: 71% cleaning schedules checked and signed in Resus	Target: 90% Actual: 89%	Target: 90% Actual: 90.5%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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.	31/08/2022	Delayed – revised date 31 October 2022	66% compliance with correct wearing of PPE in August, included in Junior doctor induction. Further audit delayed until October 2022 to allow further communication and engagement with staff who are non-compliant.	% in all staff wearing correct PPE in line with ED SharePoint PPE Guidelines	N/A	Target: Actual: 75%	Target: 90% Actual: 70%	Target: 90% Actual: 66%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC8.3- Reminder at clinical and nursing handovers basic IPC: Bare below elbows, changing gloves and washing hands.	17/07/2022	Complete	IPC reminders at handovers and in ED Matron Newsletter (w/c 18/07). Compliance with basic IPC: Hand hygiene – 100%	% compliance with basic personal IPC	N/A	Target: N/A Actual: 75%	Target: 90% Actual: 100%	Target: Actual: 100%

UEC Outcome 9: (Trust outcome 13) We are assured that incidents are consistently reported and harm accurately assessed

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Complete	Monthly Datix themes fed back to teams in a "You Reported – We Acted" poster, during staff meetings, emails from ND to Matrons as part of QUEST and to education team.	% staff reporting safety concerns on Datix		N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
UEC9.2- Encourage all staff to report safety concerns via Datix or a conversation with Clinical Governance Team.	17/07/2022	Complete	Review of Datix reporting by staff groups undertaken. Nursing, Support workers, clinicians and clerical staff and orderlies complete moderate number of Datix. Housekeeping and domestic staff tend to raise issues with senior member of Nursing staff to complete Datix on their behalf and work is needed with this group.	Consistent improvement in MDT reporting safety concerns		Target: Increase in Housekeeper /Domestic Datix reporting	Target: Increase in Housekeeper /Domestic Datix reporting	N/A

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

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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 Medical Director (Operations) / DMD to review operational oversight of risk, issues and performance.	17/07/2022	Complete	AEM Project document produced to identify project aims, objectives and progress that will be reviewed and updated at AEM Executive for sign off in September.	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	Jun progress	Jul progress	Aug Progress
OGN 1.1- Ensure fetal monitoring (Antenatal & Intrapartum) is undertaken and recorded consistently reflecting NICE (2017) Intrapartum Care Guidelines (CG190	17/07/2022 – revised date of 30 September 2022	On track	• Fetal monitoring training compliance remains over 90% with ongoing monitoring. • A Fetal Surveillance Matron has been appointed who will develop and implement a full day fetal monitoring training programme in line with national guidance. • Further increase in compliance with Fresh Eyes to 82% • Findings from the rolling audit of Fresh Eyes continues to be fed back to staff in real-time and this will continue until fully embedded.	> 90% compliance with fetal monitoring (CTG and intermittent auscultation).	25/05 – 70% compliance	Target: 80% Actual:84.1%	Target: 90% Actual: 95.6%	Target: 90% Actual:94%
				>90% compliance with fresh eyes assessment.	Audit reviewed – new tool	N/A	Target: 90% Actual:73.4% (increase of 15% from 2021)	Target: 90% Actual: 82%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
OGN 1.2- Ensure maternal monitoring is undertaken consistently and documented.	17/07/2022 – revised date of 30 September 2022	On track	• Rolling weekly MEOWS audit on Postnatal wards and antenatal wards in progress • Three weeks data demonstrates sustained improvement in MEOWS compliance on all wards • Additional MSW on all AN ward shifts to ensure timely observations • Enhanced education for staff undertaken • Communication of compliance improvement shared with Teams on closed FB group • Current NEWTT audit data under analysis • New rolling weekly NEWTT audit adapting MEOWS template and methodology planned to commence September 2022	> 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	Target: 89.9% Actual: 82.56%	Target: 90% Actual: 90.5% Midwives 84.6% Medical	Target: 90% Actual: Midwifery: 90.5% Medical 71.1%
					Neonatal Life Support May 58%	Target: 65% Actual: 69.6%	Target: 75% Actual: 82.9%	August Training compliance figures not yet available
				>90% compliance with recording of MEOWS and NEWTT.	Audits MEOWS and NEWTT complete final reports awaited	N/A	N/A	Target: 90% Actual: Riv AN-82% Norfolk-86% Whirl- 92%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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– revised date of 5 September 2022	On track	• BSOTS records agreed at OGN guideline meeting • Staff training on new BSOTS inc SOP and process underway • Interim Estates work complete • Agreement at Triumvirate regarding reintroduction of paper records to reflect a complete narrative of the maternity pathway enabling full risk assessment at each care episode.	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 32 minutes (not a BSOTS standard).	Data not available	Target: ≥ 95% Actual: 93% Target: ≤ 30 mins Actual: 30	Target: 95% Actual: 96.04% Target: ≤ 30 mins Actual: 30

