Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary
Report to the Trust Board
Being Held on 29 November 2022

Subject	CQC Action Plan 2022 – Update Report October 2022
Supporting TEG Member	Jennifer Hill, Medical Director (Operations)
Author	Sue Butler, Head of Patient and Healthcare Governance Andrew Timms, Compliance Manager Rachel Smith, Compliance Manager
Status[1]	Discuss

PURPOSE OF THE REPORT

To provide the Trust Executive Group with an update on progress against the priority workstreams under each of the five improvement programmes and areas of intensive support in response to the recent CQC re-inspection.

KEY POINTS

As reported last month, following CQC re-inspection and in discussion with NHS E it was agreed that a new approach was needed to ensure continued improvement, building on our achievements to date. The new approach incorporates a broader range of priority workstreams under the following five improvement programmes:

- Mental Health (mental health; mental capacity; and learning disability and autism)
- Fundamentals of Care (falls, deteriorating patients, medicines management, pressure area care, IPC and patient records)
- Quality Governance (Assurance reporting, risk, incidents, patient engagement, and care group governance)
- Well-led (Risk management, Fit and Proper Persons and Board Development)
- Workforce (training and staffing)

In addition, there are three improvement programmes for areas requiring intensive support:

- Urgent and Emergency Care
- Maternity services
- Specialised Cancer

Each improvement programme has now been summarised on a 'plan on a page' outlining key workstreams, immediate priorities, outcomes, and delivery dates. Each 'plan on a page' is included in this report along with the first monthly progress report, outcomes from Quality Support Visits, and key performance data.

For the intensive support programmes, a plan on a page has been developed for Urgent and Emergency Care and Specialised Cancer. A monthly update is included for Urgent and Emergency Care and monthly updates for Specialised Cancer will commence next month. Maternity Services is reported separately through a detailed monthly update to Quality Board and a monthly submission to CQC. New actions identified after receipt of the CQC inspection report will be incorporated into the appropriate improvement programme 'plan on a page'.

At the start of this report, each Improvement Programme has been given a RAG rating based on the level of assurance from Quality Support Visit data, performance data and progress against the plan. Two improvement programmes have been rated as green (Quality Governance and Well-led) and three rated as amber (Mental Health, Fundamentals of Care and Workforce). No improvement programmes have been rated as red.

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	

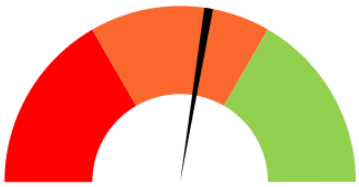
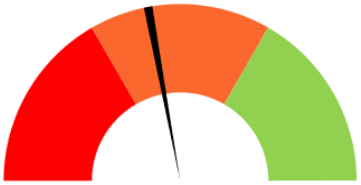
RECOMMENDATIONS

The Board of Directors are asked to note the progress made against each Improvement Programme over the past month and the rationale / mitigation for the corresponding RAG ratings.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	16/11/2022	
Quality Committee	21/11/2022	

CQC Action Plan – Improvement Programme Status

RAG Rating	Position
 Mental Health, Learning Disability and Autism	• Progress achieved on a number of priorities • Staff not always completing Datix when an episode of restrictive practice has taken place, continuing to engage with staff and AEM weekly governance huddles including an overview of restrictive practice episodes • Recent concerns expressed by CQC about patient monitoring after rapid tranquillisation • Awaiting training plan which will require Learning and Development Team support • Lack of engagement in some parts of the Trust with mental health training. New professional lead for mental health appointed who will support this. • Quality Support Visits show variable understanding from nursing staff of the MCA/DOLS process.
 Fundamentals of care	• Good progress made on a number of priorities supported by data, such as a reduction in falls per 1000 bed nights. • IPC Accreditation scheme audit modules gradually being updated but making slow progress. Reliant on QUEST staff and IPC Team capacity. • 55% of inpatient areas have completed the Medicine Management Checklist • Quality Support Visits continue to highlight areas of concern with regard to medicine management (cupboards and fridges not locked, unattended drugs, resus trollies not being checked) and patient records (laptops being left logged in and unattended, documents containing PID being left on nurses' station, notes trollies not being lockable).
 Quality Goverance	• Progress made in a number of areas. • Quality Boards are in place on wards and risk clinics being established. • Review of Care Group governance meetings commenced and central review of care group governance resource underway • Quality Support Visits have identified a number of wards that did not have up to date information on the Quality Board. This was fed back to ward staff at each visit.
 Well Led	• Well-led review underway and initial findings presented to Board of Directors strategy session. • Strategic Risk Deep Dive reviews commenced in line with the Board Assurance Framework operating principles. • A schedule of manageable workstreams to support adoption has been developed to ensure Board engagement.
 Workforce	• Directorates continue to receive monthly reports showing outstanding mandatory and job specific training. • Training performance currently 92% for both mandatory and job specific training. • Staffing priorities under development and will be presented in the December report.

IMPROVEMENT PROGRAMME PLAN ON A PAGE – MENTAL HEALTH, LEARNING DISABILITY AND AUTISM

Lead: David Black/ Avril Kuhrt Oversight Group: Mental Health Steering Group

Restraint and rapid tranquilisation

Areas of work

- Trust Policies
- Documentation and investigation of restraint and rapid tranquilisation.
- Training staff in appropriate use of force
- Monthly reports on data relating to the use of restrictive interventions

Immediate priority areas

- Use of Force policy and rapid tranquilisation policy
- Patient information on Use of Force
- Appointment of a Responsible Person and Deputy Responsible Person

These will result in

- Policy in line with Mental Health Units (Use of Force) Act 2018
- Information to patients to reduce further episodes and explain their rights
- Number of Datix and associated investigations completed
- Themes identified for improvement through review of data
- % relevant staff completed training
- Learning from incidents collated and routinely discussed each quarter

We will deliver by (date)

- Immediate priorities by Dec 2022

Supporting Strategies or Frameworks

- Mental Health Action Plan 2022-2023

Learning Disability & Autism

Areas of work

- Training and staff awareness
- Improving communication with patients, staff and carers
- Strategy for improvement in LD/Autism care

Immediate priority areas

- Accessible letters/ information for patients
- Use of hospital passports
- Recruitment to new LD posts
- Improve links with community services- LD specialist nurses

These will result in

- Meeting statutory requirements
- Improved understanding of reasonable adjustments
- Improved care and communication for LD/autism patients/ families

We will deliver by (date)

- Immediate priorities by April 2023

Supporting Strategies or Frameworks

- Learning Disability improvement standards for NHS trusts

Mental Health

Areas of work

- Daily mental health risk assessment (DMHRA) and training
- Ligature Risk Assessment training
- Parity of esteem and improving understanding of the links between physical and mental health

Immediate priority areas

- Trust wide implementation of DMHRA
- Anti-ligature work in A&E and AMU
- Scope the capacity of STH mental health team to support wards
- Appointment of Mental Health Programme Manager

These will result in

- Improved risk assessments (mental health and ligature risk) and actions trust wide
- Improved care to patients with MH needs
- % patients referred to Liaison Mental Health or reason not referred documented
- % of relevant patients for whom decision-making is documented regarding need for 1-1 care and observation.
- % fully completed DMHRA
- % staff trained in completing DMHRA
- Reduction in episodes of attempted ligature use

We will deliver by (date)

- Immediate priorities by April 2023

Supporting Strategies or Frameworks

- Mental Health Action Plan 2022-2023

Mental Capacity

Areas of work

- Documentation of decision-specific capacity assessments and best interest decisions.
- Support and guidance for ward staff on DoLS and MCA
- Lawful deprivation of patient after initial 7-day urgent DoLS authorisation has expired.
- Appreciative enquiry into application of MCA for hospital patients who lack capacity with no criteria to reside

Immediate priority areas

- Improve documentation of capacity assessment best interests' decisions.
- Involvement of families/carers in best interest decisions where appropriate

These will result in

- Meeting statutory requirements for MCA/DOLS/LPS
- Improved number of patients who lack capacity to consent to care and treatment will have clearly documented and timely decision specific capacity assessments and best interests' decisions.
- All patients who are subject to a DoLS authorisation will be identifiable via the Whiteboard.
- MCA Team will demonstrate evidence of and frequency of support visits to in-patient areas highlighted by CQC.
- Improved communication with families/carers - reduce complaints

We will deliver by (date)

