Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary
Report to the Board of Directors
Being Held on 31 January 2023

Subject	CQC Action Plan 2022 – Update Report January 2023
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 Board of Directors 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

An update is provided for a broad range of priority workstreams under five improvement programmes:

- Mental Health (mental health; mental capacity; and learning disability and autism)
- Fundamentals of Care (falls, deteriorating patients, medicines management, IPC, hazardous substance management 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 is 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 monthly progress update, 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, with a monthly progress update included in this report. Maternity Services is reported separately through a detailed monthly update to Quality Board and a monthly submission to CQC. A mapping exercise has been completed (Appendix 2) to ensure that actions from the previous inspection in October 2021 have either been completed or carried forward. Following publication of the CQC inspection report, new actions identified will be incorporated into the appropriate improvement programme 'plan on a page', as outlined in Appendix 3.

At the start of the 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 Workforce) and three rated as amber (Mental Health, Fundamentals of Care and Well Led). It is proposed that the workforce Plan on a Page is closed as the only concern raised by CQC in the 2022 report with regard to staff training, is safeguarding training. The CQC report included a new 'should do' in respect of appraisal rates, but training and appraisal rates have clear oversight within the Trust, through the People Committee and will be monitored through business as usual processes.

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	

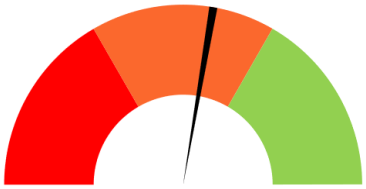
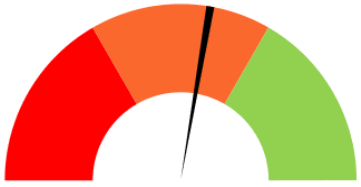
RECOMMENDATIONS

The Board of Directors is asked to note progress made against each Improvement Programme over the past month and the rationale / mitigation for the corresponding RAG ratings, and to support the proposal to close the Workforce Plan on a Page.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	11/01/2023	✓
Quality Committee	16/01/2023	✓
Board of Directors	31/01/2023	

CQC Action Plan – Improvement Programme Status

RAG Rating	Position
 Mental Health, Learning Disability and Autism	• Progress achieved on a number of priorities • Use of Force and Rapid Tranquilisation Policy approved • Plan to commence restrictive practice training • Guideline for making reasonable adjustments approved • Reaudit of Health Passport underway • Mental Health Programme Manager job description rewritten • Training figures stalled due to resource, but Band 8a Mental Health Professional Lead replacement commences in post 31 January 2023. • Quality Support Visits show a lack of understanding of nursing staff of the MCA/DOLS process.
 Fundamentals of care	• Good progress made on a number of priorities, supported by data e.g. falls per 1000 bed nights and storage of hazardous substances. • Falls Educator commenced training on walking aids and completion of lying and standing blood pressure. • 61 wards have the number of a deteriorating patient bleep visible on their e-whiteboard, and the deteriorating patient screening tool has been revised and is in use. • COSHH risk assessments have been updated and the number of amber areas has reduced from 15 to 5. • Transferring the IPC Accreditation Programme into QUEST is a long-term project limited by capacity of QUEST team. Work is underway on further modules, including IV Cannulae Insertion, Ongoing Care and Standard Precautions. • Business cases drafted for Lead Nurse Medicines Governance and for temperature monitoring system for pharmacy and laboratory medicine. • Agreed New Controlled Drug Oversight Group to be established, to report to Medicines Safety Committee. • Approval for Information Governance mandatory training to include security and updating of Trust Health Record. • Quality Support Visits continue to highlight areas of concern with regard to medicine management (cupboards and fridges not locked, smart cards left in laptops, unattended drugs, resus trollies not being checked).
 Quality Goverance	• Progress made in a number of areas. • A new assurance reporting structure and Terms of Reference to be presented for TEG approval. • Extreme risk summary drafted and early discussions with care groups commenced. • Working group established looking at culture in theatres. • PSIRF Implementation Group established with gap analysis and timeline for delivery. • Investigation training delivered for OGN. • Quality Strategy completed and consultation underway with stakeholders. • 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 their Quality Board.

 Well Led	• Well-led review is complete, and results were presented at Board Strategy Session. Key areas for improvement will be incorporated into the plan on a page. • Strategic Risk Deep Dive reviews continue in line with the Board Assurance Framework operating principles. • Implementation of policy requirements incorporated within planning work for current NED appointment process.
 Workforce	• Mandatory Training Compliance has improved from 92% to 93%. • Job Specific Essential Training remains stable at 92%. • Medical and Dental compliance remains stable at 81%. • Monthly non-compliance reports continue to be issued.

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: December 2022

Workstream	Progress last month	Plan for next month
Restraint and rapid tranquilisation	• Use of Force policy and Rapid tranquilisation approved by MH steering group • Use of force leaflet with PILS for completion • Reducing restrictive practice trainers met and plans in place to start training- this will be a four-day course as it cannot be condensed. It includes de-escalation, breakaway techniques and safe restraint and is Restraint Reduction Network approved.	• To finalise and submit policies for approval as controlled document • Leaflet to be completed and reviewed by patient groups • Review of restrictive practice Datix submitted recently with feedback to governance teams regarding their investigations • Finalisation of dates for first reducing restrictive practice courses
Learning Disability and Autism	• Working group set up to develop the trust LD and autism strategy • Trust guideline for making reasonable adjustments signed off • Reaudit of the use of Health Passport in progress	• Awaiting ICB plan for roll out of Oliver McGowan training (level 1 and 2) • Visit to SCH to look at reasonable adjustments regarding clinic letters and administration around outpatient appointments and waiting lists • Continue to develop trust strategy for LD and autism • Completion and analysis of Health Passport audit
Mental Health	• Mental Health Programme Manager job description rewritten • Training figures stalled due to the above vacancy and training package is not available on PALMS • DMHRA form has been modified to include a tick box to indicate referral to STH MH team	• Advertise for Mental Health Programme Manager following re-submission for banding • Band 8a Mental Health Professional Lead to start on 30/1/23 • Audit results to be presented to Nurse Director's meeting, with particular reference to referral to MHLT. • Action plan to be agreed to improve compliance.

Workstream	**OUTCOMES** (including measures)	EVIDENCE
Restraint and rapid tranquilisation	• Episodes of restrictive practice documented on DATIX in December	• 29 episodes recorded in December • 23 episodes using rapid tranquilisation, others restraint alone • AMU highest number of episodes- 7 • 24 of the cases state that appropriate physical health monitoring was used post rapid tranquilisation
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	• Significant increase in episodes of self-harm and ligature • 7 episodes of attempted ligatures (3 same regular patient within 2 days), one with apron, one with bandage from wound, 3 with own belongings, 2 call buzzers. • 4 episodes of self injury (cutting, biting, lighter burns), 3 foreign body insertion into old wounds (all same patient) • 1 ingestion alcohol hand gel (different patient) • 33% completed DMHRA training; 69% completed in AEM (Data unchanged)

		• Level 1 MH awareness 96% (100% within AEM) for staff required to complete • Level 2a MH awareness 87.9% for staff required to complete • Audit demonstrated 85% of DMHRA forms completed against the standard of 100% for patients presenting with mental health concerns. • Noticeable decline in compliance with 40% being referred to MHLT regardless of risk against the standard of 100% (67% in previous audit in Oct 2021). • 98% of patients presenting with mental health concerns have mental health icon on e-Whiteboard

Workstream	RISKS	MITIGATIONS
Restraint and rapid tranquilisation	• Staff not always completing a DATIX when an episode of restrictive practice has taken place • Observations after rapid tranquilisation not always documented • Investigations and learning from incidents not thorough and not being communicated to teams from governance teams • Some episodes being recorded on DATIX inappropriately • Ethnicity not being documented on DATIX	• Governance teams 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 DATIX not required (e.g. lorazepam for alcohol withdrawal
Learning Disability and Autism	• 18,000 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 • Appointed a band 6 and 7 LD professional to provide support to patients, staff and improve awareness of LD and autism
Mental Health	• Lack of resource to push training • Mental Health Professional Lead (MHPL) who was responsible for driving forward the Mental Health improvement work and audits left STH in October • Lack of engagement in some parts of the trust	• New professional lead for mental health appointed, but will aim to develop understanding of mental health issues throughout trust and continue with DMHRA and ligature risk assessment training

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.

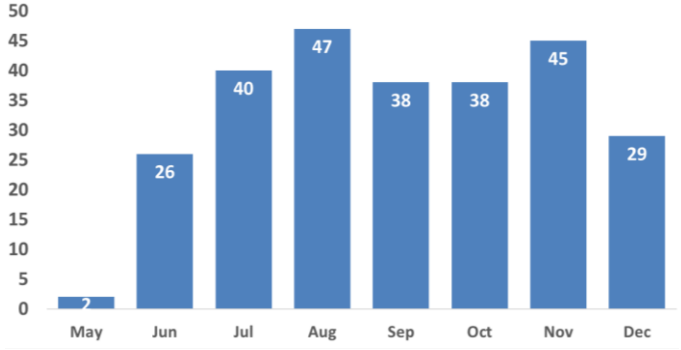
	MCA / DOLS	NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 2, NGH - ROBERT HADFIELD 5	Staff did not have good understanding of the process for patients on DOLS beyond initial 7 days application. A patient had a DOLS icon but documentation was still in process of being completed and not sent to Mental Capacity team. The MDT when questioned around process for DOLS applications and actions did not seem to have a good understanding. Confusion regarding what falls under MCA and MHA. A patients DOLS had expired in November, but DOLS icon remained in place on whiteboard. Patient was medically fit for discharge.

