Ashford and St. Peter's Hospitals NHS Foundation Trust

**COUNCIL OF GOVERNORS**
**8th June 2022**

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| **AGENDA ITEM** | 8.3 |
| **TITLE OF PAPER** | CQC Action Plan Progress Report |
| **EXECUTIVE SUMMARY** | |

The November 2021 unannounced CQC Inspection covered the Safe and Well led Domains in Medicine and Surgery on both the Ashford and St. Peter's hospital sites. This paper summarises progress made against the Trust Post Inspection Action Plan. The comprehensive plan is appended below and provides details of the actions for improvement, time frames and progress to date.

**MUST ACTIONS**

There were two actions the Trust MUST take in order to comply with its legal obligations around CQC Regulation 12(2)(d) & (e). The Trust has provided the CQC with a copy of this action plan and will provide regular updates to the CQC as required.

**Management of medical devices in St Peter's Theatres** – During their visit the CQC identified a number of medical devices in theatres overdue for servicing. Since November 2021, a plan to ensure all medical devices are serviced was completed. A project to amalgamate, reconcile and upgrade the Trust wide medical devices asset register with all medical devices in the Trust is nearing completion and implementation of the new system is planned for August 2022. To further strengthen medical devices management in the Trust, service level agreements with Estates, EBME, and clinical departments have been drafted to ensure management responsibilities for medical devices is clear and effectively dispensed. Progress monitoring for this MUST action is via the relaunched Medical Devices Committee.

**Environmental repairs required in SPH main Theatres** – to maintain good infection prevention control standards. Damage through wear and tear of walls, floors and, fittings were highlighted for repair during the inspection.
A programme of minor estates works for 2022 is in place and ongoing with works completed during educational half days when theatre lists are reduced. The major works programme has been costed by contractors but was then paused due to the implementation of Surrey Safe Care. Full completion is expected in Autumn 2022.

**SHOULD ACTIONS**

There were 13 actions the inspection identified the Trust SHOULD take because it was not doing something required by a regulation, but it was not breaching the regulation overall. Key areas for improvement were,

- Culture in Theatres
- Pharmacy staffing, medicines guidelines and reconciliation
- Mandatory and safeguarding training
- Clinical practice – MUST scores, NG Tube management, timely physiological observations and 'bare below the elbows

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| | • Staffing<br><br>All clinical practice actions are either designated quality priorities for improvement during 2022/23 and or included as part of the Trust Ward Accreditation improvement programme and Harms free care strategy with progress monitored via regular Division Harms Free Care meetings, the Harms Free Care Oversight Group, and regular audits.<br><br>Good progress has been made across all areas for improvement with many actions completed. Ongoing work is progressing to complete ESR data cleanse so that mandatory training is correctly reflected by the system and there are also Divisional recovery plans in place for mandatory training.<br><br>A number of improvements have been achieved and are planned around Theatre culture. These included the recent launch of the new 'Theatre Charter' which was developed and ratified by the multidisciplinary theatre team and sets out the expected standards for conduct, courtesies, and team behaviours. There are further plans for a targeted programme by an external provider 'a Kind Life' and PPA to work with staff in August and July 2022 respectively.<br><br>Work to progress the improvements around medicines reconciliation and ward-based pharmacy technician cover are progressing with a number of pharmacy vacancies expected to be filled by early Autumn 2022. The service is currently supporting the Trust wide implementation of electronic prescribing.<br><br>**OTHER ACTIONS**<br>The other actions identified are included in Divisional recovery plans with oversight and are monitoring via the Trusts CQC Oversight Committee, the Quality of Care Committee and Divisional Exception Reports.<br><br>  <br>2022 CQC Inspection Action Plan May 2022 |
| **PRESENTED BY** | Andrea Lewis, Chief Nurse |
| **DATE** | 8th June 2022 |
| **ACTION** | The Council is asked to RECEIVE the report |