- Immediate priorities by April 2023

Supporting Strategies or Frameworks

- Mental Capacity Act Action Plan 2022-23

IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL – MENTAL HEALTH, LEARNING DISABILITY AND AUTISM

Period covered: October 2022

WORKSTREAM	PROGRESS LAST MONTH	PLAN FOR NEXT MONTH
Restraint and rapid tranquilisation	• Use of Force Policy and updated rapid tranquilisation policy distributed to members of Mental Health Steering Group and other appropriate teams for review • Patient information leaflet in progress • All security staff completed RRN approved training in de-escalation and restraint • L and D planning commenced for NAViGO training for trainers	• To finalise and submit policies for approval as controlled document • Leaflet to be completed and reviewed by patient groups • Both the foundation (de-escalation) and foundation plus course (restraint holds/taking safely to the ground) due to run this month followed by an instructor course.
Learning Disability and Autism	• Guideline for looking after patients with LD and autism within AEM launched • Equipment to make reasonable adjustments available in the Emergency Department • 2 LD specialist roles advertised • Health passport training provided by Una Cunningham and Anita Winter	• Awaiting ICB plan for roll out of Oliver McGowan training (level 1 and 2) • Sign off of a trust guideline in making reasonable adjustments • Interviews for LD specialist roles • Visit to SCH to look at reasonable adjustments regarding clinic letters and administration around outpatient appointments and waiting lists • Reaudit of the use of Health Passport planned for November • Commencing development of LD and autism strategy
Mental Health	• DMHRA training and ligature training uploaded to PALMS • Agreement for a Mental Health Programme Manager	• Advertise for Mental Health Programme Manager • Awaiting replacement for professional lead for Mental Health

WORKSTREAM	OUTCOMES (including measures)	EVIDENCE
Restraint and rapid tranquilisation	• Episodes of restrictive practice documented on DATIX in October	• 38 episodes in October. 32 document de-escalation, in 4 cases de-escalation was not appropriate, in 2 cases no documentation of de-escalation attempts. AEM and ID two highest numbers of episodes. • 29 episodes document physical health monitoring, 6 reasons documented why physical health monitoring not possible, 3 nothing documented
Learning Disability and Autism	• Feedback from patients and those that support them • Training data for staff	• 110 staff have had training in the health passport
Mental Health	• Self harm and ligature episodes • Training data for staff • % fully completed DMHRA with appropriate actions taken	• 1 episode of attempted ligature; 4 episodes of self-harm in October • 33% completed DMHRA training; 69% completed in AEM. • Level 1 MH awareness 95.89% (100% within AEM)

WORKSTREAM	IMPACT ON PATIENTS	IMPACT ON STAFF
Restraint and rapid tranquilisation	• Less risk of harm from improved de-escalation • Improved information to patients to explain their rights and reduce further episodes	• Reduced risk of harm through unnecessary restraint • Reduced risk of injury carrying out restraint without appropriate training • Improved de-escalation skills and confidence in managing agitated/ aggressive patients
Learning Disability and Autism	• Improvement in providing reasonable adjustments • Improved communication with patients and those who support them • Better communication with community teams • Improved care for these patients	• Improved support once LD specialist roles in place • Confidence in managing patients with LD/autism • Understanding of the importance of communication with families/care staff
Mental Health	• Safer care for patients experiencing poor mental health	• Increased confidence in looking after patients with mental health problems

WORKSTREAM	RISKS	MITIGATIONS
Restraint and rapid tranquilisation	• Staff not always completing a DATIX when an episode of restrictive practice has taken place • Investigations and learning from incidents are not thorough and not being communicated to teams from governance teams • Some episodes are being recorded on DATIX inappropriately • Ethnicity not being documented on DATIX (cannot be mandatory for every DATIX and cannot be linked to Lorenzo)	• Governance teams to be aware when reviewing cases of violence and aggression to ensure that there are no missed cases that should have been documented as restrictive practice • AEM weekly governance huddles to include overview of restrictive practice episodes • Governance teams to feed back to teams when a DATIX not required (e.g. lorazepam used for alcohol withdrawal • Endeavouring to find a solution to this to avoid having to go through each DATIX manually
Learning Disability and Autism	• 18000 staff to train with a face-to-face strategy (level 2) • Feedback from patients and those that support them is lower than national average	• Awaiting plan from ICB but clearly will need to be managed through our L&D team •
Mental Health	• Lack of resource to push training • Mental Health Professional Lead (MHPL) left STH 19th October who was responsible for driving forward the Mental Health improvement work and audits, therefore a risk to the improvement work on Mental Health. • Lack of engagement in some parts of the trust	• DMHRA and ligature training available on PALMS as JSET • New professional lead for mental health appointed, once in post, key aim will be to develop understanding in other areas of the trust

Quality Support Visits

The table below presents the outcomes from Quality Support Visits over the past month for wards that have been rated as amber or red in terms of assurance for Mental Health. These issues were reported back following the visits.

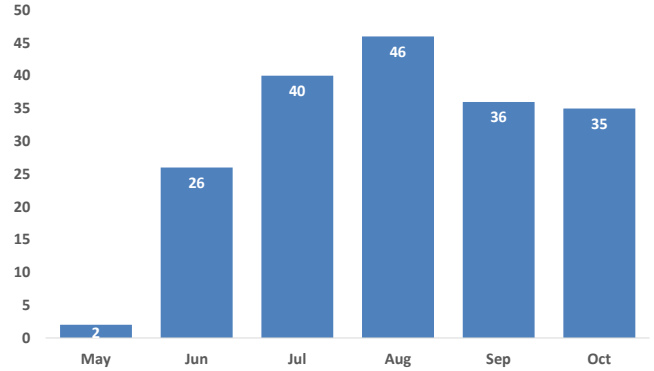
	Mental Health	NGH - CHESTERMAN 3	Medical staff do not attend Safety Huddles
	MCA / DOLS	NGH - ACCIDENT AND EMERGENCY NGH - SAC / HUNTSMAN 8 NGH - FRAILTY UNIT	Variable understanding of MCA/DOLS process by nursing staff. Suggested that they contact the MCA team for additional support with training to build confidence.

PERFORMANCE DATA – MENTAL HEALTH, LEARNING DISABILITY AND AUTISM

Period covered: October 2022

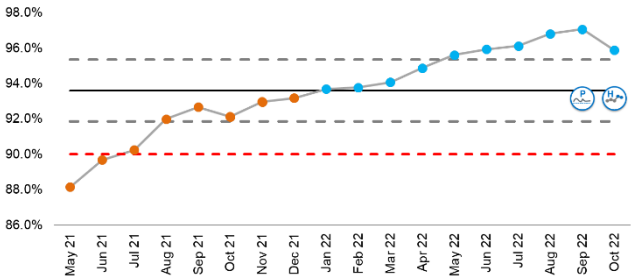
Restraint and rapid tranquilisation

No. of restrictive practice incidents per month



Mental Health

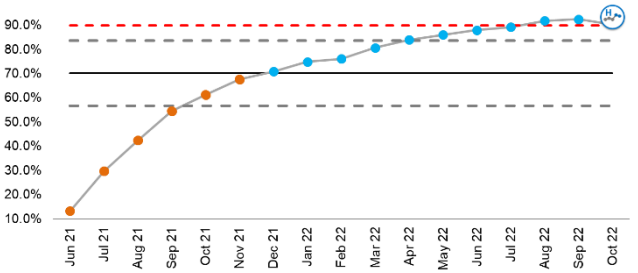
Mental Health Awareness Level 1 Training Compliance



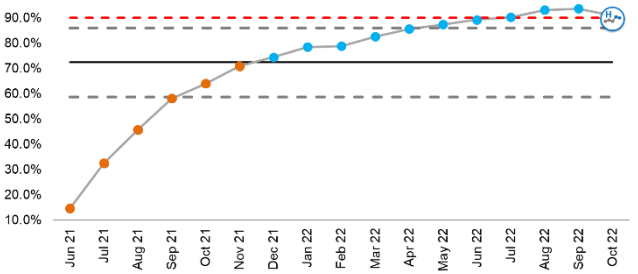
Trust target illustrated by red dash line --------

Mental Capacity

Mental Capacity Act Training Compliance



Mental Capacity Act (DOLS) Training Compliance



IMPROVEMENT PROGRAMME PLAN ON A PAGE – FUNDAMENTALS OF CARE (PART 1)

Lead: Chris Morley Operational Lead: Karen Jessop

Falls

Oversight Group: Falls Steering Group

Areas of work

- Falls risk assessments
- Walking aids availability in key areas
- Lying and standing blood pressure

Immediate priority areas

- Agree changes required by ED and initiate within Lorenzo form.
- Develope screencast version of walking aid training
- Continue weekly audit of L&S BP which includes education
- Falls Educator to commence in post to support and embed use of FRA, L&S BP and walking aid provision