PERFORMANCE DATA – MENTAL HEALTH, LEARNING DISABILITY AND AUTISM

Period covered: December 2022

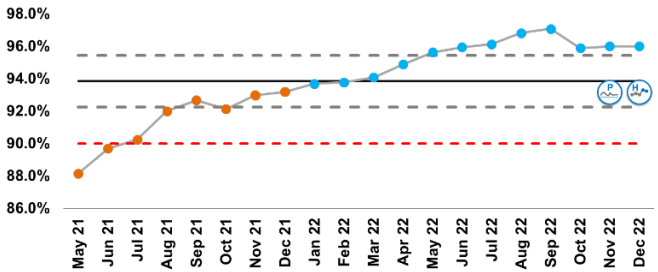
Restraint and rapid tranquilisation

No. of restrictive practice incidents per month



Mental Health

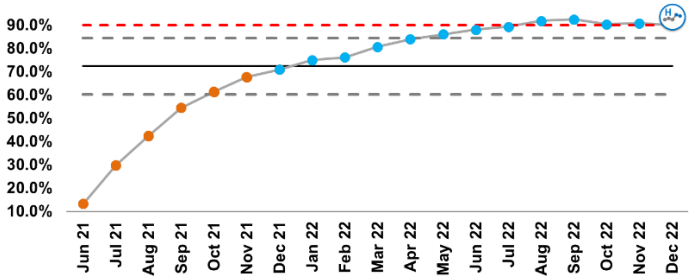
Mental Health Awareness Level 1 Training Compliance



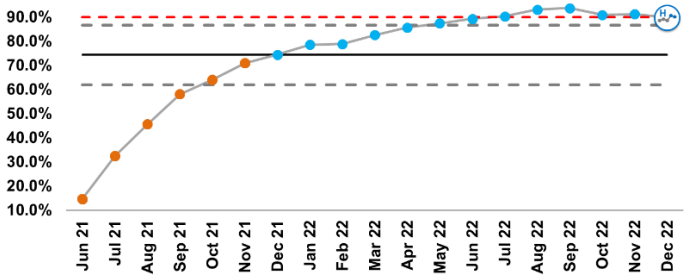
Trust target illustrated by red dash line --------

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 - [COMPLETE]
- Peer review audits - [COMPLETE]
- Assimilate all the above into the Trust IPC Programme - [COMPLETE]

Immediate priority areas

- Transferring the IPC Accreditation Programme into QUEST is a long term project. The limiting factor is the capacity of the QUEST team to undertake this work. Work is continuing on the first module (Cleaning and Decontamination audit) to be transferred. This will be a test module and once finalised, other modules will follow.

These will result in

- Accreditation audit templates being reviewed and updated with appropriate metrics - [COMPLETE]
- Accreditation audit templates uploaded onto Accreditation database for users - ONGOING
- Accreditation audits being reviewed and decision which audits will be part of peer review programme - [COMPLETE]
- Commencement of matron peer review audits - [COMPLETE]
- Peer review audits regularly submitted to Accreditation database - ONGOING
- All the above being within the Trust IPC Programme - [COMPLETE]

We will deliver by (date)

- a) will depend on Quest capacity – no date given to us by the Quest Team

Supporting Strategies or Frameworks

-

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

-

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: December 2022

Workstream	Progress last month	Plan for next month
Falls	• ED Falls Risk Assessment changes agreed, and sent to Lorenzo form builder • Data now readily available to measure compliance with completion within Trust guidance • Falls educator focussing on issuing of walking aids and completion of L&S BP, education commenced in both areas	• FRA for ED implemented once received • For educator to embed in focus areas to support sustained change • Identify high risk areas to focus work on FRA completion on transfer • Review of L&S BP actions to see what alternative work and education could be implemented to make improvements
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 supporting wards to ensure deteriorating patient bleep on e-WB • Continue roll out of e-whiteboard alert across inpatient areas • Recruitment of deteriorating patient nurse (interview end Jan) • Audit time from escalation to response and identify areas requiring further education/input • Continue delivery of deteriorating patient study days with focus on high risk areas
Hazardous Substances	• Visited B Floor outpatient at RHH: Reviewed 8 departments and provided feedback to area managers. • Updated in-patient areas following feedback. Amber areas have reduced from 15 to 5 as departments have updated their COSHH risk assessments.	• JW out-patient areas • Visit 4 Community sites: Manor Clinic; Wheata Place; Firth Park; Graves Sports Centre
Infection Prevention and Control	• Transferring the IPC Accreditation Programme into QUEST is a long term project limited by capacity of QUEST team. IPC Accreditation scheme accessible and visible within QUEST. Cleaning and Decontamination and Hand Hygiene audit tools now complete and uploaded to Quest. Commode Cleaning audit tool due to be uploaded. Work underway on further modules (currently IV Cannulae Insertion and Ongoing Care, and Standard Precautions) to modify for Quest, with remainder to follow. • Updating modules within the Accreditation scheme re scoring - all now updated as appropriate - COMPLETED. • 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. To be monitored long term via Accreditation scheme and IPC Programme - COMPLETED • Assimilating the above into annual Trust IPC Programme to be monitored by IPC Committee - this has been undertaken – COMPLETED	• Work with Connexica to transfer IPC accreditation programme modules to QUEST. Connexica keen to continue progressing at pace after Christmas break. • Test QUEST templates via laptops initially • Help requested to address access to/test templates via portable ward devices • Develop and expand peer review process to include IPC link nurse. IPC Team supplying list of IPC Link Workers to LB PA who will devise a programme for IPC Link Worker Peer Review similar to the original Matrons Peer Review programme.
Medicine Management	• Produced draft business case and job description for Lead Nurse – Medicines Governance	• Submit business case for Lead Nurse – Medicines Governance • Submit joint business case to CIT for temperature monitoring system for Pharmacy and Laboratory Medicine

	• Outline business case started for temperature monitoring system for Pharmacy and Laboratory Medicine • All data for ambient temperature excursions collated and analysed, local actions identified. Full report being written. • Meeting with Information Services to review issues with live dashboard for omitted critical medicines was postponed • Met with Quality Director and agreed new Controlled Drug Oversight Group will report to MSC	• Finalise ambient temperature project report (for submission to MSC in February). • Meet with Information Services to resolve issues on live dashboard for omitted critical medicines • Develop terms of reference for new Controlled Drug Oversight Group.
Patient Records	• Updated progress to the Healthcare Records Committee Approval for Information Governance Mandatory Training to include security and updating of Trust Health Record	• Update on the IG training is ongoing – scope underway • Schedule monthly 'Red' & Amber ward visits to continue • Progress Update to Healthcare Record Committee

Workstream	OUTCOMES (including measures)	EVIDENCE
Falls	• FRA completion data unavailable this month – digital team contacted • Falls / 1000 bed nights across inpatient areas – the month of November has seen a reduction to 5.9 falls / 1000 bed nights following the rise to 7.0 in October, this is more in line with September's data of 6.1. • Data for completion of L&S BP for first 3 weeks in December ranges from 65% - 77%. Level of escalation of those with a deficit in L&S BP ranges from 75% - 100%	• SRQ dashboard data of falls / 1000 bed nights • Weekly L&S BP audit data
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 • Deteriorating patient e-alert pilot continues	• Quality support visits feedback • The e-whiteboard alert has improved the time in which deteriorating patients are clinically reviewed • Video and training pack created to support pilot areas e alert

Hazardous Substances	• Outpatient areas: 8 departments in RHH, Floor B:
	  ○ Red – Medical outpatients; Diabetes Centre Clinic; James West Centre; Ophthalmology outpatient;
	  ○ Amber – Ophthalmic imaging; Annie Boardman Suite
	• No chemical storage – Orthoptics Department 1 and 1A
		• Compliance rates for in-patient areas (81 wards visited)
		  ○ Green - 75 wards fully compliant
		  ○ Amber –5 wards have secure storage but require updated COSHH assessments
		  ○ Red – General Critical Care (RHH)
		• Compliance rates for outpatient areas (15 storage areas inspected)
		  ○ Green – 7 fully compliant
		  ○ Amber – 2 require COSHH risk assessments
		  ○ Red – 4 require COSHH cabinet and updated COSHH risk assessments.

Infection Prevention and Control	• Accreditation scheme audit modules all now appropriately updated • Progress being made by QUEST and IPC Team re formatting the IPC audit modules for the QUEST platform - ONGOING • The IPC Accreditation scheme will be accessible and functioning on the QUEST platform providing ward to board assurance - ONGOING	• Updated Accreditation modules 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 • IPC Accreditation scheme accessible and visible via a tile within QUEST • IPC Programme on Trust intranet has the above objectives within it

Medicine Management	• 40% of inpatient areas completed MMC by 28th December • 24% of inpatient areas showed ≥95% compliance with MMC • 0 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 • Safety Risk and Quality Dashboard
Patient Records	• Ward audit completed on 9 wards. Output from audit showed 3 wards with patient casenotes left unattended and all 9 wards had a number of laptops left logged in and unattended. • Nursing staff leaving cards in laptops to secure for usage. • Nurse in charge notified of outputs of visits and copies of the Health Record Reminder sheets left on ward	• HRC Meeting Minutes

Workstream	RISKS	MITIGATIONS
Falls	• Wards do not engage with the improvement work • Lorenzo form not returned as quickly as planned • Winter pressures impact on improvement work	• Educator up and running engaging well with ward teams • Positive relationship with digital team
Deteriorating patients	• Possible 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) • Delayed or omitted administration of a critical medicine (RR ID 2691)	• 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. • 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 • Strengthen content of Health Record Training around security and updating of the Patient Health Record • 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.