| REF | MUST/SHOULD | Service | Site | Area for improvement | Action Required | Strategic Committee Oversight/Executive Sponsor | Leads | Timeline | Progress Update May 2022 | | | | | | |
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| 1 | MUST | Surgery | SPH | The service must ensure that damage to flooring, walls and fittings in the theatre and recovery areas is repaired | 1. Create report detailing all maintenance issues in order of priority<br>2.Set out a work programme that includes the required theatre closures<br>3.**Minor Works plan -** commence minor repairs work programme to coordinate with Quality and safety Half days<br>4.**Major Works Plan** - cost out of hours contractor requirements for repairs<br>5.**Major Works Plan** - coordinate repair plan with theatre operating programme<br>6. Set up service level agreements with Estates and theatres to ensure management responsibilities for environmental theatre repairs/minor works is clear and effectively dispensed<br>7. Ensure regular IPC environmental audits to highlight any risks | Modern Healthcare/Director of Strategy and Sustainability | GS-ACT Triumvirate, Theatre Service Manager, in consultation with Estates (Dexter Caeiro) | 1. By November 2021<br>2. By November 2021<br>3. January 2022, 19th May 2022, 18th July 2022, 20th september 2022, 23rd November 2022<br>4. March 2022<br>5. Plan to commence April 2022<br>6. April 2022<br>7. IPC enviroment audit completed by Division in May 2022 | 1. Complete<br>2. Complete<br>3.Plan in place - flooring repairs made to main corridors in January 2022 programme ongoing.<br>4. IPC Refurbishment Plan & Priority work lists ready for actioning (major works costed) - COMPLETE<br>5. Final schedule plan expected Autumn 2022<br>6. SLA draft completed V8- Estates to finalise the structure of the SAL and share with The Division for agreement<br>7. On-going | | | | | | |
| 2 | MUST | Surgery | SPH | The service must ensure all medical devices are serviced regularly | 1. Provide a plan to address outstanding medical device servicing<br>2. Complete all outstanding servicing in theatres<br>3. Staff to continue daily checks of all equipment prior to use<br>4. Reconcile the existing database system and asset register with all medical devices in the Trust<br>5. Implement the new medical devices asset management system<br>6. Set up service level agreements with Estates/EBME/clinical departments to ensure management responsibilities for medical devices is clear and effectively dispensed<br>7. All Divisions to check their medical devices service history to ensure they are up to date | Modern Healthcare/Director of Strategy and Sustainability | GS-ACT Triumvirate, Theatre Service Manager in consultation with Estates EBME Lead | 1. November 2021<br>2. February 2022<br>3. November 2021<br>4. November 2021<br>5. Roll out June 2022<br>6. Theatres by April 2022 - other areas to follow<br>7. April 2022 | 1. Complete<br>2. Complete<br>3. Complete and ongoing<br>4. and 5. launch pilot in August 2022 - Consultancy outsouced and delay in completion of asset register.<br>6. SLA draft completed by Estates final structure to be reported to Medical Devices Committee.<br>7. Divisions monitored through the CQC Oversight Committee & mock inspections: Outpatients, ED & CAU & Programme in place for ongoing checks | | | | | | |
| 3 | SHOULD | Surgery | SPH | The service should consider the culture in theatres and how to address issues in a way that will produce effective and embedded improvement | 1. External Organisational (OD) Development Intervention - Establish appropriate external provider, commission, and arrange delivery<br>2. Safety Culture Survey, analyse and share the results, agree and implement plan<br>3. Theatre Charter - agree survey and launch, analyse results, arrange focus group to discuss, prepare draft charter, proposal to Trust Exec Committee for input, approval, and support<br>4. Practitioner Performance Advice (PPA) Team Review - An intervention specifically targeting the Anaesthetic Consultant body; the review will look at behaviours