These will result in

- 50% completion of weekly risk assessment reviews
- 40% completion of falls risk assessment in ED
- 50% of relevant patients with walking aid available on assessment units
- 50% of staff trained on supplying and fitting walking aids
- 70% of patients who have lying and standing blood pressure monitored

We will deliver by (date)

- 30 December 2022

Supporting Strategies or Frameworks

- NICE guidance - Falls in older people CG161
- RCP – falls prevention in hospital
- National Audit of Inpatient Falls (NAIF)

Deteriorating Patients

Oversight Group: Deteriorating Patient Committee

Areas of work

Introduce a deteriorating patient bleep holder on all inpatient wards
Include deteriorating patient check and challenge in safety huddles.
Test and introduce e-whiteboard alert for escalation of patient deterioration

Immediate priority areas

- Deteriorating bleep holder displayed in e-whiteboard
- Information services to produce fortnightly report to monitor number of wards compliance
- Deteriorating patient review as standard within safety huddles
- E-whiteboard alert and escalation form trial rollout to phase 1 wards
- Relaunch deteriorating patient study package

These will result in

- All inpatient wards to display deteriorating patient bleep holder on e-whiteboard
- Evidence of early identification and escalation of deteriorating patient
- Identify themes in delays to recognition and escalation of deteriorating patient

We will deliver by (date)

31/03/2023

Supporting Strategies or Frameworks

- NICE guidance-Acutely ill patients in hospital
- RCP- Sepsis recognition and diagnosis
- Deteriorating patient committee STH
- GPICS V2

Medicine Management

Oversight Group: Medicines Safety Committee

Areas of work

- Safe and secure storage of medicines and gases
- improve compliance with Medicines Management Checklist (MMC)
- Medicines reconciliation
- Medicines administration
- Medication incidents

Immediate priority areas

- Submit business case for Lead Nurse for Medicine Management
- Fridge temperature monitoring system for high-risk areas
- Evaluation of ambient temperature excursions
- Launch live dashboard for omitted critical medicines
- Investigate ‘not recorded’ doses
- Establish Controlled Drug Oversight Group

These will result in

- 100% of inpatient areas completing MMC
- 90% of inpatient areas showing ≥95% compliance with MMC
- Reduced incidents of wasted medicines/delayed treatment due to fridge failure
- Plan for preventing ambient temperature excursions in identified at risk areas
- Reduction in omitted doses of critical medicines
- 0% of prescribed doses with administration “not recorded”
- Wider awareness of and engagement with controlled drug issues

We will deliver by (date)

- April 2023

Supporting Strategies or Frameworks

- Medicine Code
- Temperature Management of Medicines Policy
- Controlled Drug standard operating procedures
- Medicines Safety Strategy

IMPROVEMENT PROGRAMME PLAN ON A PAGE – FUNDAMENTALS OF CARE (PART 2)

Lead: Chris Morley Operational Lead: Karen Jessop

Infection Prevention and Control

Oversight Group: Infection Prevention & Control Committee

Areas of work

- IPC Accreditation Programme on QUEST platform –
- Scoring systems for all IPC Accreditation audits
- Peer review. [COMPLETE]

Immediate priority areas

a) Transferring the Accreditation Programme into QUEST. The limiting factor is the capacity of the QUEST team to undertake this work.

b) Updating modules within the Accreditation scheme - deadline of Jan 2023.

- Assimilate into annual Trust IPC Programme to be monitored by the IPC Committee

These will result in

- Accreditation audit templates being reviewed and updated with appropriate metrics
- Accreditation audit templates uploaded onto Accreditation database for users
- Accreditation audits being reviewed and decision which audits will be part of peer review programme
- Commencement of matron peer review audits
- Peer review audits regularly submitted to Accreditation database

We will deliver by (date)

- a) will depends on Quest capacity – no date given to us by the Quest Team but possibly Dec 2022, b) Jan 23 c) Dec 2022

Supporting Strategies or Frameworks

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Hazardous substance management

Oversight Group: Safety & Risk Committee

Areas of work

- Safe use and storage of chemicals in all clinical and non-clinical areas
- Up to date COSHH risk assessments available in all clinical areas
- Updated COSHH policy and guidance

Immediate priority areas

- Identify and visit non-inpatient clinical areas
- Re-visit in-patient areas where improvement has been reported
- Audit of COSHH risk assessments in line with the COSHH policy and guidance.

These will result in

- 100% of all clinical areas will have received a quality support visit to advise on safe storage of chemicals.
- 100% of cleaning chemicals stored in line with the measures identified in the local COSHH Risk Assessment and meet the standards set in the Trust guidance document.
- 100% of wards without secure door access to chemical storage area will have a lockable COSHH cupboard for storing hazardous products.
- Tristel cleaning solution will be made up, used and stored in line with training and Trust guidance.

We will deliver by (date)

- 31/03/2023

Supporting Strategies or Frameworks

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Patient records

Oversight Group: Healthcare Records Committee

Areas of work

- Health Records Policy [COMPLETE]
- Role-based education and training [COMPLETE]
- Audit effectiveness of training. [COMPLETE]
- Develop health records training
- Review ward assurance audits [COMPLETE]
- Review audit outcomes [COMPLETE]

Immediate priority areas

- Continue to visit the 'red' wards identified with health records concerns
- Ongoing development of the Health Records training

These will result in

- Training package available for all staff,
- Training compliance monitored in PALMS
- Improved record keeping monitored by audit
- Improved ward safety around the digital and paper record, monitored by ward visits and audits

We will deliver by (date)

- 31/03/2023

Supporting Strategies or Frameworks

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IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL – FUNDAMENTALS OF CARE

Period covered: October 2022

WORKSTREAM	PROGRESS LAST MONTH	PLAN FOR NEXT MONTH
Falls	• ED Falls Risk Assessment changes agreed, and sent to Lorenzo form builder • Screen cast in development for measurement and issue of walking aids • Falls educator in post 31 October • Lying and Standing BP audit and education recommenced in October	• FRA for ED implemented • Educator commenced work on FRA, walking aid work and education round L&S BP
Deteriorating patients	• 61 wards have deteriorating patient bleep visible on e-whiteboard • The e-whiteboard alert is operational on E-Floor, Chesterman 3/4 and Firth 9 • Deteriorating patient screening tool revised and in practice	• Continue roll out of e-whiteboard alert across inpatient areas • Recruit deteriorating patient nurse
Hazardous Substances	• Completed 2 new compliance visits – Brearley 2 and Burns Unit • Completed 3 compliance re-visits – AMU, Huntsman 4, Huntsman 5	• Develop schedule of compliance visits of non-inpatient clinical areas • Undertake chemical storage compliance visits at Charles Clifford Hospital • Undertake compliance re-visit to JW in-patient wards and all outpatient areas • Follow up visits to areas flagged as red.
Infection Prevention and Control	• Transferring the IPC Accreditation Programme into QUEST is a long term project limited by capacity of QUEST team. • Updating modules within the Accreditation scheme re scoring underway (deadline Jan 2023). • The peer review of 4 aspects of the IPC accreditation programme continues. The matrons have a programme schedule of visits and confirmed process on inputting of data into the IPC data base • Assimilate into annual Trust IPC Programme to be monitored by IPC Committee –in IPC Programme for 2022/23	• Work with Connexica to transfer IPC accreditation programme to QUEST. • Test QUEST templates • Develop and expand peer review process to include IPC link nurse.
Medicine Management	• Reviewed job descriptions from other Trusts for Lead Nurse – Medicines Governance • Pharmacy and Laboratory Medicine to collaborate on joint business case for temperature monitoring system • Project to evaluate ambient temperature excursions registered with CEU and survey disseminated • Live dashboard for omitted critical medicines built and tested • Obtained terms of reference from other Trusts for Controlled Drug Oversight Groups	• Conclude description and business case for Lead Nurse – Medicines Governance • Conclude URS for temperature monitoring system to meet Pharmacy and Laboratory Medicine requirements • Collate responses to ambient temperature survey, review temperature logs on QUEST and visit areas with identified excursions. • Clarify queries on live dashboard for omitted critical medicines • Agree reporting structure for new Controlled Drug Oversight Group and agree terms of reference for STHFT
Patient Records	• Progressed the conversation around the Trust Heath Record training • Progress update to Healthcare Records Committee	• Schedule monthly ‘Red’ ward visits from November

WORKSTREAM	OUTCOMES (including measures)	EVIDENCE
Falls	• Reduction in falls per 1000 bed nights • L&S BP data, since restarted audit and education in October, patients who should have a L&S BP completed ranges from 67% to 83% • Level of escalation of those with a deficit in L&S BP ranged between 50% and 75%	• Falls data shows change from over 7 falls / 1000 bed nights March to May down to 5.7 falls / 1000 bed nights in September • L&S BP data demonstrates patients who should have a L&S BP completed ranges from 67% to 83%
Deteriorating patients	• Safety huddles to include deteriorating patient check • Testing of e-whiteboard alert functionality • Increased awareness of deteriorating patient bleep and e-whiteboard alert	• Quality support visits feedback • The e-whiteboard alert has improved the time in which deteriorating patients are clinically reviewed

Hazardous Substances	From the five wards visited over the past month:
	<u>Green rated wards</u>
	• Burns Unit - Good practice observed
	• Huntsman 5 - Good practice observed
	• Acute Medical Unit (Huntsman 2/3) - Re-visit found improvement with chemicals stored securely and COSHH risk assessments up to date
	<u>Amber rated ward</u>
	• Huntsman 4 - Chemicals stored on shelves and moved to COSHH cupboard
	<u>Red rated ward</u>
	• Brearley 2 - Relocated from RHH three days previously. No lockable domestic cleaning trolley available, no COSHH cupboard available. Re-visit required
		• Compliance rates for in-patient areas (81 wards visited)
		  ○ Green - 64 wards fully compliant
		  ○ Amber – 14 wards have secure storage but require updated COSHH assessments
		  ○ Red – 3 Norfolk Ward; General Critical Care (RHH); Brearley 2. Require secure storage.