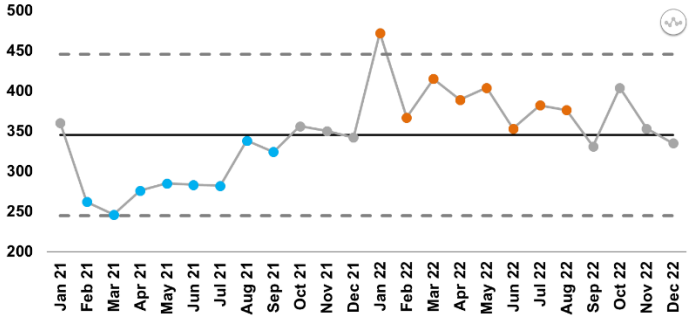
	Medicine Management	NGH - HUNTSMAN 6, NGH - ROBERT HADFIELD 4, NGH - ROBERT HADFIELD 5	The drugs fridge had been left unlocked and unattended.
	Patient Records	NGH - BREARLEY 1, NGH - HUNTSMAN 6, NGH - HUNTSMAN 7, NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 3, NGH - ROBERT HADFIELD 4, NGH - ROBERT HADFIELD 6, NGH - SAC / HUNTSMAN 8	Smart cards left in laptops which were unattended and logged into a clinical system containing PID.
	Deteriorating Patients	NGH - SAC / HUNTSMAN 8	Not all F1's and none of the F2's currently have bleeps allocated, described as an issue in terms of the escalation and timely assessment of deteriorating patients.
	Infection Prevention and Control	NGH - Acute Medical Unit (AMU)	No alcohol hand gel present at entrance to Huntsman 2 or Huntsman 3, nor consistently hand gel available at the entrance to each bay. Told that patients had tried to consume the gel and thus it had been removed.
	Medicine Management	NGH - BREARLEY 7, NGH - FRAILTY UNIT, NGH - HUNTSMAN 4, NGH - ROBERT HADFIELD 2, NGH - ROBERT HADFIELD 6	Drugs left out on side in Clinical room. Resuscitation trolley not checked since 09/12/2022 A drug trolley left unattended and unlocked in a bay. Green pharmacy bin in clinical room left unlocked by pharmacy staff. Drugs cupboards in clinical room unlocked due to missing keys. Not assured that the medicine room could only be accessed by Registered Nurses or other staff authorised to handle/manage medicines. Drugs left out on side in the clinical room.

PERFORMANCE DATA – FUNDAMENTALS OF CARE

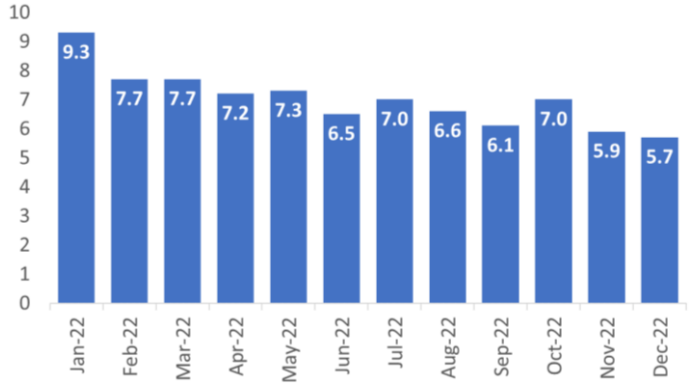
Period covered: December 2022

Patient falls

Patient Falls Reported

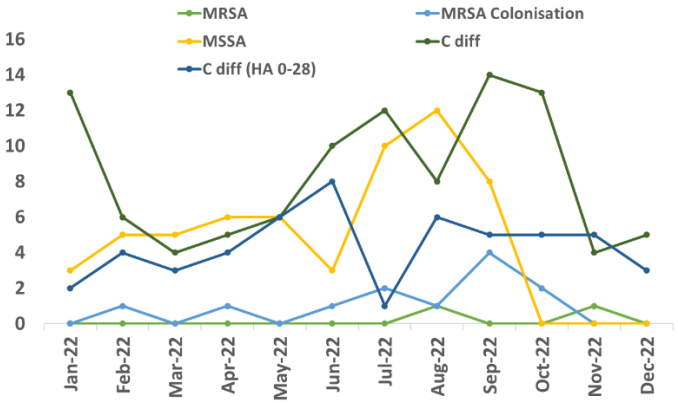


Patient falls reported per 1000 bed nights



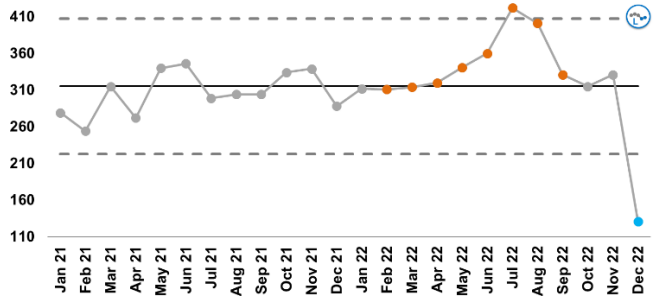
Infection Prevention and Control

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: December 2022

Workstream	Progress last month	Plan for next month
Assurance Reporting	• Structure and ToR drafted, consultations in progress. Paper in early draft to go to TEG in January for approval	• Finish paper for TEG for approval of new structure
Risk	• Risk Clinics in progress • Extreme risk summary drafted and early discussions with care groups commencing	• Continue Risk Clinics • Produce guidance on 'parent' risks • Draft first Extreme risk summary paper for Risk Management Sub Committee along with agenda and other papers
Incidents, Actions & Learning	• Working Group looking at culture in theatres • PSIRF Implementation Group commenced with gap analysis and timeline for delivery • Delivery of Investigation training for OGN	• Roll out of action amendment process – discussion with Governance Leads about moving significant delays into performance processes • Action amendment process and proforma to go to SRF for consultation / agreement • Theatre Culture Group looking at action cards for unexpected events
Patient Engagement & Experience	• Quality Strategy finished and shared with stakeholders for views • PSP role discussion with existing PSPs	• Develop timeline of Patient Engagement implementation of strategy by March 2023 for PEEC • To draft PSP network ToR, and new role descriptions by end March 2023 • Conclude consultation on Quality Strategy to finalise for TEG
Care Group Governance	• Review of Care Group governance meetings commenced • Central review of care group governance resource underway • Care Group Governance assurance highlight report template drafted and shared with Care Groups for views	• Continue review of care group governance – aim for completion Jan 2023

OUTCOMES (including measures)	**EVIDENCE**
• Quality Strategy for safety, effectiveness and patient experience & engagement • Aim for improved SCORE on culture in operating theatres • From Jan 2023, no actions from serious incidents delayed more than 12 months	• Documents currently in draft • Working Group for theatre culture TOR, baseline SCORE results

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.

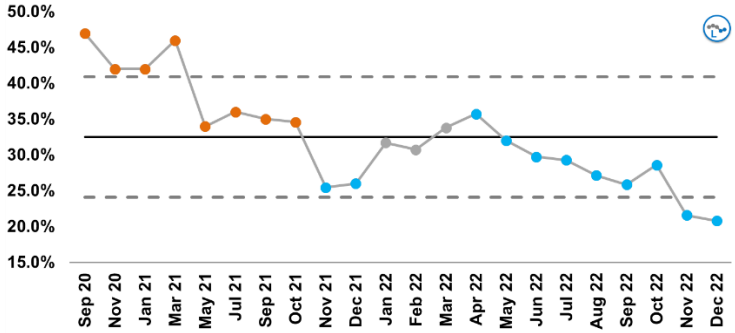
	NGH - Acute Medical Unit (AMU), ,NGH - BREARLEY 1 NGH - BREARLEY 2, NGH - BREARLEY 3, NGH - BREARLEY 5, NGH - BREARLEY 6, NGH - BREARLEY 7, NGH - HUNTSMAN 4, NGH - HUNTSMAN 6, NGH - HUNTSMAN 7, NGH - RENAL UNIT F, ,NGH - ROBERT HADFIELD 1, NGH - ROBERT HADFIELD 2, NGH - ROBERT HADFIELD 4, NGH - ROBERT HADFIELD 6, NGH - SAC / HUNTSMAN 8	The nurse staffing board had not been updated. Information on the Welcome board and Governance board was out of date . The pressure ulcer and falls data on the Governance board didn't have dates.
	NGH - BREARLEY 4	The data on the Welcome board and Quality board had not been updated since August. Unfortunately, Sister was not on the ward at the time of our visit hence the red RAG rating.