that may be impacting upon the way the team function and behave<br>- Seek consent of participants<br>- Commission review (minimum of 6-8 weeks in advance of the review is undertaken)<br>- PPA review to take place<br>- Analysis of results<br>- Agree actions to be implemented<br>- Implement and review<br>5. Further targeted OD Intervention to support cultural transformation - This intervention has a specific focus on the reduction of bullying in the workplace and seeking a respectful resolution to matters, which involves co-creating an approach with colleagues<br>- identify External Provider<br>- Commission intervention with provider<br>- Engage speciality in delivery plan<br>- Roll out intervention across the speciality<br>- Review and evaluate the intervention | People Committee/Director of Workforce<br>Medical Director<br>Chief Nurse | GS-ACT Triumvirate with HR Business Partner | 1. December 2021<br>2. March 2022<br>3. Seek approval and support March 2022, launch charter across the organisation April 2022<br>4. Consent & PPA commission Feb 2022; PPA review May 2022 subject to availability, remaining action timeframes to be confirmed following PPA review<br>5. Identify provider Feb 2022, commission and enagage speciality March 2022, roll out intervention May 2022 subject to provider availability, evaluate Autumn 2022 | 1. Completed - Civility Saves Lives commissioned and delivered a masterclass / TED Talk approach. Participants were provided with tools they could use in the workplace<br>2. Completed- Survey results data was analysed and results were shared with Division, Plan in place which is aligned with existing actions and interventions<br>3. Completed-Theatre Charter developed May 2022<br>4. Consent and PPA request complete, PPA review in July 2022<br>5. External provider - 'A Kind Life' identified to deliver a targeted programme, August 2022 | | | | | | |
| 4 | SHOULD | Trustwide (S&M) | SPH | The Trust should ensure patient physiological observations are completed on time | 1. Divisional Harms Free Care meetings to review this data for their wards/services and compile plans to address gaps in assurance<br>2. This is monitored via QEWS dashboard and included as part of the Ward Accreditation improvement programme<br>3. Progress with Divisional plans to be reported at the CQC Oversight Committee | Quality of Care/Chief Nurse | Trustwide, all DCNs, Triumvirates with Deputy Chief Nurse | 1. April 2022<br>2.Monthly and Ongoing<br>3. March 2022 and monthly thereafter | 1.Completed- Business as usual<br>2.Completed-Monthly and Ongoing<br>3.Completed-Monthly and Ongoing | | | | | | |
| 5 | SHOULD | Trustwide (S&M) | SPH | The service should ensure that staff can access current guidelines and reference sources when handling medicines | 1. The MSO should check that all areas have access to Medusa and remove the UCL reference books<br>2.The critical medicines policy should be ratified and distributed as a matter of priority | Digital,<br>Quality of Care/Director of Finance<br>Medical Director | DTC Divisional Triumvirate, Deputy Chief Nurse | 1.November 2021<br>2.November 2021 | 1. Completed-All UCL reference books removed from clinical areas and staff redirected to use Medusa for medicines reference<br>2.Completed-Policy distributed and posters displayed to all ward areas | | | | | | |
| 6 | SHOULD | Trustwide (S&M) | SPH/AH | The service should ensure all staff are up-to-date with their mandatory training | 1. Divisions to compile a recovery plan to ensure 90% compliance<br>2.Learning and Development to review ESR processes to ensure completed e-learning is reflected in staff records. | Quality of Care<br>People Committee/Medical Director<br>Chief Nurse<br>Director of Workforce | Trustwide, all Triumvirates with HR Business Partners | Autumn 2022 | 1. Recovery plans in place which are monitored at Divisional level with Executive Oversight.<br>2. Learning and Development Team completed ESR data cleanse and a new Dedicated Account Manager was recruited. The completion of the ESR update expected Autumn 2022. | | | | | | |