Infection Prevention and Control	• Accreditation scheme audit modules gradually updated • Progress being made by QUEST and IPC Team re formatting the IPC audit modules for the QUEST platform	• Updated Hand Hygiene module on the current IPC Accreditation database • QUEST Team may be able to show you their work on formatting the Cleaning and Decontamination module for the QUEST platform
Medicine Management	• 55% of inpatient areas completed MMC • 32% of inpatient areas showed ≥95% compliance with MMC • 2 incidents of wasted medicines due to fridge failure • 6% prescribed critical doses omitted • 2% prescribed doses with administration ‘not recorded’	• QUEST compliance report • QUEST Medicine Management Question summary • Datix ref. W286073 and W38838 • Safety Risk and Quality Dashboard
Patient Records	• HRC Meeting Minutes	• Data from Information Services compliance audits of wards rated as ‘Red’ or ‘Amber’ through Quality Support Visits has demonstrated a significant improvement. Audits found laptops being left unattended on 13 wards (first visit) reducing to one ward (follow-up visit), and case notes being left unattended on five wards (first visit) reducing to no wards (follow-up visit).

WORKSTREAM	IMPACT ON PATIENTS	IMPACT ON STAFF
Falls	• Reduction in falls per 1000 bed nights over the last 6 months, which reduces the physical and psychological impact a fall has on a patient	• Reduction in falls reduces emotional impact on staff • staff time spent recording on DATIX or completing RCAs • The falls focus has given the operational falls group a 'new lease of life' and we are seeing enthusiastic clinical staff take a lead on improvements
Deteriorating patients	• Early identification of deterioration and escalation • Timely response and clinician review	• Education and training needs met • Staff familiar with e-whiteboard alert functionality • Staff have clarity of escalation process
Hazardous Substances	• Improved safety as potentially harmful chemicals are not accessible	• Staff awareness and knowledge of safe use and storage of chemicals improved following compliance visits.
Infection Prevention and Control	• Reduced HAI	• Matrons required to undertake peer review audits long term
Medicine Management	• Potential for harm if critical doses omitted, medicines administered which have been stored at the wrong temperature or treatment delayed due to fridge failure.	• Time to complete medicine management checklists • Time to change expiry dates on all stock medicines in event of ambient temperature excursion • Potential for harm due to misappropriation of medicines
Patient Records	• Security of the patient health record	• Clear guidelines on compliance standards whilst maintaining access to the patient health record

WORKSTREAM	RISKS	MITIGATIONS
Falls	• Falls educator is not up and running as quickly as planned • Lorenzo form not returned as quickly as planned	• Robust induction and guidance in place • Positive relationship with digital team
Deteriorating patients	• Delay in roll out of e-whiteboard alert due to digital support	• Base wards to highlight individuals who can support roll out on the 10 alerting deteriorating patient wards • Recruitment of deteriorating patient nurse
Hazardous Substances	• Potential for poor practice in areas not yet visited	• Schedule of compliance visits to non-inpatient areas agreed.
Infection Prevention and Control	• QUEST staff capacity to transfer modules to QUEST • IPC Team capacity to undertake review and updating modules	• Nil
Medicine Management	• Lack of assurance of compliance with pharmaceutical temperature monitoring and medicine security (RR ID 4568) • Fridge temperature excursion not identified resulting in administration of unsuitable medicine (RR ID 1178)	• Temperature Management of Medicines Policy and SOPs. Paper temperature log sheets. 4 monthly and annual checklists completed on paper and collated manually. Business continuity action card for refrigerator failure.

	• Delayed or omitted administration of a critical medicine (RR ID 2691)	• Approved codes for recording reason for omitted doses on EPMA and report available on Safety Risk and Quality Dashboard; JSET for medical and nursing staff on insulin; supervised administration rounds included in annual medicine management checklist; approved STHFT Critical Medicines List available on intranet and check to ensure displayed in clinical areas in 4 monthly medicine management checklist; critical medicines flagged on EPMA with escalation advice specific to medicine if unable to administer.
Patient Records	• Potential breach of patient confidentiality	• Regular training and education • Ward Audits

Quality Support Visits

The table below presents the outcomes from Quality Support Visits over the past month for wards that have been rated as amber or red in terms of assurance for Fundamentals of care. These issues were reported back following the visits.

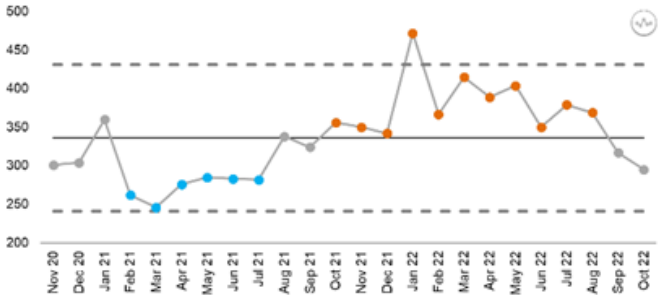
	Deteriorating patients	Acute Medical Unit	The escalation process for deteriorating patients described by some staff as confusing
	Medicine Management	BREARLEY 5, SAC / HUNTSMAN 8, Acute Medical Unit, FRAILTY UNIT, N2, M2, VICKERS 2, VICKERS 3	Cupboards in the clinical room containing medicines are not locked The drugs fridge was unlocked Pharmacy returns bin overflowing Drug trolley left unlocked and unattended.
	Patient Records	CHESTERMAN 2, Q2, G2, PALLATIVE CARE UNIT	Set of medical records was observed unattended on a bench Smart cards left in laptops that were logged into a systems with PID. Notes trolleys not lockable
	Deteriorating patients	ROBERT HADFIELD 6, SAC / HUNTSMAN 8	Doctors in training covering the ward did not have a bleep for escalating issues Safety Huddles were inconsistent and did not always a happen. Patient with NEWS 2 score of 8 had not been escalated appropriately and had only been picked up as a result of remote monitoring of the Whiteboard by the Critical Care Outreach Team.
	Medicine Management	ROBERT HADFIELD 2, ROBERT HADFIELD 4, ROBERT HADFIELD 5, ROBERT HADFIELD 6, BREARLEY 3, BREARLEY 7, Q2, G1, G2, F1, FIRTH 7, FIRTH 4	Key found in unlocked cupboard which provided access to the key cupboard and thus all the keys to unlock other cupboards (not CD's). Drugs fridge was unlocked. Observed drugs left out on the side unattended Resus trolley had not been consistently checked Green pharmacy returns box unlocked The fridge and ambient temperatures had not been recorded on 10 days over the past month.
	Patient Records	ROBERT HADFIELD 1, ROBERT HADFIELD 2, ROBERT HADFIELD 4, ROBERT HADFIELD 5, ROBERT HADFIELD 6, Acute Medical Unit	laptops which were logged into a system and unattended. Notes left unsecured and unattended at various points around the ward. Handover sheets containing PID had been left on the Nurses station.