PERFORMANCE DATA – QUALITY GOVERNANCE

Period covered: December 2022

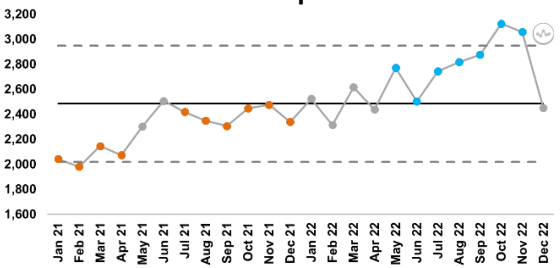
Operational Risk Management

% Risks overdue for review at end of each month

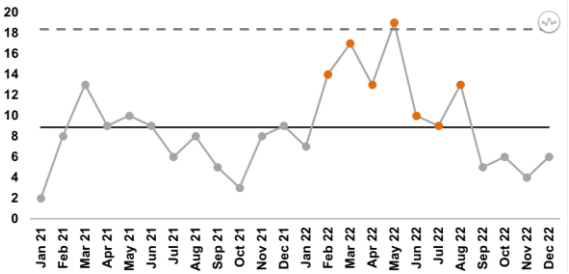


Incidents, Actions and Learning

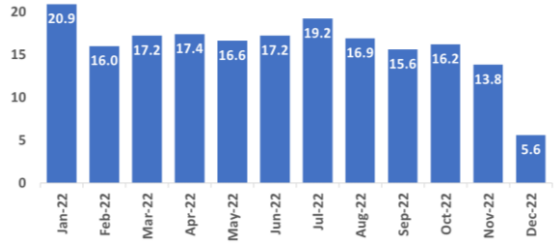
No. Patient Incidents Reported



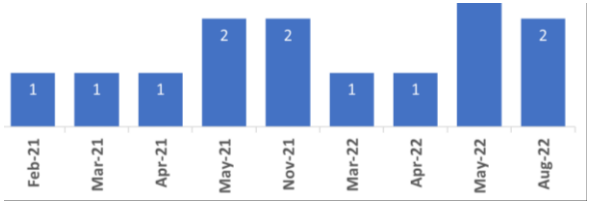
No. NEs / SIs reported



No. of incidents reported per 1000 bed nights

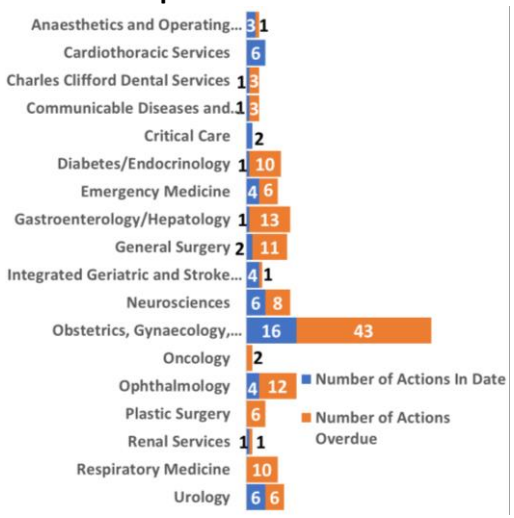


No. of Never Events reported between December 2020 and November 2022

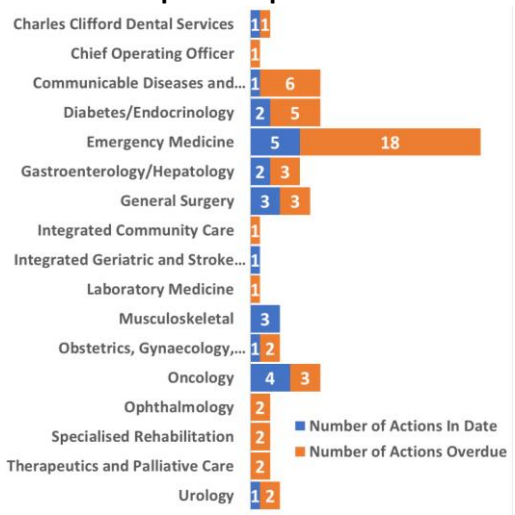


Care Group Governance

Number of open Serious Incident actions



Number of open Complaint actions

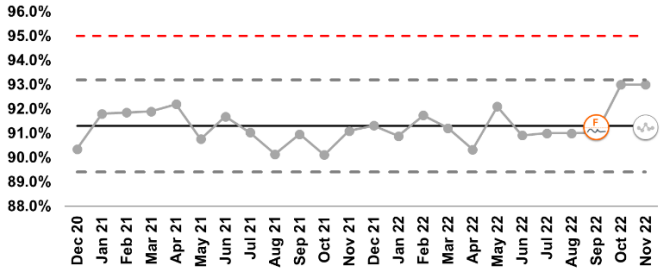


Number of open Risk actions

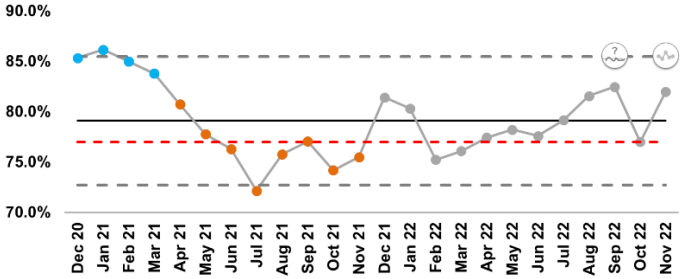
Patient Engagement & Experience

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

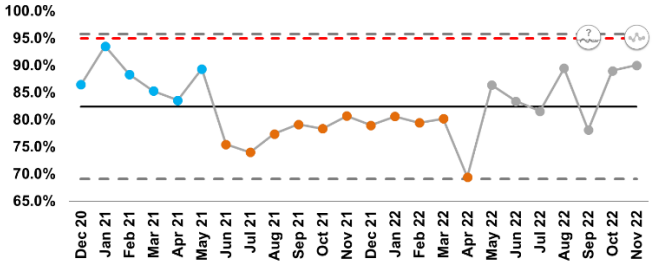
Inpatients



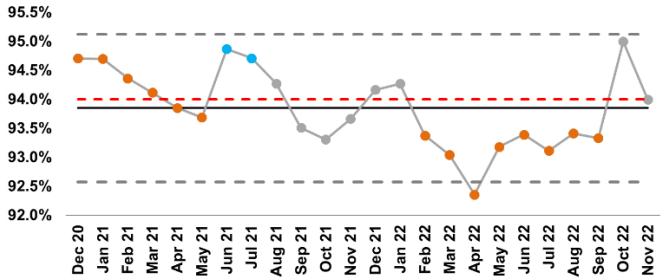
A&E



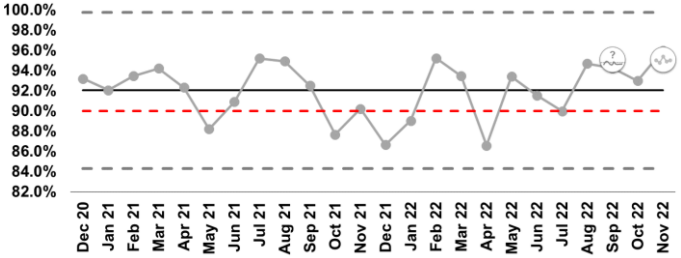
Maternity



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: December 2022

Workstream	Progress last month	Plan for next month
• Well-led review	• Finalisation of Well-led report • Board Strategy Session held 9 December 2022 – presentation of final report and discussion of key findings led by AuditOne review team • Development of proposals for improvement plan (Plan on a Page) and recommendation for TEG lead / Board oversight arrangements • Formal submission of final report to Board of Directors held in private on 20 December 2022 • Sharing of final report with Management Board members (MBB 23 December 2022)	• Further reflection on recommendations with a view to completing action plan by the end of January 2023 • Agreement of priorities for areas of governance / leadership advisory work across TEG leads
• Risk Management (Board Assurance)	• Strategic Risk Deep Dive reviews continued in line with the Board Assurance Framework operating principles • Drafting of paper to January 23 Audit Committee on operation of Board Assurance Framework to date / ongoing development	• Presentation of update to January 23 Audit Committee on operation of Board Assurance Framework to date / ongoing development
• Fit and Proper Persons	• Implementation of policy requirements incorporated within planning work for current NED appointment process (refresh and application of SOP for nominated NED)	• Review the Fit and Proper Persons Annual Report and continue to embed practice through application of SOPs
• Board Development Programme	• The Well-led report has provided a number of prompts for the Board Development Plan, there are plans in place for TEG and Board colleagues to consider the final report although this is now planned for January 2023, rather than December 2022.	• Produce the Board Development Plan

OUTCOMES (including measures)	**EVIDENCE**
• Increased Board assurance/scrutiny of the strategic risks and risk management • Development and improved performance of the Board of Directors	• BoD and Board Committee minutes • NHSE and CQC feedback and inspection outcomes

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

Areas of work

- Monitor performance of mandatory and job specific training through Trust Performance Framework.

Immediate priority areas

- Continue to send monthly reports to all directorates showing staff with outstanding mandatory and job specific training.