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| 7 | SHOULD | Trustwide (S&M) | SPH/AH | The service should ensure all staff are up-to-date with their safeguarding adults and safeguarding children training and level 3 training is completed by all staff involved in patient care decision making including doctors and nurses | 1. Divisions to compile a recovery plan to ensure 90% compliance<br>2.Learning and Development to review ESR processes to ensure completed e-learning is reflected in staff records<br>3. Safeguarding Team continue to implement the Safeguarding Training Strategy | Quality of Care<br>People Committee/Director of Workforce | Trustwide, all Triumvirates with HR Business Partners | Timeframes for training completion to be agreed with triumvirates at next CQC oversight committee in March 2022 | 1. Recovery plans monitored at Divisional level with Executive Oversight.<br>2. Learning and Development Team completed ESR data cleanse to ensure the level of safeguarding training required was correctly reflected in staff records. Complete<br>3. Safeguarding Team continue to implement the safeguarding training strategy and support divisions with flexible training sessions.<br>Trustwide improvement in training compliance can be seen since November 2021.<br>Safeguarding Adults L2- November 2021: 66.17% and April 2022 70.27% difference(4.10%)<br>Safeguarding Children L2 November 2021: 67.30% and April 2022 69.13% difference (1.84%)<br>Safeguarding Children - Level 3 November 2021: 61.63% and April 2022 64.14% difference 2.51% | | | | | | |
| 8 | SHOULD | Trustwide (S&M) | SPH | The service should take action so staffing numbers match the planned numbers on the ward areas | 1. Staffing recruitmnet and retention strategy in place<br>2.x3 CAT meetings as a minimum and staffing meetings to optimise staffing and patient flow and safety<br>3.Triumvirate Risk Registers to reflect level of risk within Division/speciality/service<br>4.Divisional Workforce plans to be discussed at Divisional Boards | People Committee/Director of Workforce<br>Chief Nurse<br>Medical Director | Trustwide, Deputy Chief Nurse, all Triumvirates with HR Business Partners | 1. November 2021, in place and ongoing at the time of inspection.<br>2. In place and ongoing<br>3. Staffing issues reflected on all Divisional risk registers<br>4. Monthly Divisional Board Meetings | 1. Business as usual<br>2. Business as usual<br>3. Risk Registers Reviewed at Risk Scrutiny Committee<br>4. Business as usual | | | | | | |
| 9 | SHOULD | Trustwide (S) | SPH | The Trust should ensure medicines reconciliation is completed within 24 hours | 1. As part of the Trust Quality Priorities, over 2 years the Trust aims to achieve above 80% medicines reconciliation within 24 hours in 22/23 and above 90% in 23/24. | Quality of Care/Medical Director<br>Chief Nurse | Chief Pharmacist | 2022/23 – 80% compliance<br>2023/24 – 90% compliance in line with National standards. | 1. Included in the Trust Quality Priorities. | | | | | | | |
| 10 | SHOULD | Trustwide (S) | SPH/AH | The service should consider a formalised way to record mortality and morbidity meetings | 1. Mortality Improvement Lead to develop a Trust standard framework/approach to Mortality and Morbidity meetings in collaboration with Divisional Triumvirates and Governance Leads | Quality of Care/Medical Director<br>Chief of Patient Safety | Divisional Directors/Triumvirate Governance Leads | 1. Commence April 2022 | 1. Mortality Lead was recruited and starts in August 2022. | | | | | | | |
| 11 | SHOULD | Trustwide (M) | SPH | The service should ensure that it continues to develop a safer discharge process and that all clinical staff are empowered to discharge people safely | 1. As part of the Trust Quality Priorities aims, through focussed quality Improvement initiatives, to reduce the number of incidents, complaints and PALs concerns related to patient discharge by 20% | Quality of Care/Chief Nurse | Deputy Chief Nurse<br>Divisional Triumvirates and QI team | 1. 2022/2023 | 1. Quality improvement initiatives in place as part of the Trust Quality Priorities 2022/2023- Right to Reside, C2A | | | | | | | |
| 12 | SHOULD | Trustwide (M) | SPH | The Trust should ensure naso-gastric tubes are managed in line with national guidance | 1. Ensure current Trust Action plans which relate to the NHS/PSA/RE/2016/006 safety alert are progressed with oversight at the Safety and Quality Committee | Quality of Care/Chief Nurse<br>Medical Director | Divisional Triumvirates<br>Deputy Chief Nurse<br>Consultant Nurse Harms Free Care | 1. Novermber 2021 and ongoing | 1.Monitored monthly at the The Harms Free Care Oversight Group.<br>Ongoing work with Surrey Safe Care to ensure all elements of alert are met. Quick reference guide being created and e-learning module being updated and April 2022 audit results being collated. Update in July 2022. | | | | | | | |