PERFORMANCE DATA – FUNDAMENTALS OF CARE

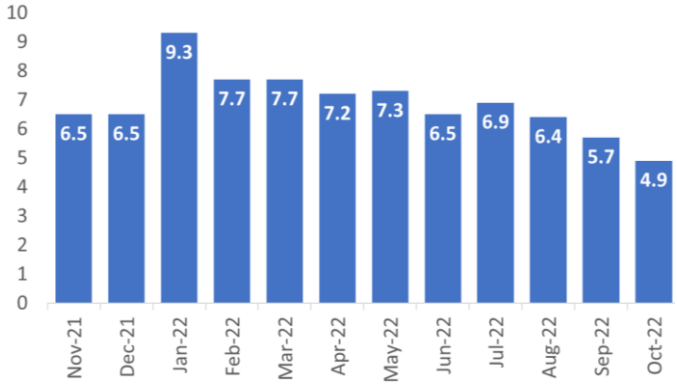
Period covered: October 2022

Patient falls

Patient Falls Reported

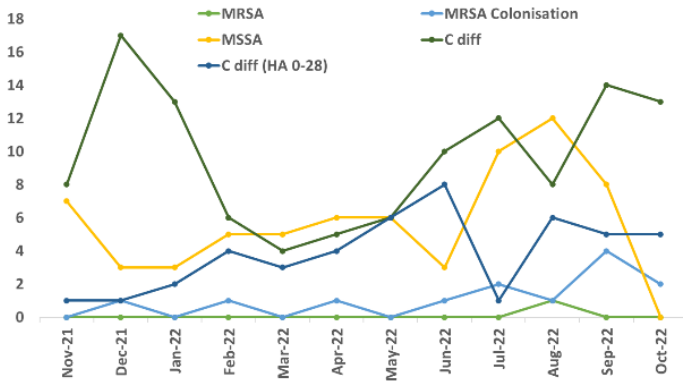


Patient falls reported per 1000 bed days



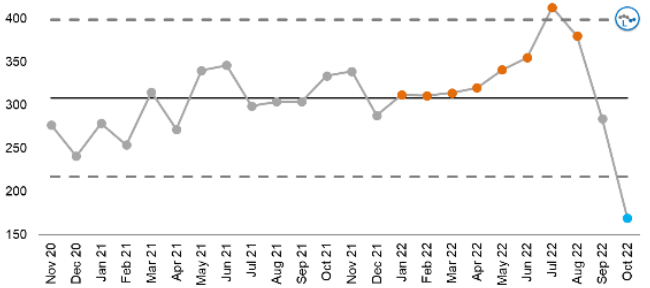
Infection Prevention and Control

Reported infection incidents by type and month



Medicines Management

Number of medication error incidents reported by month



IMPROVEMENT PROGRAMME PLAN ON A PAGE – QUALITY GOVERNANCE

Lead: Jennifer Hill / Angie Legge Group: Quality Committee

Assurance Reporting	Operational Risk Management	Incidents, Actions and Learning	Patient Engagement & Experience	Care Group Governance
Areas of work	**Areas of work**	**Areas of work**	**Areas of work**	**Areas of work**
• Specialty groups and reporting structures • Highlight reporting processes • Care group assurance to Board	• Risk Group Structures, identification & escalation of risk • Knowledge and understanding • Culture of risk review	• Incident reporting • SMART and evidenced actions • Clear evidence of learning • PSIRF Implementation	• Improve Patient Engagement • Visibility of patient experience at Board level • Addressing results of patient feedback • Good PALS responses	• Governance reporting within Care Group • Governance reporting to corporate • Governance resourcing
Immediate priority areas	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**
• Review existing groups & reporting • Care Group Engagement • Review templates for reporting	• Timeliness of review • Cleanse of current register • Risk group functionality • Care Group engagement	• Engagement with Care Groups • Review of action and learning process • PSIRF gap analysis & transition timetable • Human Factors training • Quality Boards	• Patient Engagement & Experience Strategy within Quality Strategy • Establish workstreams to address patient feedback • Develop role of Patient Safety Partners • Care Group Engagement	• Review of Governance resource in Care Groups • Identify assurance routes within Care Groups • Review and refresh directorate governance guidance based on Care Group feedback
These will result in	**These will result in**	**These will result in**	**These will result in**	**These will result in**
• Focused escalation of concerns & mitigations • Assurance streams which can be triangulated by Board members • Board awareness of key concerns and mitigations	• Focused risk register, less work, appropriate risk management • Good links of escalation /de-escalation with BAF (Internal Audit) • Care Groups able to manage their risks (Internal Audit)	• Reduction in harm repetition • Meeting PSIRF deadline • Evidence of action delivery and improvements • Good articulation of learning	• Increase in areas where patient voice is heard • Patient Stories at appropriate groups / committees • Tangible evidence of improvements based on feedback	• Appropriate escalation within Care Groups with mitigation of concerns • Appropriate escalation to corporate • appropriate governance to cover required areas
We will deliver by (date)	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**
• April 2023	• April 2024	• Sept 2023	• Sept 2024	• April 2024
Supporting Strategies or Frameworks	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**
	• Risk Management Policy and Framework	• PSIRF • National Patient Safety Strategy • Incident Management Policy	• Quality Strategy • National Patient Safety Strategy • Framework for Patient Safety Partners	• Quality Governance Policy • Directorate Governance Framework

IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL– QUALITY GOVERNANCE

Period covered: October 2022

WORKSTREAM	PROGRESS LAST MONTH	PLAN FOR NEXT MONTH
Assurance Reporting	• Reviewing corporate groups • Quality Director meeting care group leaders	• Finalise corporate group restructure with new TOR and workplans for presentation at TEG
Risk	• Risk Clinics being set up	• Commence risk clinics, aim to complete all care groups before Christmas • Draft extreme risk summary with 3 care groups
Incidents, Actions & Learning	• Quality Boards in place on wards • Working Group looking at culture in theatres	• Action plan from Theatre Working Group
Patient Engagement & Experience	• Finalising Quality Strategy with Patient Experience & Engagement section • First meeting of Patient Experience & Engagement Committee held	• Quality Strategy to go to stakeholder comment and approvals • Draft PSP role and supportive network for Care Group linkage •
Care Group Governance	• Review of Care Group governance meetings commenced • Central review of care group governance resource underway	• Continue review of care group governance – aim for completion Jan 2023 • Draft care group governance assurance highlight report template

OUTCOMES (including measures)	EVIDENCE
• Quality Strategy for safety, effectiveness and patient experience & engagement • Aim for improved SCORE on culture in operating theatres	• Documents currently in draft • Working Group for theatre culture TOR, baseline SCORE results

IMPACT ON PATIENTS	IMPACT ON STAFF
• To date none, but in the long run this should help improve experience and safety	• Potential increase meeting requirement on care group triumvirate staff, some groups will be taken out of the system

RISKS	MITIGATIONS
• Risk that a line of assurance may be lost in new group structure • Increased pressure on care group triumvirates through increased meeting requirement • PSPs attached to care groups may cause frustrations to both PSPs and staff	• Responsibilities of groups being taken out to be mapped against draft new process, • Existing workplans to be mapped against new group structure • Discuss attendance requirements, ensure value through attendance • Engage Care Group representation in design and implementation, ensure support networks with feedback loops from implementation

Quality Support Visits

The table below presents the outcomes from Quality Support Visits over the past month for wards that have been rated as amber or red in terms of assurance for Quality Governance. These issues were reported back following the visits.

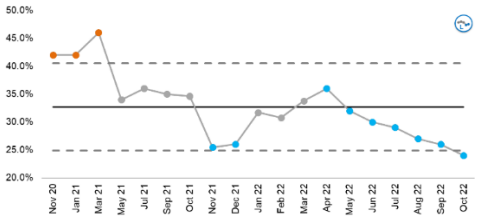
	NGH - ROBERT HADFIELD 2 NGH - ROBERT HADFIELD 4 NGH - CHESTERMAN 2 NGH - SAC / HUNTSMAN 8 NGH - Acute Medical Unit (AMU) RHH - N2 RHH - L1 RHH - I1 RHH - F1	Quality Board not up to date Medical and/or nursing staff unaware of Quality Board
	NGH - ROBERT HADFIELD 5 NGH - ROBERT HADFIELD 6 NGH - CHESTERMAN 4 NGH - CHESTERMAN 3	Both Welcome Board and Quality Board had not been updated.