These will result in

- Performance >90%

We will deliver by (date)

- Ongoing

Supporting Strategies or Frameworks

- Induction, mandatory and job specific training policy
- Core Skills Training Framework (England 1.1)

IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL– WORKFORCE

Period covered: December 2022

Workstream	Progress last month	Plan for next month
Staff training	• Mandatory Training Compliance has improved from 92% to 93% • Job Specific Essential Training has remained stable at 92% • Medical and Dental compliance has remained stable at 81% • Monthly non-compliance reports issued	• Target improvement for Medical and Dental staff compliance • Identify subjects or directorates which fall below the 90% target and communicate with staff regarding need to complete training • Produce monthly non-compliance reports • Mapping of STH training requirements to ESR competencies (to aid acknowledgement of medical staff training compliance) • Review Mandatory Training requirements against the Core Skills Training Framework (CSTF England 1.1)

Workstream	**OUTCOMES** (including measures)	EVIDENCE
Staff training	• Communication with target groups • Improved compliance with Medical and Dental Staff • Monthly non-compliance report distributed to Directorate Triumvirates • Mapping of ESR competencies completed • Documented improvement plan for mapping to the CSTF	• Record of communication with target groups • Compliance data • Non-compliance reports available • Mapping tool available with all references stated • Improvement plan available

Workstream	RISKS	MITIGATIONS
Staff training	• Reputational damage – negative press from CQC inspections, coroners' reports, patient complaints, litigation and disaffected staff • Patients Harm – due to incorrect clinical treatment, because of staff not performing in line with current Trust standards and policy • Financial damage – corporate fines, compensation for patient harm • Failure of the Trust to comply with legal duties	• Provision of monthly non-compliance reports to Trust Triumvirates • Personal communications with non-compliant staff for worst performing subjects • Introduction, of a passporting system to reduce duplication of training • Training of managers to utilise the Mandatory Training Dashboard • Provide standardised reports to Trust committees leading for subjects • Identification of hot spots for non-compliance

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 • Recruit additional wellbeing champions particularly at B5 to act as peer support • Active AEM representation at Violence & Aggression Group	• 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 • Sharing Complaints themes and anonymised comments with staff • 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: December 2022

Workstream	Progress last month	Plan for next month
Quality & Safety	• Installation of Whiteboards in ED - Drop-in training sessions for staff to learn how to use the new Whiteboard before go-live. Go live date confirmed for January. • Re-launch of hydration stations. Hydration group has met and in continuous discussions around best use of hydration stations and equipment. There are now hydration stations in all Teams areas to provide patients with refreshments more regularly. • Catering Manger arranged for taste testing of hot food options for ED. • New Falls Risk Assessment incorporated into Nursing Assessment • Trial of handheld devices in ED for observations – data to be gathered for January update. • 'Simulation Wednesdays' for deteriorating patients commenced and sepsis study days.	• Targeted work to improve IPC audit results. • Mental Health, Falls, Nutrition and Hydration and Deteriorating patient improvement groups to meet in January • Continuous auditing of IPC standards will be fed back to staff via ED Matron Newsletter. For next month, Commode cleaning audit results will be highlighted.
Workforce and Wellbeing	• SNCT results • Civility and Respect breakfast club • Wellbeing champions increased	• Further SNCT study planned for January 2023 • Civility and Respect breakfast club
Leadership	• Nurse Director and Deputy Nurse Director undertaking 'back to the floor' shifts • Compassionate Leadership places have been awarded for a range of staff groups • Nursing staff focus group to discuss team responsibilities and ways to improve intentional rounding.	• More Army team training days • Sharing the new CQC report and celebrating the improvement ensuring improvement sustained
Staff Engagement	• Staff engagement work with nursing staff is ongoing. • Increase wellbeing champions and freedom to speak up advocates	• DND to train as Freedom to Speak up Guardian.
Patient Experience	• Weekend SDEC	• Deputy Operations director has made progress with the waiting times appearing on the waiting room screen. • IAU coordinator support role to be tested until March

OUTCOMES (including measures)	**EVIDENCE**
• Hand Hygiene IPC audits are up 10% to 90%. Commode audits are down slightly from 85% to 68%. • Weekly commode audits undertaken	• Waiting room is monitored by streaming Sister 12 hours a day. • Staff Survey results. • Audit results

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).	• Recruited to the MHPL post and established temporary support with DMHRA audits. Now to be managed by Central Nursing.

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)

IMPROVEMENT PROGRAMME PROGRESS REPORT DETAIL– SPECIALISED CANCER SERVICES (SCS)

Period covered: December 2022

Workstream	Progress last month	Plan for next month
Shaping The Future and Service Planning	• Tumour site initial Demand and Capacity assessment completed for breast • Tumour site meetings established for Breast and Urology.	• Further work required to refine the demand and capacity model for ongoing use.
Workforce and Resource Planning	• A&C Review near completion	• Paper to BPT for additional resources
Research and Service Improvement	• Cerner preparation meetings ongoing • List of projects completed for Improvement Director resource • First strategy meeting of the WP education Group	• Improvement Director resource to be recruited
A&C, Telephony, and IT Optimisation	• Review of data quality • A&C Performance framework near completion • Drive around SY to review the clinician IT experience	• Ops Manager Improvement to be recruited • A&C performance framework to be rolled out
Risk, Health and Wellbeing	• Consider the feedback from the staff survey	• Risk consolidation exercise underway aligned to the new Trust Risk Assessment approach

OUTCOMES (including measures)	**EVIDENCE**
• Improved Data Assurance	• 34 Access Plans removed from the system (423 down to 389)

RISKS	**MITIGATIONS**
• Staff health and well being • Lack of capacity to meet service demand • Delays in patient care	• Recruitment, workforce redesign, process efficiency improvement • Feedback to specialised Cancer Improvement board - Consideration of mutual aid or ceasing some services • Risks and incidents being added to Datix for clinical review

Appendix 1: Quality Support Visits - RAG rating by ward and outcome (at 3 January 2023)

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
Medicine	RHH	CIU (P2)																																															
Medicine	RHH	E1/E2																																															
Surgery	RHH	F1																																															
Surgery	RHH	F2																																															
Surgery	RHH	G1																																															
Medicine	RHH	G2																																															
Medicine	RHH	H1 (formally Q1)																																															
Surgery	RHH	I1																																															
Medicine	RHH	L1																																															
Medicine	RHH	L2																																															
Medicine	RHH	M2																																															
Surgery	RHH	N2																																															
Medicine	RHH	O1																																															
Medicine	RHH	P3/P4																																															
Medicine	RHH	Q2																																															
UEC	NGH	A&E																																															
Medicine	NGH	ACUTE MEDICAL UNIT																																															
Medicine	NGH	BREARLEY 1																																															
Medicine	NGH	BREARLEY 3																																															
Medicine	NGH	BREARLEY 4																																															
Medicine	NGH	BREARLEY 5																																															
Medicine	NGH	BREARLEY 6																																															
Medicine	NGH	BREARLEY 7																																															
Medicine	NGH	CCU																																															
Medicine	NGH	CF UNIT																																															
Medicine	NGH	CHESTERMAN 1																																															
Medicine	NGH	CHESTERMAN 2																																															
Surgery	NGH	CHESTERMAN 3																																															
Surgery	NGH	CHESTERMAN 4																																															
Surgery	NGH	FIRTH 2																																															
Surgery	NGH	FIRTH 3																																															
Surgery	NGH	FIRTH 4																																															
Medicine	NGH	FIRTH 7																																															
Surgery	NGH	FIRTH 8																																															
Surgery	NGH	FIRTH 9																																															
Medicine	NGH	FRAILTY UNIT																																															
Surgery	NGH	HUNTSMAN 2																																															
Surgery	NGH	HUNTSMAN 3 (TAU)																																															
Medicine	NGH	HUNTSMAN 4																																															
Surgery	NGH	HUNTSMAN 5																																															
Surgery	NGH	HUNTSMAN 6																																															
Surgery	NGH	HUNTSMAN 7																																															
Medicine	NGH	OSBORNE 1																																															
Medicine	NGH	OSBORNE 4																																															
Medicine	NGH	PALLATIVE CARE UNIT																																															
Medicine	NGH	RENAL UNIT E																																															
Medicine	NGH	RENAL UNIT F																																															
Medicine	NGH	ROBERT HADFIELD 1																																															
Medicine	NGH	ROBERT HADFIELD 2																																															
Medicine	NGH	ROBERT HADFIELD 3																																															
Medicine	NGH	ROBERT HADFIELD 4																																															
Medicine	NGH	ROBERT HADFIELD 5																																															
Medicine	NGH	ROBERT HADFIELD 6																																															
Surgery	NGH	SAC / HUNTSMAN 8																																															
Medicine	NGH	VICKERS 2																																															
Medicine	NGH	VICKERS 3 (formally BR2)																																															
Maternity	JW	LABOUR WARD																																															
Maternity	JW	NEONATAL UNIT (NNU)																																															
Maternity	JW	NORFOLK WARD																																															
Maternity	JW	RIVELIN WARD																																															
Maternity	JW	WHIRLOW WARD																																															
Medicine	WPH	WARD 2																																															
Medicine	WPH	WARD 3																																															
Community	COM	SPARC (Beech Hill)																																															

Appendix 2: 2021 CQC Inspection Must Do Requirement Status

In the 2021 CQC inspection report, 85 'must do' requirements were highlighted and 26 'should do' recommendations. As reported to the Trust Executive Group in August 2022, all 26 'should do' recommendations have either been completed or are addressed through other existing workstreams.

The table below lists the 85 'must do' requirements, providing an update on progress against each requirement and whether these have been carried forward by CQC in the 2022 inspection report. The oversight arrangements for each 'must do' requirement is also detailed.

Overall, 22 'must do' requirements have been carried forward and included in the new 53 'must do' requirements highlighted in the 2022 inspection report. 43 of the original 85 'must do' requirements are now complete, with the remaining 42 ongoing and have been incorporated into the relevant Plan on a Page or is part of another workstream, such as the IPC Programme.