| 13 | SHOULD | Trustwide (M) | SPH | The Trust should ensure that food and nutrition charts are accurately completed | 1. As part of the Trust Quality priorities, the aim will be for 98% of Malnutrition Universal Screening Tools (MUST) are correctly completed within 48 hours of admission.<br>2. Improve by 25% correct completion of Fluid Balance Charts with progress monitored via Tenable ward based quality audit, ward accreditation programme and Divisional Harms Free Care meetings. | Quality of Care/Chief Nurse<br>Medical Director | Divisional Triumvirates<br>Deputy Chief Nurse<br>Consultant Nurse Harms Free Care | 1.Commencing April 2022/23<br>2 Commencing April 2022/23 | 1. Monitored monthly at the The Harms Free Care Oversight Group.<br>2. A focused intensive education programme was underway. | | | | | | | |
| 14 | SHOULD | Trustwide (M) | SPH | The service should consider increasing pharmacy cover on the wards to support staff with stock issues and the discharge process | 1.Review pharmacy staff working hours on wards , mobilising workforce to match work demands and patient care needs/complexity<br>2.Recruit pharmacy staff to support enhanced hours [8am to 8pm] on the high admission ward area – Clinical Admissions Unit [Dependent on Business Case]<br>3.Identify ward areas that could benefit from having an embedded pharmacy technician in ward teams to improve communication and quick resolution of medicines management issues [Repurpose ward vacancy funds to recruit embedded pharmacy technicians – DCNs to support model] | Quality of Care/Chief Nurse<br>Medical Director | Chief Pharmacist<br>Deputy Chief Pharmacist and Pharmacy Clinical Services Manager | 1.September 2022<br>2.September 2022]<br>3.March 2023 | 1. Service currently in business continuity.<br>2. A significant number of vacancies to be filled late summer / early autumn 2022..<br>3. Review in March 2023. | | | | | | | |
| 15 | SHOULD | Trust wide (S) | AH | The service should ensure that all staff are bare below the elbows in clinical areas | 1. Regular ward observational audits via Tenable<br>2. IPC Annual Audit programme<br>3. Audits for discussion as part of Harm Free Care Divisional meetings<br>4. IPC Integral to Ward Accreditation Programme | Quality of Care/Medical Director<br>Chief Nurse | Divisional Triumvirates, Matrons, CNLS, IPC Team | Programme in place Trust wide IPC audits, Ward Accreditation and Divisional Harm Free Care meetings | 1. Complete<br>2. Complete<br>3. Complete<br>4. Complete | | | | | | | |
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| Ref | OTHER ACTIONS | Service Level | Division | Area for Improvement | Action Required | Strategic Committee Oversight | | | | | | | | | | |
| 16 | OTHER ACTIONS | Trustwide | Trustwide | Appraisals below target (due to the pandemic) | 1. Divisions to compile a recovery plan to ensure 90% compliance | Quality of Care/Medical Director<br>Chief Nurse | Divisional Triumvirates, Matrons, CNLS, | 1. March 2022 | 1. Complete- Local recovery action plans in place. | | | | | | | |
| 17 | OTHER ACTIONS | Trustwide | Trustwide | Staff said that they rarely saw Trust Executives in the department | 1. Executive Team to consider a programme of departmental visits once the pandemic control measures are removed | Quality of Care/ Executive Team | Executive Team | 1. Once IPC control measures allow | 1. Current IPC control measures remain unchanged | | | | | | | |
| 18 | OTHER ACTIONS | Trustwide | Trustwide | Staff did not always make sound judgements around people's safeguarding needs.<br>Staff did not feel supported because safeguarding teams did not visit the wards | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | Safeguarding Committee in place with Divisional Representation where training compliance and learning is discussed.<br>The adult social care teams have reconfigured their hospital based team resulting in fewer staff being based in the hospital.<br>The Trust safeguarding team continue to support staff. | | | | | | | |
| 19 | OTHER ACTIONS | Trustwide | GSM | Not all middle managers were conversant with details of "stranded" patients | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | Complete- Do not use that term anymore. Medically Fit For Discharge (MFFD). | | | | | | | |