PERFORMANCE DATA – QUALITY GOVERNANCE

Period covered: October 2022

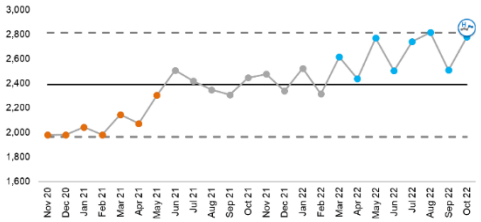
Operational Risk Management

% Risks overdue for review at end of each month

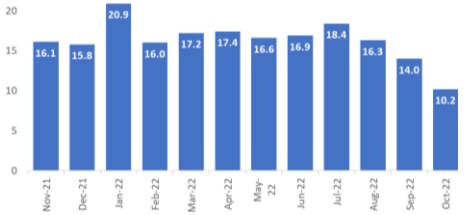


Incidents, Actions and Learning

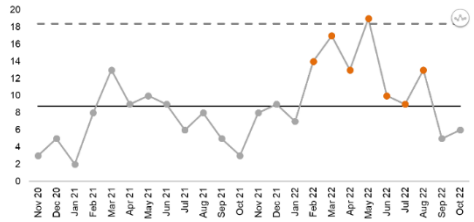
No. Incidents Reported



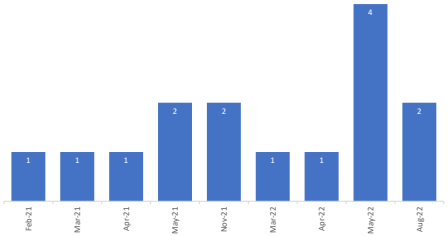
No. of incidents reported per 1000 bed days



No. NEs / SIs reported

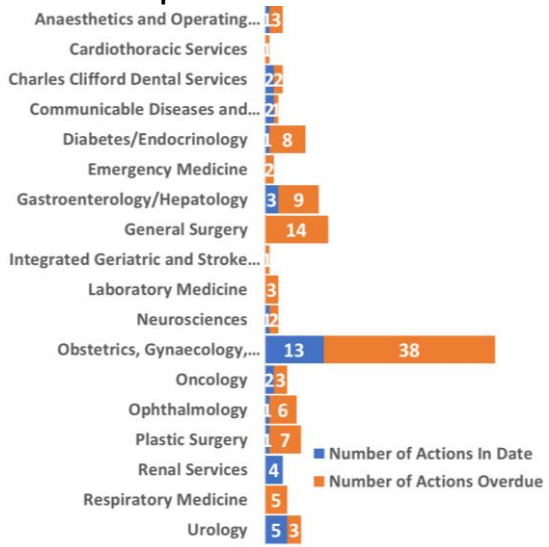


No. of Never Events reported between November 2020 and October 2022

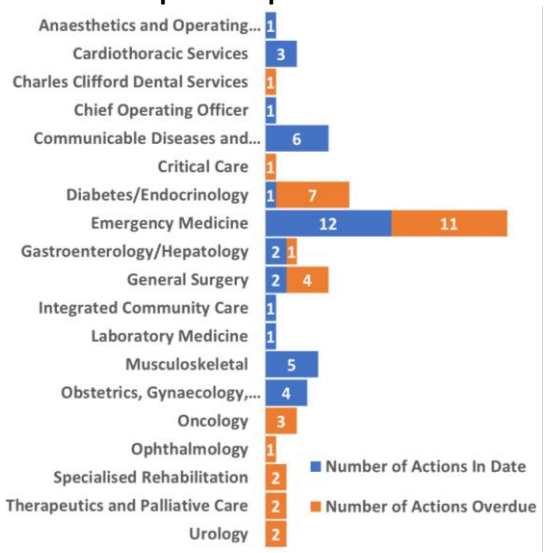


Care Group Governance

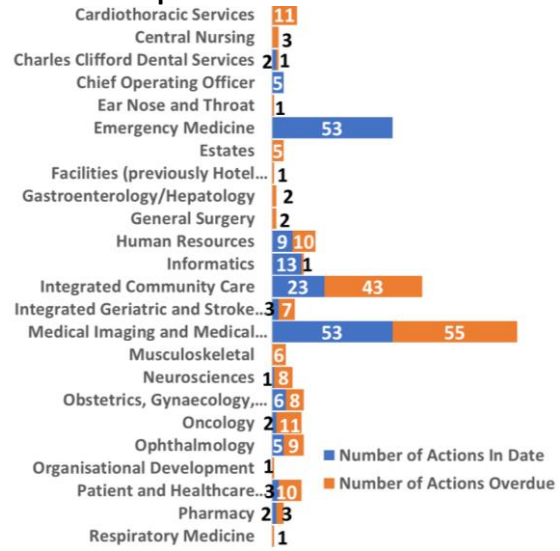
Number of open Serious Incident actions



Number of open Complaint actions



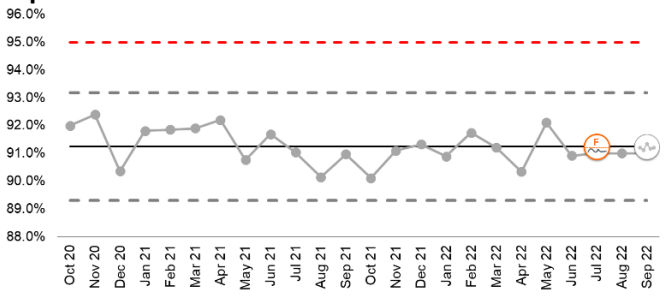
Number of open Risk actions



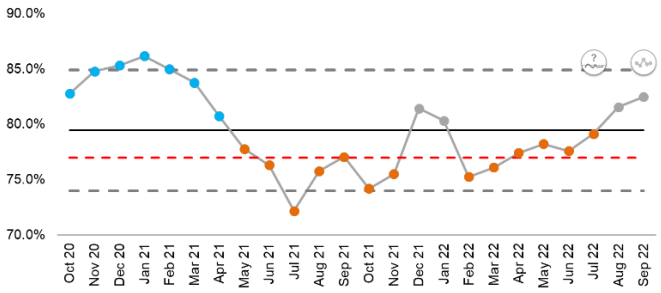
Patient Engagement & Experience

Friends and Family Test – percentage of patients who would recommend the Trust:

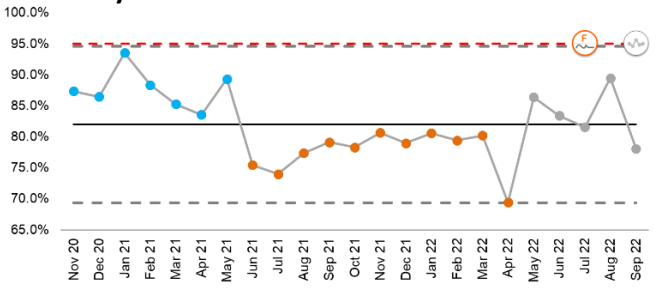
Inpatients



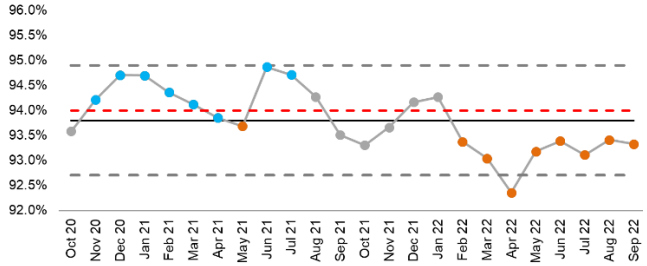
A&E



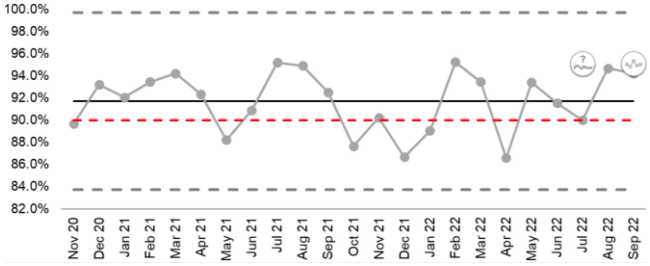
Maternity



Outpatients



Community



Trust target illustrated by red dash line --------

IMPROVEMENT PROGRAMME – WELL-LED

Lead: Sandi Carman Operational Lead: Judith Green Oversight Group: TEG and Board of Directors

Well-led Review	Risk Management	Fit and Proper Persons	Board Development Programme
Areas of work	**Areas of work**	**Areas of work**	**Areas of work**
• Commission and undertake Well-led review • Development of an Action Plan based on review recommendations	• Update Framework for Risk Management to reflect revised oversight arrangements for the management of risk. • Develop and implement Board Assurance Framework (BAF) • Implement Corporate Risk Register Report (CRRR) • Review of risk management arrangements	• Update Fit and Proper Persons Policy to align with regulatory findings requirements • Ensure all Personal Files up to date and align with policy requirements (including development of checklist) • Embed practice through application of SOPs and production of the Annual Report (enhanced content)	• Creation of a forward-thinking Board Development Programme
Immediate priority areas	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**
• Implementation of the interviews / focus groups / meeting observations / surveys and document submissions	• Creating and embedding the new Board Assurance Framework • Creating Corporate Risk Register Report and embedding reporting to the Board of Directors • Risk Register Data Quality	• Implement three yearly DBS Checks • Review and improve the Annual Report to the Board of Directors to report on the wider scope of the policy	• Conclusion of Well-led Review and consideration of findings
These will result in	**These will result in**	**These will result in**	**These will result in**
• Identification of recommendations for prioritisation / incorporation within the Board Development programme • Compliance with Code of Governance best practice	• Effective systems and processes in place to ensure Board oversight of the management of risk and provision of assurance to the Board of Directors	• Effective systems and processes in place to ensure adherence to the Fit and Proper persons requirements and regulations	• Board of Directors with improved skills and insight into the key components that support the organisation being well-led
We will deliver by (date)	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**
• November 2022	• March 2023	• November 2022	• December 2022
Supporting Strategies or Frameworks	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**
• CQC and NHSE Well-led KLOES • NHS Code of Governance • STH Annual Governance Statement	• STH Framework for Risk Management • STH Annual Governance Statement • Head of Internal Audit Opinion	• STH Fit and Proper Persons Policy • Fit and Proper Persons Regulations • NHS Provider Licence	• CQC and NHSE Well-led KLOES • NHS Provider Licence

IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL– WELL LED

Period covered: October 2022

PROGRESS LAST MONTH	PLAN FOR NEXT MONTH
• Well-led review underway and initial finding presented to BoD strategy session • Strategic Risk Deep Dive reviews commenced in line with the Board Assurance Framework operating principles	• Review the Fit and Proper Persons Annual Report and embed practice through refresh and application of SOPs • Give consideration to the themes of the Board Development Programme following the delivery of the final Well-led review report

OUTCOMES (including measures)	EVIDENCE
• Increased Board assurance/scrutiny of the strategic risks	• BoD minutes

IMPACT ON PATIENTS	IMPACT ON STAFF
• Focus on mitigations in place to reduce the potential for reduced quality of care/ patient experience	• Focus on mitigations in place to reduce the potential for poor staff experience, satisfaction impacting on health and wellbeing

RISKS	MITIGATIONS
• Insufficient Board engagement	• Scheduling of manageable workstreams to support adoption

IMPROVEMENT PROGRAMME PLAN ON A PAGE – WORKFORCE

Lead: Mark Gwilliam/Rebecca Robson Oversight Group: HR Strategy Group

Staff training	Admin staff: attraction	Admin staff: recruitment	Admin staff: training	Admin staff: retention
Areas of work	**Areas of work**	**Areas of work**	**Areas of work**	**Areas of work**
• Monitor performance of mandatory and job specific training through Trust Performance Framework.	• Careers Fairs • Social media campaigns • On-line events • Schools engagement • Promoting total rewards package • Promotion of flexible working options • Review of recruitment materials • Revised website	• Process improvement to reduce Time to Hire KPI • Collaborative working with DWP & other agencies • Growth company – pilot to interview ahead of formal application • Innovative approaches to transform process inc TRAC onboarding module • Reviewing onboarding processes • IT system improvements • Extension of NHSP	• Increasing development opportunities for admin roles • Expanding apprenticeship offer • Reviewing career structures and professionalisation of admin roles • Reviewing induction processes	• Working with high-risk areas to understand reasons for leaving • Refreshment of exit questionnaires and interview process • Introduction of retention questionnaire and interviews • Promotion of total rewards package linked to new People Strategy • Trust Wide Administrative Profession Programme – creating a career framework for A&C roles and celebrating the profession each year on World Admin Day
Immediate priority areas	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**
• Continue to send monthly reports to all directorates showing staff with outstanding mandatory and job specific training.	• Identify and prioritise high risk roles • Focus on band 2 roles	• Reducing Time to Hire • Improving candidate experience	• Developing portfolio of opportunities for admin roles • Promoting apprenticeships to existing and potential staff • Revised corporate induction programme	• Actions to address themes from reason for leaving work • Actions to address outputs from analysis of exit interviews
These will result in	**These will result in**	**These will result in**	**These will result in**	**These will result in**
• Performance >90% • For October 2022, performance is currently 92% for both mandatory and job specific training	• Greater awareness of roles available • Increase in applicant numbers	• Candidates processed faster • Reduced candidate attrition	• Increased number of applicants • Improved rates of retention • Positive feedback from new recruits following induction	• Impactful actions • Improved rates of retention • Improved staff engagement scores
We will deliver by (date)	**We will deliver by (date)**	**We will deliver by (date)**	**These will result in**	**These will result in**
• Ongoing	• Immediate priorities by Dec 2022 then ongoing	• Immediate priorities by Dec 2022 then ongoing	• Immediate priorities by April 2023	• Immediate priorities by April 2023
Supporting Strategies or Frameworks	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**	**Supporting Strategies or Frameworks**
• Induction, mandatory and job specific training policy • Core Skills Training Framework	•	•	•	•

IMPROVEMENT PROGRAMME PLAN ON A PAGE – Urgent and Emergency Care

Lead: Acute and Emergency Medicine Triumvirate Group: Acute and Emergency Medicine Executive Group

Quality and Safety	Workforce & Wellbeing	Leadership	Staff Engagement	Patient Experience
Areas of work	**Areas of work**	**Areas of work**	**Areas of work**	**Areas of work**
• Falls Risk • Mental Health • Deteriorating patients in ED • Nutrition and Hydration in ED • IPC • SDEC	• NHS Staff Survey Action Plan • Violence & aggression • Education & Training plan • ED Streaming Sister • Recruitment with SNCT results • Develop FEN Nursing Competency Framework • Professional Nurse Advocates	• Reviewing roles and responsibilities of senior leadership team • Reviewing Nursing team structure and encouraging team working • AMU Big Conversation • Leadership and Team building training	• Ensuring all staff feel they have a voice • FFT staff recognition certificates • Staff engagement plan	• Increase FFT response rate • Provide clear information to patients in the waiting room • Learning from complaints • FFT feedback to staff • Charity £ to improve patient experience • Patient dignity champions
Immediate priority areas	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**
• Establish a way to visualise Falls Risk • Ensure that 100% of Mental Health patients have a completed risk assessment • Documentation of intentional rounding • Improve compliance with NEWS and escalation • ED minor estates work to reconfigure workspace • eWhiteboards task lists	• Communicate Staff Survey Action Plan to all staff • Secure funding for 12 hr/day Streaming Sister • Develop staff wellbeing model • Roll out PNA service in ED	• Providing leadership training opportunities to staff • Review Named Nursing structure and development of leadership roles • Changes to Tier 4 rota	• Fortnightly meetings between ND/DND and staff with two way feedback • Back to the floor shifts for ND/DND • Paper collection of staff views and response back from ND/DND/Matron • Involving staff in change / improvement work (see Quality and Safety)	• Implement FFT Business Cards • Waiting room presentation • Establish a complaints group • Increase provision of housekeepers • Dignity champions in ED and AMU
These will result in	**These will result in**	**These will result in**	**These will result in**	**These will result in**
• Reduction in falls in ED • Reduction in ligature attempts in ED/AMU • Improved documentation of intentional rounding and reduction in deteriorating patients • Better oversight of patients in the department timely escalation of alerts	• Reduction in violence and aggression episodes • Proactive waiting room monitoring and more appropriate placement of patients • Increase staff satisfaction at work	• Recognisable Nursing Team Leader structure • 12 members of staff completing Leadership training • 20 members of staff completing Army Team Building exercises • 15 members of staff completing compassionate leadership training • Consistent Senior Decision makers across all areas in ED	• Open feedback with staff • Staff feeling valued • Staff actively involved in change and improvement	• Learning from complaints and FFT • Improved patient experience
We will deliver by (date)	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**
• April 2023	• April 2023	• January - April 2023	• January 2023	• January 2023

IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL – URGENT & EMERGENCY CARE