2021 Ref	**2021 Requirement**	**Included in 2022 Must Do requirements?**	**Action Status** (Complete / not complete)	**Business as usual** (Yes/No)	**Oversight arrangements** (committee/group or report)	**C/F to 2022 Plan on a Page?** (Yes/No)
MD01	The trust must ensure it implements effective systems to ensure staff assess and manage the risks to service users in relation to their mental health. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Mental Health Steering Group	Mental Health, Learning Disability and Autism
MD02	The trust must ensure it implements effective systems to identify, assess and manage risks in relation to care environments including the risks related to infection prevention and control. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Oversight through the annual IPC programme	No – oversight through the Trust IPC annual Programme
MD03	The trust must ensure it implements effective systems to ensure staff consistently assess and manage risks in relation to falls. (**Trust wide / Trust wide**)		Ongoing	No	FRA for inpatient areas live and in use FRA for ED waiting for update from form builder Audit built by digital team waiting to go live – once live will enable targeting of low compliance Falls Strategic Group	Fundamentals of Care
MD04	The trust must ensure it implements effective systems to ensure staff consistently assess and manage risks in relation to service users who may be deteriorating. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Deteriorating Patient Committee	Fundamentals of Care
MD05	The trust must ensure there is enough suitably skilled nursing and midwifery staff to ensure patient safety. (**Trust wide / Trust wide**)		Ongoing	Yes	People committee	No
MD06	The trust must ensure it implements effective systems to ensure staff adhere to the Mental Capacity Act. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Mental Health Steering Group	Mental Health, Learning Disability and Autism
MD07	The trust must ensure effective operational oversight of risk, issues and performance. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Safety and Risk Committee	Quality Governance
MD08	The trust must ensure it implements effective systems to monitor incidents involving restrictive interventions including restraint and rapid tranquilisation. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Mental Health Steering Group Safety and Safety Committee	Mental Health, Learning Disability and Autism

MD09	The trust must ensure it implements effective systems to ensure incidents are reported consistently and to ensure reports are categorised appropriately to reflect harm sustained by service users. (**Trust wide / Trust wide**)	Yes	Ongoing	Yes	Safety and Risk Committee via IQSR	Quality Governance
MD10	The trust must ensure that all board members have been subject to all the appropriate fit and proper person checks and that these are recorded. In addition, the trust should comply with its own FPPR policy by ensuring that there is evidence of the qualitative assessment and values-based assessment directors had undergone as part of the recruitment process. (**Trust wide / Trust wide**)		Complete	Yes	TEG and Board of Directors	Well-led
MD11	The service must ensure that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Nutrition and hydration improvement group	Urgent and Emergency Care
MD12	The service must ensure that service users are treated with dignity and respect, ensuring the privacy of service users. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Champions in place across the Trust and now business as usual. Action to be removed from CQC Action Plan.	Urgent and Emergency Care
MD13	The service must ensure that it is effectively assessing the risks to the health and safety of service users of receiving the care or treatment. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Monthly 'spot check' audits Mental Health Steering Group	Urgent and Emergency Care
MD14	The service must ensure that assessments of the risks to the health and safety are carried out in line with national guidelines and mitigate risks posed to patients. (**Urgent and Emergency Care / NGH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD15	The service must ensure that care and treatment is provided in a safe way to patients, including actions is taken when issues are identified in audits. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Acute and Emergency Medicine Executive Group	No
MD16	The service must ensure that patients who are streamed away from the emergency department are reviewed in line with the systems and process in place, by staff who are suitably trained and competent to do so. (**Urgent and Emergency Care / NGH**)		Complete	Yes	AEM Educators	Urgent and Emergency Care
MD17	The service must ensure that the nutritional and hydration needs of service users are met. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Nutrition and hydration improvement group	Urgent and Emergency Care
MD18	The service must ensure that all premises and equipment used by the service provider is fit for use and cleaned in line with trust and national guidelines. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Senior Sister spot checks	Urgent and Emergency Care
MD19	The service must ensure they maintain appropriate standards of hygiene. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Senior Sister spot checks	Urgent and Emergency Care
MD20	The service must ensure that systems or processes are established and operated effectively. (**Urgent and Emergency Care / NGH**)		Complete	Yes	Acute and Emergency Medicine Executive Group	No
MD21	The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (**Urgent and Emergency Care / NGH**)		Complete	Yes	Safety and Risk Committee via IQSR	No
MD22	The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions	Yes	Ongoing	Yes	Acute and Emergency Medicine Executive Group	Urgent and Emergency Care

	taken in relation to the care and treatment provided (**Urgent and Emergency Care / NGH**)					
MD23	The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in line with national guidance. (**Urgent and Emergency Care / NGH**)		Complete	Yes	AEM Educators	Urgent and Emergency Care
MD24	The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (**Urgent and Emergency Care / NGH**)		Complete	Yes	AEM Educators	Urgent and Emergency Care
MD25	The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks (**Medical Care / NGH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD26	The service must ensure the proper and safe management of medicines (**Medical Care / NGH**)	Yes	Ongoing	Yes	Medicines Safety Committee	Fundamentals of Care
MD27	The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (**Medical Care / NGH**)		Complete	Yes	Safety and Risk Committee	No
MD28	The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (**Medical Care / NGH**)	Yes	Ongoing	Yes	Health Records Committee	Fundamentals of Care
MD29	The service must have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to comply with the fundamental standards (**Medical Care / NGH**)		Complete	YES	Integrated Performance Report	No
MD30	The service must ensure areas used to store hazardous and biological waste are locked at all times. (**Medical Care / NGH**)		Complete	Yes	Ongoing actions to provide assurance around safe storage of chemicals are included in the Fundamentals of Care action on a page	Fundamentals of Care
MD31	The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. This includes the completion of mandatory training. (**Surgery / NGH**)		Complete	Yes	People committee Integrated Performance Report	Workforce
MD32	The service must ensure that all staff receive safeguarding training for adults and children, as necessary which includes PREVENT, to evidence that systems and processes are operated effectively to prevent abuse of service users. (**Surgery / NGH**)	Yes	Ongoing	Yes	People Committee	Workforce
MD33	The service must ensure that all premises and equipment used by the provider must be clean, secure and properly maintained. This must include the secure storage of cleaning chemicals. (**Surgery / NGH**)		Complete	Yes	Ongoing actions to provide assurance around safe storage of chemicals are included in the Fundamentals of Care action on a page	Fundamentals of Care
MD34	The service must ensure there is a safe and effective system for the storage, administration and reconciliation of medicines, including medical gases. (**Surgery / NGH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD35	The service must ensure all medical gases are stored safely and pose no fire or health and safety risks. Storage information and guidance must be clearly documented in the medicines' management policy. (**Surgery / NGH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care

MD36	The service must ensure there are fire safety risk assessments in place for the premises, which include the storage of medical gases. (**Surgery / NGH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD37	The service must ensure that assessments of risk to the health and safety are carried out in line with national guidelines and mitigate risks posed to patients. (**Surgery / NGH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD38	The service must ensure that there are enough nursing staff to provide safe care and treatment. (**Surgery / NGH**)		Complete	YES	Twice Daily Staffing Huddle Embedded with senior oversight during staffing escalation Teams Duty Matron Shift Log Nurse & Midwifery Staffing	No
MD39	The service must ensure that surgical patients have their individual needs assessed and that care planning is personalised to meet their individual needs. This must include the assessment of mental capacity and cognitive impairment assessments and emotional needs. (**Surgery / NGH**)		Complete	Yes	Mental Capacity Team	No
MD40	The service must ensure that medicines are stored safely. (**Surgery / NGH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD41	The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this. This must include the management and investigation of incidents and the learning following incidents. (**Surgery / NGH**)		Complete	Yes	Safety and Risk Committee via IQSR	No
MD42	The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This must include the implementation of staffing risk review, which reflects the acuity of patients. (**Surgery / NGH**)		Ongoing	Yes	Mental Health Steering Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD43	The service must ensure effective risk and governance systems are implemented that supports safe, quality care. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Safety and Risk Committee	Quality Governance
MD44	The service must improve the monitoring of the effectiveness of care and treatment. Timeliness of reviews and implementation of change. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD45	The service must ensure audit information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD46	The service must ensure correct processes are in place for investigating complaints, recognising incidents from complaints and improving complainants' responses. (**Maternity Services / JW**)		Complete	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD47	The service must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing women and babies to the risk of harm. (**Maternity Services / JW**)		Ongoing	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD48	The service must ensure systems are put in place to ensure that midwifery staff were suitably qualified, skilled and competent to care for and meet the needs of women and babies within all areas of the maternity services,		Complete	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services