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	Jun progress	Jul progress	Aug Progress
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	Complete	The pathway has been reviewed and a risk assessment for administration of critical medicines has been approved by RVG.	Improved prescribing and administration of ongoing medications in labour ward triage.	16/20 (80%) critical medications were prescribed / had clinical reason why not (3). 10/13 (77.3%) critical medicines administered on time (One administered late due to patient request, one unavailable, and one administered 1h 15 min late)	N/A	N/A	N/A

Action	Target completion	Status	Update	Metrics	Baseline data	Jun progress	Jul progress	Aug Progress
OGN 2.2- Ensure compliance with the pathway for prescribing and administration of all ongoing medications in labour ward assessment unit (LWAU) (linked to BSOTS)	30/10/2022	On track	Information captured on QUEST and included on Maternity safety Huddle.	% critical medications prescribed, unless clinical reason why it was not.	80%	N/A	N/A	Data not yet available from QUEST
				% of critical medicines administered on time.	77.3%	N/A	N/A	Actual: 97%

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	Jun progress	Jul progress	Aug Progress
OGN 3.1- Complete Birth Rate Plus full assessment for maternity staffing and undertake a review against current maternity establishment.	30/06/2022– revised date of 19 August 2022	Delayed – revised date of 30 September	• Assessment complete • Midwifery & Operations Directors met with BR+ report authors to agree final version of report. • Awaiting meeting with Finance colleagues to agree next steps. Planned for 12th September. • Maternity funded establishment rebased to include Ockenden monies for b5&6 midwifery posts.	Staffing levels in line with "Safe Midwifery Staffing for Maternity Settings" NICE guideline (NG4) 2015	Reviewed twice daily recorded and shared via OGN SitRep	N/A	N/A	Target: Align BR + recommendations with rebased funded establishment and agree with finance.

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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	Action complete	Staffing levels in line with acuity 4 hourly (intrapartum areas) and 8 hourly elsewhere.	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	Jun progress	Jul progress	Aug Progress
OGN 3.3- Recruitment of relevant staff to all vacant posts.	17/07/2022– revised date of 30 September 2022	On track	• 19 NQM planned to commence in post September 2022 • 1 B6 Midwife returned to JW August 2022 • Trust agreed to increase IR midwife recruitment from 20-25 • Fetal Surveillance Matron post appointed to in July, planned to commence in trust November 2022 • NHSEI funded R&R pastoral support B7 commencing in post September 2022 • Midwifery Director submitted NHSE R&R Direct Support Offer action plan for assurance and sign off to Regional Maternity Team. • Recruitment for 8a Education Maternity Matron, Deputy HoM Operations & Workforce and 8C Head of Midwifery planned for September 2022	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	Target: All vacancies fully appointed. Actual: Approximately 57.92 wte vacancy

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
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– revised date of 30 September 2022	On track	• Further supplementary training for Matrons and band 7 ward leaders undertaken by BR+ • Matrons continue to produce monthly Red flag reports including analysis and actions.	Reduction in number of red flags	Targets to be set once baseline established	N/A	N/A	Target: 100% supernumerary Labour Ward Coordinator

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	Jun progress	Jul progress	Aug Progress
OGN 4.1- Implement the Maternity Governance Toolkit reflecting the Perinatal Quality Surveillance Model.	17/07/2022– 30 Sept 2022	On track	On track, monthly Maternity & Neonatal Safety Report presented at Board of Directors by Midwifery Director Clinical Director and Operations Director	A range of key indicators for the service reflecting the perinatal quality surveillance model.	Monthly board paper	Target: 100% Actual: 100%	Target: 100% Actual: 100%	Target: 100% Actual: 100%

