NHS
Nottingham
University Hospitals
NHS Trust

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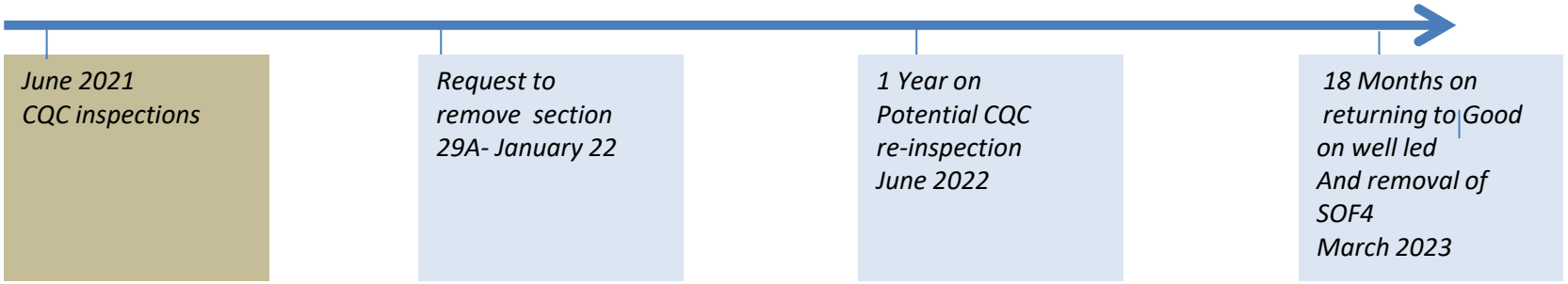
Well-Led Action Plan Progress Update

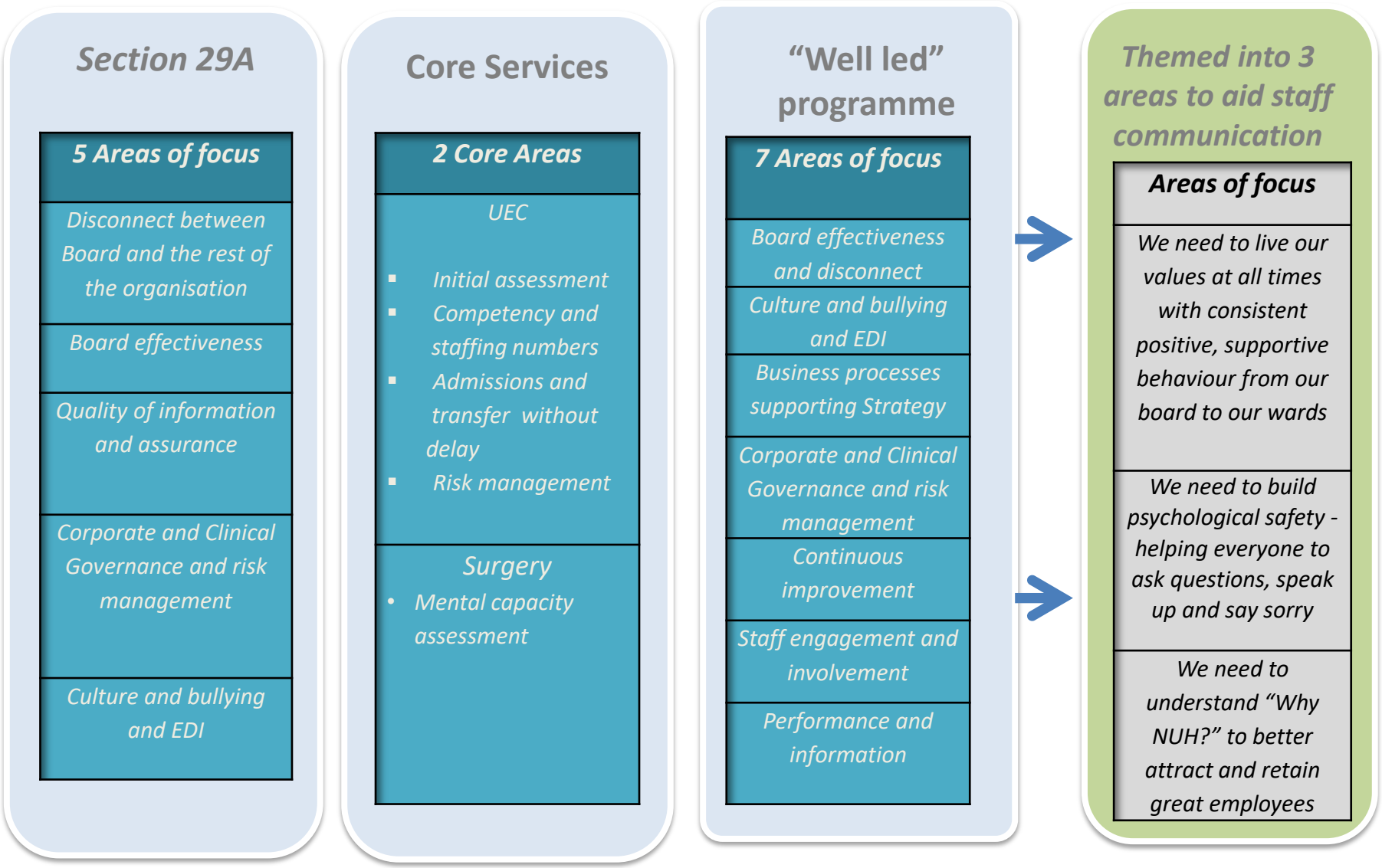
Scale of the challenge ahead expected milestones

The Trust needs to work toward:

- Removal of section 29A –significant improvements expected by 28 January 22
- Preparing for a potential CQC re-inspection 1 year on
- Planning for returning to “Good” on well led within next 18 months
- Exiting SOF4 by March 2023



We have a complex and far reaching programme that impacts of all aspect of the Trust's work. Many of the actions that we need to address under the Well-Led element cross over the section 29A warning Notice
We simplified this in 3 themes to aid communication and engagement with staff.