Period covered: October 2022

Workstream	Progress last month	Plan for next month
Quality & Safety	• Ongoing trial of 'Falls signs' at the end of beds of patients at risk of falls. • Installation of e-Whiteboards in ED • Discussions between Catering Manager, Housekeepers and DND to ensure patients waiting over 12 hours . • Dishwasher installed to provide hydration stations to patients in every area. • Identified key stakeholder for the following focus groups: Nutrition & Hydration, Deteriorating Patients, Mental Health, Falls. • Weekly 'Simulation Wednesdays' for deteriorating patients commenced and sepsis study days. • AMU has been accredited with IPC accreditation.	• Audit of falls risk assessment completion and number of falls in ED to measure impact of 'Falls Sign' trial. • Ensure E-Whiteboards fully functional in ED to display key icons, including mental health, nutrition and hydration status and falls risk. • ED minor estates work to allow more space for staff and better oversight of each area. • Improvement groups to meet regularly. • Implement changes to Falls Risk Assessment. • Targeted work to improve IPC audits results.
Workforce and Wellbeing	• Streaming sister funding has been secured and recruitment has commenced. • Staff Wellbeing model is in development phase in partnership with clinical psychologists.	• Psychologist to meet with band 7s in November. • PNAs to attend AEM executive • SNCT results to inform a business case for additional nursing workforce resource.
Leadership	• Trial of Tier 4 medical rota to provide enhanced medical leadership in ED to be trialled in January . • Nurse Director and Deputy Nurse Director have been undertaking 'back to the floor' shifts • Advert for Matron post is live.	• 20 members of staff completing Army Team Building exercises. • Nursing staff focus group to discuss team responsibilities and ways to improve intentional rounding.
Staff Engagement	• Staff engagement work with nursing staff is ongoing. • All staff have received a copy of the NHS Staff Survey Action Plan • NHS Charity agreed to provide handheld radios for patients with dementia. Dementia clocks ordered for ED. • Identified dignity champions in AMU and ED.	• ND and DND to continue back to floor shifts. • Increase wellbeing champions and freedom to speak up advocates.
Patient Experience	• Waiting room presentation live on the TV in main waiting room to provide patients with information on likely waiting times. • Themes from complaints shared with Matrons.	• Waiting room presentation to be downloaded onto iPads to provide coverage across the entire waiting room area. • Housekeepers to distribute business cards with QR codes on their drinks rounds to encourage FFT Feedback Survey to increase response rate. • Complaints as standing agenda item on the Band 6/7 meetings to discuss learning from complaints.

OUTCOMES (including measures)	**EVIDENCE**
• Hand Hygiene IPC audits 80%, and Commode audits 85%. • Additional doctor shifts rostered for busiest periods funded via winter monies. • Better oversight of patients in the waiting area.	• Waiting room is monitored by streaming Sister 12 hours a day. • Staff Survey results.

IMPACT ON PATIENTS	**IMPACT ON STAFF**
• Patients provided with more information on their expected journey through A&E via the Waiting room presentation. Patients will feel more informed and this will be evidenced by a reduction in negative comments around lack of information.	• Engagement with staff on their views/feedback as part of the engagement plan, staff will feel listened to.

RISKS	**MITIGATIONS**
• Mental Health Professional Lead (MHPL) left STH on 19th October. As she was driving Mental Health improvement work and audits, this is a risk to the Mental Health improvement work . • Staffing and operational pressures have impeded the AMU Big Conversation and the meeting of focus groups (nutrition and hydration, deteriorating patients, mental health and falls). • Auditor for carrying out the monthly audits on 10 patient notes to review completion of falls risk assessment, nutrition and hydration status and correct escalation of deteriorating patients has moved off admin duties, leaving a gap.	• Recruited to the MHPL post and established temporary support with DMHRA audits. • Dates for focus groups have been established for November. • An auditor to carry out the audits of 10 sets of patient notes has been identified and they will carry out the audits monthly.

IMPROVEMENT PROGRAMME PLAN ON A PAGE – Specialised Cancer Services (SCS)

Lead: SCS Triumvirate Oversight Group: SCS Improvement Board

Shaping The Future and Service Planning	Workforce and Resource Planning	Research and Service Improvement	A&C, Telephony, and IT Optimisation	Risk, Health and Wellbeing
Areas of work	**Areas of work**	**Areas of work**	**Areas of work**	**Areas of work**
• Agreeing a model for NSO delivery across South Yorkshire, Bassetlaw and Northeast Derbyshire. • Demand and Capacity (D&C) modelling by Tumour site. • Developing options for capacity generation by working differently or managing demand differently. • Improving financial transparency.	• Agree tumour site MDT workforce required to meet capacity requirements. • Create career pathways and recruitment strategies to attract, built and retain a future sustainable MDT workforce e.g Nursing consultants ACP's, radiographers etc • Ensure we are maximising the utilisation of all clinical and non-clinical space	• Maintain our standing as a Research Centre, support clinical trials and reduce delays to study set up. • Develop a list of impact service improvements. • Embrace technology that supports efficiencies in service delivery • Increase business case writing capacity and capability • Prepare for Cerner	• A&C process improvement plan • A&C structure and resource level review • Expansion of the Netcall telephony in use in WAU to support admin services and improve patient access • IT optimisation	• Transparency of top risks and plans for mitigation. • Improved communications • Staff engagement plan from staff survey • Staff Health and Wellbeing Plan • Promotion of Freedom to Speak Up Champions
Immediate priority areas	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**	**Immediate priority areas**
• CA led development of an options appraisal • D&C modelling in Breast and Urology • Tumour site whole team meetings to agree a plan in respond to the D&C data. • Budget review	• Tumour site meetings following D&C modelling to agree a future workforce model • Recruitment and development strategies for main career routes • Review of clinic space utilisation and options for expansion	• Capture research ideas for short turn around funding opportunities • Recruit dedicated operational and clinical resource to support a programme of improvements. • Agree a top 3 priority service improvements e.g improving the blood hub process / uncoupling SACT treatment and outpatient appoints	• A&C away day to set the improvement agenda. • Paper to BPT on A&C resources • Telephony infrastructure planning • Creation of access and system profiles for clinical staff working across different locations.	• Articulation of top 5 risks • Business planning engagement • WPCC newsletter • Addressing excessive e-mail culture
These will result in	**These will result in**	**These will result in**	**These will result in**	**These will result in**
• Future service model for delivering NSO oncology that will enable medium term planning and stronger SLA development. • Quantified understanding of our gaps to drive targeted solutions.	• Short and medium term workforce plans • Clearer career routes for key professions in Specialised Cancer enabling targeted recruitment campaigns and events. • Better quantification of space constraints to inform solutions	• Responsiveness to research opportunities and trial set up • Capacity and capability to support improvement without detriment to Business as usual • Focused programme of improvement projects we can collectively support • Smoother Cerner transition	• Greater clarity over ownership of A&C processes steps. • Fewer process breakdowns and improved patient and clinician experience. • Improvements to simple IT Issues access to systems and speed of connections	• Trust level clarity of top 5 risks • Clear structures for staff engagement • Improved awareness of changes taking place • Less surprises • Fewer e-mails containing clearer communication
We will deliver by	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**	**We will deliver by (date)**
• Future service model agreed by Mid 2023 • D&C work completed for all tumour sites by end of April 2023.	• Future whole directorate medium term Workforce Plan Q1 2023	• Improvement resource in place Q4 2022/23 • Cerner roll out May 24	• A&C Away Day (Nov 22) • A&C Paper to BPT (Dec 22) • Telephony roll out started Jan (2023)	• WPCC newsletter commenced (Oct 22) • Business plan submitted with top 5 risks (Nov 22)

Appendix 1: Quality Support Visits - RAG rating by ward and outcome (at 4 November 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

CORE SERVICE	SITE	WARD	Outcome 1 Mental Health Visit: 1 2 3 4	Outcome 2 MCA/DOLs Visit: 1 2 3 4	Outcome 4 Falls Visit: 1 2 3 4	Outcome 5 Deteriorating Patients Visit: 1 2 3 4	Outcome 6 Individual Needs Visit: 1 2 3 4	Outcome 7 Medicine Management Visit: 1 2 3 4	Outcome 8 Hazardous Substances Visit: 1 2 3 4	Outcome 9 Nurse Staffing Levels Visit: 1 2 3 4	Outcome 10 Trained Staff Visit: 1 2 3 4	Outcome 11 Patient Records Visit: 1 2 3 4	Outcome 12 IPC Visit: 1 2 3 4	Outcome 13 and 14 Incidents and Learning Visit: 1 2 3 4
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	H1 (formally 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												
PRIORITY WARDS THIRD WAVE														
Medicine	RHH	P3/P4												
Medicine	RHH	O1												
Medicine	RHH	L2												
Surgery	NGH	CHESTERMAN 4												
Medicine	NGH	RENAL UNIT E												
Medicine	NGH	VICKERS 3 (formally BR2)												
Surgery	NGH	FIRTH 8												
Medicine	NGH	OSBORNE 1												
Medicine	NGH	ROBERT HADFIELD 4												
Medicine	NGH	BREARLEY 1												
Surgery	NGH	FIRTH 3												
Medicine	NGH	OSBORNE 4												
TIER 1 WARDS														
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	PALLATIVE CARE UNIT												
Medicine	NGH	RENAL UNIT F												
Medicine	NGH	ROBERT HADFIELD 1												
Medicine	NGH	ROBERT HADFIELD 3												
Medicine	NGH	ROBERT HADFIELD 5												
Medicine	NGH	VICKERS 2												
Medicine	RHH	CIU (P2)												
Medicine	RHH	L1												
Medicine	RHH	M2												
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)												