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| 20 | OTHER ACTIONS | Trustwide | GSM | For those with complex mental health and social care needs there were reported gaps in the process. The CQC received several enquiries from third party organisations about missed opportunities by staff to complete safeguarding referrals with some patients left alone without support. | 1. Digital PTL platform launch<br>2. Clarified access arrangements to the PTL with all ward areas, Matrons and discharge teams.<br>3. Any unresolved issues to be escualated to the Corporate Team.<br>4. Open Walton Care Unit for MFFD | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | 1. Launched in November 2021. Complete.<br>2. Complete<br>3. Complete and on-going<br>4. Walton was closed 19.05.2022 after improved patient flow in ASPH. Two wards, 1 Nurse led and 1 Therapy Led (Holly & Swift) currently open for for MFFD patients. | | | | | | |
| 21 | OTHER ACTIONS | GSM | GSM | The service could make the environment on SAMS more Dementia Friendly. Ward bays caring for people with dementia were not all designed or laid out in line with current best<br>practice for example the University of Stirling standards for dementia design. Only one bay, which had appropriate flooring and coloured walls and equipment to help dementia patients navigate the area safely | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | 1. Dementia friendly ward enviroments are integral to all healing arts projects.<br>2. Two wards awarded £50,000 and projects to improve enviroment will ensure they are dementia friendly.<br>3.Estates Team include a dementia friendly approach in all redevelopment projects, | | | | | | |
| 22 | OTHER ACTIONS | GS-ACT | GS-ACT | Staff, patients, and visitors used Falcon Ward as an access corridor. There were no facilities to make the ward secure although there were security measures across the whole site which acted as mitigation. This also made the ward busy at all times and had a negative impact on patient experience. | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | Included in the Abbey Wing Redevelopment plan. | | | | | | |
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| 7 | SHOULD | Trustwide (S&M) | SPH/AH | The service should ensure all staff are up-to-date with their safeguarding adults and safeguarding children training and level 3 training is completed by all staff involved in patient care decision making including doctors and nurses | 1. Divisions to compile a recovery plan to ensure 90% compliance<br>2.Learning and Development to review ESR processes to ensure completed e-learning is reflected in staff records<br>3. Safeguarding Team continue to implement the Safeguarding Training Strategy | Quality of Care<br>People Committee/Director of Workforce | Trustwide, all Triumvirates with HR Business Partners | Timeframes for training completion to be agreed with triumvirates at next CQC oversight committee in March 2022 | 1. Recovery plans monitored at Divisional level with Executive Oversight.<br>2. Learning and Development Team completed ESR data cleanse to ensure the level of safeguarding training required was correctly reflected in staff records. Complete<br>3. Safeguarding Team continue to implement the safeguarding training strategy and support divisions with flexible training sessions.<br>Trustwide improvement in training compliance can be seen since November 2021.<br>Safeguarding Adults L2- November 2021: 66.17% and April 2022 70.27% difference(4.10%)<br>Safeguarding Children L2 November 2021: 67.30% and April 2022 69.13% difference (1.84%)<br>Safeguarding Children - Level 3 November 2021: 61.63% and April 2022 64.14% difference 2.51% |
| 8 | SHOULD | Trustwide (S&M) | SPH | The service should take action so staffing numbers match the planned numbers on the ward areas | 1. Staffing recruitmnet and retention strategy in place<br>2.x3 CAT meetings as a minimum and staffing meetings to optimise staffing and patient flow and safety<br>3.Triumvirate Risk Registers to reflect level of risk within Division/speciality/service<br>4.Divisional Workforce plans to be discussed at Divisional Boards | People Committee/Director of Workforce<br>Chief Nurse<br>Medical Director | Trustwide, Deputy Chief Nurse, all Triumvirates with HR Business Partners | 1. November 2021, in place and ongoing at the time of inspection.<br>2. In place and ongoing<br>3. Staffing issues reflected on all Divisional risk registers<br>4. Monthly Divisional Board Meetings | 1. Business as usual<br>2. Business as usual<br>3. Risk Registers Reviewed at Risk Scrutiny Committee<br>4. Business as usual |
| 9 | SHOULD | Trustwide (S) | SPH | The Trust should ensure medicines reconciliation is completed within 24 hours | 1. As part of the Trust Quality Priorities, over 2 years the Trust aims to achieve above 80% medicines reconciliation within 24 hours in 22/23 and above 90% in 23/24. | Quality of Care/Medical Director<br>Chief Nurse | Chief Pharmacist | 2022/23 – 80% compliance<br>2023/24 – 90% compliance in line with National standards. | 1. Included in the Trust Quality Priorities. |