Action	Target completion	Status	Update	Metrics	Baseline date	Jun progress	Jul progress	Aug Progress
OGN 4.2- Ensure senior oversight of audit results via the Directorate Quality Governance Group.	17/07/2022	Complete	Action complete	Audits are completed in a timely manner and robust actions are taken in response to findings	N/A	N/A	N/A	NA

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 phase 2 wards have been revisited and most areas are showing good progress with good nursing engagement. There is variable level of engagement across other disciplines. A Survey has been completed by Senior Sisters/Charge Nurses which is being reviewed. A self-assessment proforma is being created and results will be shared with the triumvirate to review, noting strengths and weaknesses and requesting an action plan for improvement. A Survey has been designed to obtain feedback from non-nursing colleagues, focussing on barriers to attendance. The QUEST question for safety huddles is live and will provide assurance as to whether MDT Safety huddles are occurring daily in that area. The implementation team continues to offer support to ward teams, and an action log and report are being created to describe the full implementation.
Priority Corporate Workstream - Ward Boards	Patient and visitor Ward Entrance Boards and staff Quality Boards are fully installed on 12 priority wards & Jessop Wing with Trust-wide roll out near completion. Processes have been built in to review the boards through Ward Accreditation and Quality Support Visits.

Appendix 2: Quality Support Visits - RAG rating by ward and outcome (at 2 September 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 1, Outcome 2, Outcome 4, Outcome 5, Outcome 6, Outcome 7, Outcome 8, Outcome 9, Outcome 10, Outcome 11, Outcome 12, Outcome 13 and 14 — Visit: 1 2 3

CORE SERVICE	SITE	WARD
PRIORITY WARDS FIRST WAVE		
Medicine	NGH	ACUTE MEDICAL UNIT
Medicine	NGH	BREARLEY 5
Medicine	NGH	BREARLEY 6
Medicine	NGH	BREARLEY 7
Medicine	NGH	FRAILTY UNIT
Medicine	RHH	G2
Medicine	RHH	Q1
Surgery	NGH	FIRTH 2
Surgery	NGH	HUNTSMAN 6
Surgery	NGH	HUNTSMAN 7
Surgery	NGH	SAC / HUNTSMAN 8
Surgery	RHH	I1
PRIORITY WARDS SECOND WAVE		
Medicine	NGH	BREARLEY 4
Medicine	NGH	CHESTERMAN 1
Medicine	NGH	ROBERT HADFIELD 2
Medicine	NGH	ROBERT HADFIELD 6
Medicine	RHH	E1/E2
Medicine	RHH	Q2
Medicine	WPH	WARD 3
Surgery	NGH	CHESTERMAN 3
Surgery	NGH	FIRTH 4
Surgery	NGH	HUNTSMAN 3 (TAU)
Surgery	RHH	F2
Surgery	RHH	N2
TIER 1 WARDS		
Medicine	NGH	BREARLEY 1
Medicine	NGH	BREARLEY 2
Medicine	NGH	BREARLEY 3
Medicine	NGH	CCU
Medicine	NGH	CF UNIT
Medicine	NGH	CHESTERMAN 2
Medicine	NGH	FIRTH 7
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 3
Medicine	NGH	ROBERT HADFIELD 4
Medicine	NGH	ROBERT HADFIELD 5
Medicine	NGH	VICKERS 2
Medicine	RHH	CIU (P2)
Medicine	RHH	L1
Medicine	RHH	L2
Medicine	RHH	M2
Medicine	RHH	O1
Medicine	RHH	P3/P4
Surgery	NGH	CHESTERMAN 4
Surgery	NGH	FIRTH 3
Surgery	NGH	FIRTH 8
Surgery	NGH	FIRTH 9
Surgery	NGH	HUNTSMAN 2
Surgery	NGH	HUNTSMAN 5
Surgery	RHH	F1
Surgery	RHH	G1
UEC	NGH	A&E
Medicine	WPH	WARD 2
Community	COM	SPARC (Beech Hill)
Maternity	JW	LABOUR WARD
Maternity	JW	NORFOLK WARD
Maternity	JW	RIVELIN WARD
Maternity	JW	WHIRLOW WARD
Maternity	JW	NEONATAL UNIT (NNU)