	including areas where women were waiting to be seen. (**Maternity Services / JW**)					
MD49	The service must ensure risk assessments and risk management plans are completed in accordance with national guidance and local service policy and documented appropriately. (**Maternity Services / JW**)		Complete	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD50	The service must ensure that delays to induction of labour is significantly reduced. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD51	The service must ensure that the CTG monitoring of women and their babies are undertaken in line with national guidance and best practice. (**Maternity Services / JW**)		Complete	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD52	The service must ensure correct processes are in place for investigating serious incidents that reduce delays and accuracy of investigations. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Safety and Risk Committee via IQSR	Quality Governance
MD53	The service must improve lessons learned and the sharing of lessons learned amongst the whole team and the wider service. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Maternity Improvement Programme and Maternity & Neonatal Safety Report	Maternity Services
MD54	The service must ensure improved infection control. (**Maternity Services / JW**)	Yes	Ongoing	No	IPC Committee IPC accreditation in 2022 IPC Programme and will also be in 2023 IPC programme. Transfer of IPC Accreditation Programme to QUEST part of an ongoing workstream	Fundamentals of Care
MD55	The service must ensure safe systems and processes to prescribe, administer, record and store medicines are in place and applied. (**Maternity Services / JW**)	Yes	Ongoing	Yes	Medicines Safety Committee	Fundamentals of Care
MD56	The service must ensure that patients have their individual needs assessed and that care planning is personalised to meet their individual needs. This must include the assessment of mental capacity and cognitive impairment assessments and emotional needs. (**Medical Care / RHH**)		Complete	Yes	Mental Capacity Team	No
MD57	The service must ensure service users are treated with dignity and respect. Ensuring the privacy of the service user. (**Medical Care / RHH**)		Complete	Yes	Champions in place across the Trust and now business as usual. Action to be removed from CQC Action Plan.	No
MD58	The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks (**Medical Care / RHH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD59	The service must ensure the proper and safe management of medicines (**Medical Care / RHH**)	Yes	Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD60	The service must ensure that staff complete mental capacity and best interest decisions, and they must clearly document the assessment and decision making-making process. (**Medical Care / RHH**)	Yes	Ongoing	Yes	Mental Capacity Team	Mental Health, Learning Disability and Autism
MD61	The service must ensure that a service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. (**Medical Care / RHH**)		Complete	Yes	Mental Capacity Team	No
MD62	The service must ensure that all premises and equipment used by the provider must be clean, secure and properly maintained. This must include the secure storage of cleaning chemicals. (**Medical Care / RHH**)		Complete	Yes	Ongoing actions to provide assurance around safe storage of chemicals are included in the Fundamentals of Care plan on a page	Fundamentals of Care

MD63	The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this. This must include the management and investigation of incidents and the learning following incidents. (**Medical Care / RHH**)		Complete	Yes	Safety and Risk Committee and IQSR	Quality Governance
MD64	The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This must include the implementation of staffing risk review, which reflects the acuity of patients. (**Medical Care / RHH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group Twice Daily Staffing Huddle Embedded with senior oversight during staffing escalation Teams Duty Matron Shift Log Nurse & Midwifery Staffing	Mental Health, Learning Disability and Autism Fundamentals of Care
MD65	The service must have enough suitably qualified, competent, skilled and experienced persons deployed to comply with the fundamental standards (**Medical Care / RHH**)		Complete	Yes	Integrated Performance Report	No
MD66	The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. This includes the completion of mandatory training. (**Surgery / RHH**)		Complete	Yes	People committee Integrated Performance Report	Workforce
MD67	The service must ensure that all staff receive safeguarding training for adults and children, as necessary which includes PREVENT, to evidence that systems and processes are operated effectively to prevent abuse of service users. (**Surgery / RHH**)	Yes	Ongoing	Yes	People committee	Workforce
MD68	The service must ensure that all premises and equipment used by the provider must be clean, secure and properly maintained. This must the secure storage of cleaning chemicals. (**Surgery / RHH**)		Complete	Yes	Ongoing actions to provide assurance around safe storage of chemicals are included in the Fundamentals of Care action on a page	Fundamentals of Care
MD69	The service must ensure there is a safe and effective system for the storage, administration and reconciliation of medicines, including medical gases. (**Surgery / RHH**)		Complete	Yes	Medicines safety committee	No
MD70	The service must ensure all medical gases are stored safely and pose no fire or health and safety risks. Storage information and guidance must be clearly documented in the medicines' management policy. (**Surgery / RHH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD71	The service must ensure there are fire safety risk assessments in place for the premises, which include the storage of medical gases. (**Surgery / RHH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD72	The service must ensure that assessments of risk to the health and safety are carried out in line with national guidelines and mitigate risks posed to patients. (**Surgery / RHH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD73	The service must ensure that there are enough nursing staff to provide safe care and treatment. (**Surgery / RHH**)		Complete	Yes	Twice Daily Staffing Huddle Embedded with senior oversight during staffing escalation Teams Duty Matron Shift Log Nurse & Midwifery Staffing	No
MD74	The service must ensure that surgical patients have their individual needs assessed and that care planning is personalised to meet their individual needs. This must include the assessment of mental capacity and cognitive impairment assessments and emotional needs. (**Surgery / RHH**)		Complete	Yes	Mental Health Steering Group	No
MD75	The service must ensure that medicines are stored safely. (**Surgery / RHH**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care

MD76	The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this. This must include the management and investigation of incidents and the learning following incidents. (**Surgery / RHH**)		Complete	Yes	Safety and Risk Committee via IQSR	Quality Governance
MD77	The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This must include the implementation of staffing risk review, which reflects the acuity of patients. (**Surgery / RHH**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group Embedded with senior oversight during staffing escalation Teams Duty Matron Shift Log Nurse & Midwifery Staffing	Mental Health, Learning Disability and Autism Fundamentals of Care
MD78	The trust must ensure that medicines are administered safely in line with best practice. (**Community Inpatients / Beech Hill**)		Ongoing	Yes	Medicines safety committee	Fundamentals of Care
MD79	The trust must ensure staff administering medicines are offering pain relief to patients as and when required. (**Community Inpatients / Beech Hill**)		Complete	Yes	Medicines safety committee	Fundamentals of Care
MD80	The trust must ensure staff receive appropriate supervision. (**Community Inpatients / Beech Hill**)		Complete	Yes	Combined Community and Acute Medicine Nurse Director	No
MD81	The trust must ensure they have sufficient numbers of staff to respond to patient requests for support in a timely manner. (**Community Inpatients / Beech Hill**)		Complete	Yes	Twice Daily Staffing Huddle Embedded with senior oversight during staffing escalation Teams Duty Matron Shift Log Nurse & Midwifery Staffing	No
MD82	The trust must ensure the mental capacity of patients is assessed appropriately in conjunction with the Mental Capacity Act 2005 Code of practice principles. (**Community Inpatients / Beech Hill**)		Complete	Yes	Mental Health steering group	No
MD83	The trust must ensure they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users by ensuring robust governance arrangements are in place. (**Community Inpatients / Beech Hill**)		Ongoing	Yes	Mental Health Steering Group Falls Strategic Group	Mental Health, Learning Disability and Autism Fundamentals of Care
MD84	The trust must ensure patient risk assessments for specialist equipment are reviewed regularly to reduce risks to patients. (**Community Inpatients / Beech Hill**)		Complete	Yes	Combined Community and Acute Medicine Nurse Director	No
MD85	The trust must ensure that the care and treatment of service users meets their needs and preferences. (**Community Inpatients / Beech Hill**)		Complete	Yes	Ongoing review of swallow/nutrition incidents via governance meeting	No

Appendix 3: 2022 CQC Inspection Must Do and Should Do Requirements mapped to Plans on a Page

The tables below provide details of each new 'Must do' requirement and 'Should do' recommendations mapped under the relevant Plan on a Page. This information will be shared with each Lead to incorporate into the Plan on a Page template for the next update.

Mental Health, Learning Disability and Autism

2022 Ref	Type	2022 Requirement	Site / Service
MD02	New for 2022	The trust must ensure staff undertake and record appropriate observations of service users' health after administering rapid tranquilisation.	Trustwide
MD03	Carried Forward from 2021	The trust must ensure staff adhere to the requirement of the Mental Capacity Act.	Trustwide
MD07	New for 2022	The trust must ensure all staff required to physically restrain service users receive training which complies with the Restraint Reduction Network standards.	Trustwide
MD08	Carried Forward from 2021	The trust must have effective systems to ensure staff assess and manage the risks to service users in relation to their mental health.	NGH / Urgent & Emergency Care
MD11	New for 2022	The trust must ensure staff receive the appropriate training in relation to the use of restrictive interventions including restraint and rapid tranquilisation.	NGH / Urgent & Emergency Care
MD16	Carried Forward from 2021	The trust must ensure it implements effective systems to ensure staff adhere to trust policy in relation to the use of restrictive interventions including restraint and rapid tranquilisation.	NGH / Urgent & Emergency Care
MD26	Carried Forward from 2021	The trust must ensure it implements effective systems to ensure staff adhere to trust policy in relation to the use of restrictive interventions including restraint and rapid tranquilisation.	RHH / Medicine
MD27	New for 2022	The trust must ensure staff receive the appropriate training in relation to the use of restrictive interventions including restraint and rapid tranquilisation.	RHH / Medicine
MD29	Carried Forward from 2021	The service must ensure that staff complete mental capacity and best interest decisions, and they must clearly document the assessment and decision making-making process.	RHH / Medicine
MD34	Carried Forward from 2021	The trust must ensure it implements effective systems to ensure staff adhere to trust policy in relation to the use of restrictive interventions including restraint and rapid tranquilisation.	NGH / Medicine
MD35	New for 2022	The trust must ensure staff receive the appropriate training in relation to the use of restrictive interventions including restraint and rapid tranquilisation.	NGH / Medicine
MD37	Carried Forward from 2021	The service must ensure that staff complete mental capacity and best interest decisions, and they must clearly document the assessment and decision making-making process.	NGH / Medicine
SD04	New for 2022	The trust should ensure that compliance with Mental Capacity Act and Deprivation of Liberty Safeguards training for clinical staff continues to improve.	RHH / Surgery
SD10	New for 2022	The trust should ensure that compliance with Mental Capacity Act and Deprivation of Liberty Safeguards training for clinical staff continues to improve.	NGH / Surgery
SD19	Carried Forward from 2021	The trust should continue to implement effective systems to monitor incidents involving restrictive interventions including restraint and rapid tranquilisation.	NGH / Medicine