| 10 | SHOULD | Trustwide (S) | SPH/AH | The service should consider a formalised way to record mortality and morbidity meetings | 1. Mortality Improvement Lead to develop a Trust standard framework/approach to Mortality and Morbidity meetings in collaboration with Divisional Triumvirates and Governance Leads | Quality of Care/Medical Director<br>Chief of Patient Safety | Divisional Directors/Triumvirate<br>Governance Leads | 1. Commence April 2022 | 1. Mortality Lead was recruited and starts in August 2022. |
| 11 | SHOULD | Trustwide (M) | SPH | The service should ensure that it continues to develop a safer discharge process and that all clinical staff are empowered to discharge people safely | 1. As part of the Trust Quality Priorities aims, through focussed quality Improvement initiatives, to reduce the number of incidents, complaints and PALs concerns related to patient discharge by 20% | Quality of Care/Chief Nurse | Deputy Chief Nurse<br>Divisional Triumvirates and QI team | 1. 2022/2023 | 1. Quality improvement initiatives in place as part of the Trust Quality Priorities 2022/2023- Right to Reside, C2A |
| 12 | SHOULD | Trustwide (M) | SPH | The Trust should ensure naso-gastric tubes are managed in line with national guidance | 1. Ensure current Trust Action plans which relate to the NHS/PSA/RE/2016/006 safety alert are progressed with oversight at the Safety and Quality Committee | Quality of Care/Chief Nurse<br>Medical Director | Divisional Triumvirates<br>Deputy Chief Nurse<br>Consultant Nurse Harms Free Care | 1. Novermber 2021 and ongoing | 1.Monitored monthly at the The Harms Free Care Oversight Group.<br>Ongoing work with Surrey Safe Care to ensure all elements of alert are met. Quick reference guide being created and e-learning module being updated and April 2022 audit results being collated. Update in July 2022. |
| 13 | SHOULD | Trustwide (M) | SPH | The Trust should ensure that food and nutrition charts are accurately completed | 1. As part of the Trust Quality priorities, the aim will be for 98% of Malnutrition Universal Screening Tools (MUST) are correctly completed within 48 hours of admission.<br>2. Improve by 25% correct completion of Fluid Balance Charts with progress monitored via Tenable ward based quality audit, ward accreditation programme and Divisional Harms Free Care meetings. | Quality of Care/Chief Nurse<br>Medical Director | Divisional Triumvirates<br>Deputy Chief Nurse<br>Consultant Nurse Harms Free Care | 1.Commencing April 2022/23<br>2 Commencing April 2022/23 | 1. Monitored monthly at the The Harms Free Care Oversight Group.<br>2. A focused intensive education programme was underway. |
| 14 | SHOULD | Trustwide (M) | SPH | The service should consider increasing pharmacy cover on the wards to support staff with stock issues and the discharge process | 1.Review pharmacy staff working hours on wards , mobilising workforce to match work demands and patient care needs/complexity<br>2.Recruit pharmacy staff to support enhanced hours [8am to 8pm] on the high admission ward area – Clinical Admissions Unit [Dependent on Business Case]<br>3.Identify ward areas that could benefit from having an embedded pharmacy technician in ward teams to improve communication and quick resolution of medicines management issues [Repurpose ward vacancy funds to recruit embedded pharmacy technicians – DCNs to support model] | Quality of Care/Chief Nurse<br>Medical Director | Chief Pharmacist<br>Deputy Chief Pharmacist and Pharmacy Clinical Services Manager | 1.September 2022<br>2.September 2022]<br>3.March 2023 | 1. Service currently in business continuity.<br>2. A significant number of vacancies to be filled late summer / early autumn 2022..<br>3. Review in March 2023. |
| 15 | SHOULD | Trust wide (S) | AH | The service should ensure that all staff are bare below the elbows in clinical areas | 1. Regular ward observational audits via Tenable<br>2. IPC Annual Audit programme<br>3. Audits for discussion as part of Harm Free Care Divisional meetings<br>4. IPC Integral to Ward Accreditation Programme | Quality of Care/Medical Director<br>Chief Nurse | Divisional Triumvirates, Matrons, CNLS, IPC Team | Programme in place Trust wide IPC audits, Ward Accreditation and Divisional Harm Free Care meetings | 1. Complete<br>2. Complete<br>3. Complete<br>4. Complete |
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| Ref | OTHER ACTIONS | Service Level | Division | Area for Improvement | Action Required | Strategic Committee Oversight | | | |
| 16 | OTHER ACTIONS | Trustwide | Trustwide | Appraisals below target (due to the pandemic) | 1. Divisions to compile a recovery plan to ensure 90% compliance | Quality of Care/Medical Director<br>Chief Nurse | Divisional Triumvirates, Matrons, CNLS, | 1. March 2022 | 1. Complete- Local recovery action plans in place. |
| 17 | OTHER ACTIONS | Trustwide | Trustwide | Staff said that they rarely saw Trust Executives in the department | 1. Executive Team to consider a programme of departmental visits once the pandemic control measures are removed | Quality of Care/ Executive Team | Executive Team | 1. Once IPC control measures allow | 1. Current IPC control measures remain unchanged |

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| 18 | OTHER ACTIONS | Trustwide | Trustwide | Staff did not always make sound judgements around people's safeguarding needs. Staff did not feel supported because safeguarding teams did not visit the wards | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | Safeguarding Committee in place with Divisional Representation where training compliance and learning is discussed. The adult social care teams have reconfigured their hospital based team resulting in fewer staff being based in the hospital. The Trust safeguarding team continue to support staff. |
| 19 | OTHER ACTIONS | Trustwide | GSM | Not all middle managers were conversant with details of "stranded" patients | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | Complete- Do not use that term anymore. Medically Fit For Discharge (MFFD). |
| 20 | OTHER ACTIONS | Trustwide | GSM | For those with complex mental health and social care needs there were reported gaps in the process. The CQC received several enquiries from third party organisations about missed opportunities by staff to complete safeguarding referrals with some patients left alone without support. | 1. Digital PTL platform launch<br>2. Clarified access arrangements to the PTL with all ward areas, Matrons and discharge teams.<br>3. Any unresolved issues to be escualated to the Corporate Team.<br>4. Open Walton Care Unit for MFFD | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | 1. Launched in November 2021. Complete.<br>2. Complete<br>3. Complete and on-going<br>4. Walton was closed 19.05.2022 after improved patient flow in ASPH. Two wards, 1 Nurse led and 1 Therapy Led (Holly & Swift) currently open for for MFFD patients. |
| 21 | OTHER ACTIONS | GSM | GSM | The service could make the environment on SAMS more Dementia Friendly. Ward bays caring for people with dementia were not all designed or laid out in line with current best practice for example the University of Stirling standards for dementia design. Only one bay, which had appropriate flooring and coloured walls and equipment to help dementia patients navigate the area safely | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | 1. Dementia friendly ward enviroments are integral to all healing arts projects.<br>2. Two wards awarded £50,000 and projects to improve enviroment will ensure they are dementia friendly.<br>3.Estates Team include a dementia friendly approach in all redevelopment projects, |
| 22 | OTHER ACTIONS | GS-ACT | GS-ACT | Staff, patients, and visitors used Falcon Ward as an access corridor. There were no facilities to make the ward secure although there were security measures across the whole site which acted as mitigation. This also made the ward busy at all | Divisional Local Action plan to be provided in March 2022 | Quality of Care/ Executive Team | Divisional Triumvirates, Matrons, CNLS, IPC Team | 1. March 2022 | Included in the Abbey Wing Redevelopment plan. |