Fundamentals of Care

Ref	Type	2022 Requirement	Site / Service
MD18	Carried Forward from 2021	The trust must ensure that medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.	RHH / Surgery
MD19	New for 2022	The trust must ensure that it is effectively assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.	RHH / Surgery
MD22	Carried Forward from 2021	The trust must ensure that medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.	NGH / Surgery
MD23	New for 2022	The trust must ensure staff assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated.	NGH / Surgery
MD28	New for 2022	The trust must ensure that all patients have access to a call bell.	RHH / Medicine
MD30	Carried Forward from 2021	The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	RHH / Medicine
MD32	New for 2022	The trust must improve the monitoring of the effectiveness of care and treatment, timeliness of reviews and implementation of change.	RHH / Medicine
MD36	Carried Forward from 2021	The trust must continue to implement effective systems to ensure staff consistently assess and manage risks in relation to service users who may be deteriorating.	NGH / Medicine
MD38	Carried Forward from 2021	The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	NGH / Medicine
MD40	New for 2022	The trust must improve the monitoring of the effectiveness of care and treatment, timeliness of reviews and implementation of change.	NGH / Medicine
SD03	Carried Forward from 2021	The trust should ensure that all patient records are stored securely.	NGH / Urgent & Emergency Care
SD15	New for 2022	The trust should consider expanding the audit programme to include the assessment of pain and the use of preoperative fasting.	NGH / Surgery
SD16	Carried Forward from 2021	The trust should ensure that all patient records are stored securely.	NGH / Surgery
SD20	New for 2022	The trust should consider the implementation of a routine audit in relation to the administration and management of pain relief.	NGH / Medicine
SD21	New for 2022	The trust should ensure staff effectively manage the risks of infection by reviewing the use of fabric curtains and ensuring staff are bare below the elbows in clinical areas.	NGH / Medicine

Quality Governance

Ref	Type	2022 Requirement	Site / Service
MD01	Carried Forward from 2021	The trust must ensure systems operate effectively to identify, assess and manage risks in relation to care environments.	Trustwide
MD04	Carried Forward from 2021	The trust must ensure incidents including serious incidents are identified, reported consistently, and categorised appropriately to reflect harm sustained by service users.	Trustwide
MD05	New for 2022	The trust must ensure incidents including serious incidents are investigated within an appropriate timescale and improvements are made without delay.	Trustwide
MD06	Carried Forward from 2021	The trust must continue to improve, embed and sustain governance and risk management processes to assess, monitor and improve the quality of services.	Trustwide
MD20	Carried Forward from 2021	The trust must ensure that the information to allow patients to make complaints is easily accessible.	RHH / Surgery
MD21	Carried Forward from 2021	The trust must continue to improve, embed and sustain governance and risk management processes to assess, monitor and improve the quality of services.	RHH / Surgery
MD24	Carried Forward from 2021	The trust must ensure that the information to allow patients to make complaints is easily accessible.	NGH / Surgery
MD25	Carried Forward from 2021	The trust must continue to improve, embed and sustain governance and risk management processes to assess, monitor and improve the quality of services.	NGH / Surgery
MD31	Carried Forward from 2021	The service must ensure effective risk and governance systems are implemented to support safe, quality care.	RHH / Medicine
MD33	New for 2022	The trust must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance.	RHH / Medicine
MD39	Carried Forward from 2021	The service must ensure effective risk and governance systems are implemented to supports safe, hihg-quality quality care.	NGH / Medicine
MD41	New for 2022	The trust must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance.	NGH / Medicine
MD48	New for 2022	The trust must ensure that complaints are responded to within timelines outlined in their policy and procedure.	Jessop Wing / Maternity
MD49	Carried Forward from 2021	The trust must ensure effective risk and governance systems are implemented that supports safe, quality care.	Jessop Wing / Maternity
MD52	New for 2022	The trust must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance.	Jessop Wing / Maternity
SD07	New for 2022	The trust should consider methods to introduce a consistently applied audit schedule.	RHH / Surgery
SD08	New for 2022	The trust should consider expanding the existing audit schedule to include the assessment of pain.	RHH / Surgery
SD18	Carried Forward from 2021	The trust should ensure that information is widely displayed so that patients know how to complain.	NGH / Medicine

Well-Led

Ref	Type	2022 Requirement	Site / Service
SD06	New for 2022	The trust should ensure it continues to reduce the number of cancelled elective procedures.	RHH / Surgery
SD13	New for 2022	The trust should ensure it continues to reduce the number of cancelled elective procedures.	NGH / Surgery

Workforce

Ref	Type	2022 Requirement	Site / Service
SD02	New for 2022	The trust should consider methods to improve staff appraisal rates.	NGH / Urgent & Emergency Care
SD05	New for 2022	The trust should consider methods to improve staff appraisal rates.	RHH / Surgery
SD09	New for 2022	The trust should consider methods to be able to provide information at directorate and speciality levels.	RHH / Surgery
SD11	Carried Forward from 2021	The trust should ensure that compliance with safeguarding training compliance continues to improve.	NGH / Surgery
SD12	New for 2022	The trust should consider methods to improve staff appraisal rates.	NGH / Surgery
SD17	New for 2022	The trust should consider methods to be able to provide information at directorate and speciality levels.	NGH / Surgery

Urgent and Emergency Care

Ref	Type	2022 Requirement	Site / Service
MD09	Carried Forward from 2021	The trust must have effective systems to identify, assess and manage and monitor risks to infection prevention control audits.	NGH / Urgent & Emergency Care
MD10	New for 2022	The trust must ensure staff undertake and appropriately record intentional rounding of all service users and ensure this is recorded, monitored, and audited with actions taken to improve compliance.	NGH / Urgent & Emergency Care
MD12	New for 2022	The trust must implement an effective system to ensure all patients waiting to be admitted to the department from the ambulance queue are monitored for signs of deterioration.	NGH / Urgent & Emergency Care
MD13	New for 2022	The trust must ensure that patients receive treatment within agreed timeframes and national targets.	NGH / Urgent & Emergency Care
MD14	New for 2022	The trust must ensure that ambulance handovers are completed within 15 minutes in line with guidance.	NGH / Urgent & Emergency Care
MD15	New for 2022	The trust must improve patient waiting times in the Accident and Emergency department.	NGH / Urgent & Emergency Care
MD17	Carried Forward from 2021	The trust must have effective operational oversight of risk, issues and performance.	NGH / Urgent & Emergency Care
SD01	New for 2022	The trust should implement systems to ensure all patients receive an initial mental health triage on arrival to the department.	NGH / Urgent & Emergency Care

Specialised Cancer Services (SCS)

Ref	Type	2022 Requirement	Site / Service
SD14	New for 2022	The trust should consider methods to improve compliance towards the cancer two week wait targets.	NGH / Surgery

Maternity Services

Ref	Type	2022 Requirement	Site / Service
MD42	Carried Forward from 2021	The trust must ensure that delays to induction of labour continually reduce.	Jessop Wing / Maternity
MD43	Carried Forward from 2021	The trust must continue to improve and embed processes for investigating serious incidents.	Jessop Wing / Maternity
MD44	Carried Forward from 2021	The trust must continue to improve lessons learned and the sharing of lessons learned amongst the whole team and the wider service.	Jessop Wing / Maternity
MD45	New for 2022	The trust must ensure that training and performance appraisals are undertaken in line with national guidance.	Jessop Wing / Maternity
MD46	Carried Forward from 2021	The trust must ensure that staff follow systems and processes to prescribe and administer medicines safely.	Jessop Wing / Maternity
MD47	Carried Forward from 2021	The trust must improve infection control monitoring.	Jessop Wing / Maternity
MD50	New for 2022	The trust must ensure that there is an up to date risk register in place which is monitored and regularly reviewed.	Jessop Wing / Maternity
MD51	Carried Forward from 2021	The trust must improve the monitoring of the effectiveness of care and treatment, timeliness of reviews and implementation of change.	Jessop Wing / Maternity
MD53	Carried Forward from 2021	The trust must ensure audit information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance.	Jessop Wing / Maternity
SD22	Carried Forward from 2021	The trust should implement electronic recording as per MBRRACE UK guidance.	Jessop Wing / Maternity
SD23	New for 2022	The trust should continue with the recruitment programme to ensure they maintain safe staffing levels.	Jessop Wing / Maternity
SD24	New for 2022	The trust should ensure epidural wait times are monitored and audited in line with national guidance.	Jessop Wing / Maternity
SD25	New for 2022	The trust should ensure policies are reviewed regularly to reflect best practice and national guidance.	Jessop Wing / Maternity
SD26	New for 2022	The trust should ensure that consultants requested for administering an epidural are available within 30 minutes of being required.	Jessop Wing / Maternity
SD27	New for 2022	The trust should ensure that agency staff receive a full induction and understand the service.	Jessop Wing / Maternity