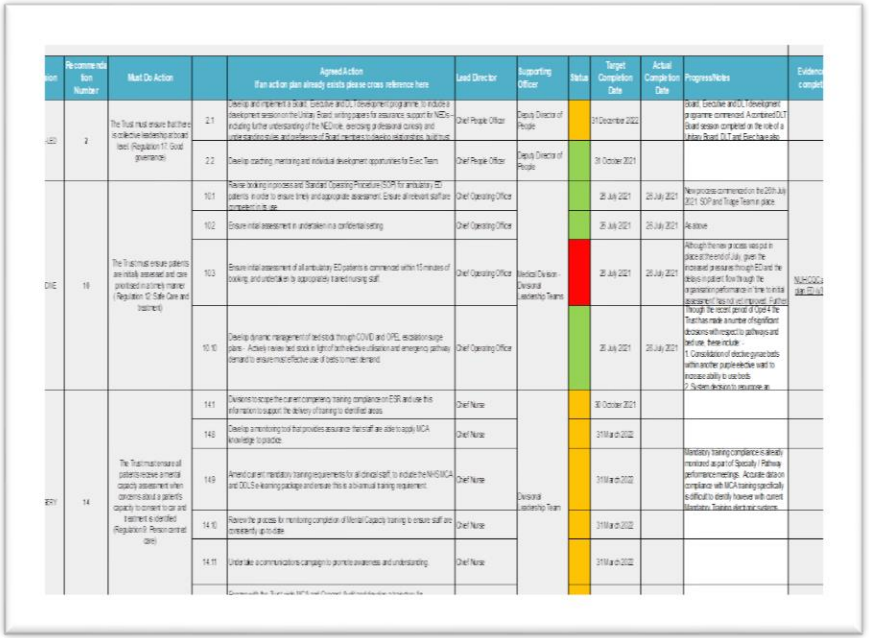
Our Improvement Plan

NHS Nottingham University Hospitals NHS Trust

Informed by staff feedback, our current improvement plan contains over 100 actions across all the areas identified by the CQC and includes:

- Actions to address the well-led element of CQC inspection
- Actions to address the section 29A warning notice
- Actions to address the core service inspections, (surgery and UEC but excludes Maternity)

We see this as the start of our 18 month journey which will take us beyond simply meeting the regulatory requirements, to building an organisation we are proud of.



	Recommendation Number	Must Do Action		Agreed Action If an action plan already exists please cross reference here	Lead Director	Supporting Officer	Status	Target Completion Date	Actual Completion Date	Progress/Notes	Evidence complete
	2	The Trust must ensure that there is effective leadership at board level. (Regulation 17: Good governance)	2.1	Develop and implement a Board, Executive and OLT development programme, to include a development session on the Unity Board, setting papers for assurance, support for NEDs - including further understanding of the NED role, exercising professional curiosity and understanding pulse, and conference of Board members to develop relationships, built on t	Chief People Officer	Deputy Director of People		31 December 2021		Board, Executive and OLT development programme commenced. A combined OLT/ Board session completed on the role of a Unity Board. OLT and Exec have also	
			2.2	Develop coaching, mentoring and individual development opportunities for Exec Team	Chief People Officer	Deputy Director of People		31 October 2021			
	19	The Trust must ensure patients are initially assessed and care prioritised in a timely manner. (Regulation 12: Safe Care and treatment)	10.1	Review booking in process and Standard Operating Procedure (SOP) for ambulatory ED patients in order to ensure timely and appropriate assessment. Ensure all relevant staff are competent in its use	Chief Operating Officer	Medical Division - Divisional Leadership Teams		26 July 2021	26 July 2021	New process commenced on the 26th July 2021. SOP and Triage Team in place.	
			10.2	Ensure initial assessment in undertaken in a confidential setting	Chief Operating Officer			26 July 2021	26 July 2021	As above	
			10.3	Ensure initial assessment of all ambulatory ED patients is commenced within 10 minutes of booking, and undertaken by appropriately trained nursing staff.	Chief Operating Officer			26 July 2021	26 July 2021	Although the new process was put in place at the end of July, given the increased pressures through ED and the delays in patient flow through the organisation performance in time to initial assessment / triage is not compliant. Further	
			10.10	Develop dynamic management of bed stock through COVID and OPEL escalation surge plans. Actively review bed stock in light of both elective utilisation and emergency pathway demand to ensure most effective use of beds to meet demand.	Chief Operating Officer			26 July 2021	26 July 2021	Through the recent period of OPEL 4 the Trust has made a number of significant decisions with respect to pathways and bed use, these include: 1. Consolidation of elective ward beds within another purple elective ward to increase ability to use beds 2. System decision to resurrect an	
	14	The Trust must ensure all patients receive a mental capacity assessment when concerns about a patient's capacity to consent to care and treatment is identified (Regulation 9: Person centred care)	14.1	Review to scope the current competency training compliance on ESR and use this information to support the delivery of training to identified areas.	Chief Nurse	Divisional Leadership Team		30 October 2021			
			14.8	Develop a monitoring tool that provides assurance that staff are able to apply MCA knowledge to practice.	Chief Nurse			31 March 2022			
			14.9	Amend current mandatory training requirements for all clinical staff, to include the MHSMCA and DOLS e-learning package and ensure this is a bi-annual training requirement.	Chief Nurse			31 March 2022		Mandatory training compliance is already monitored as part of Specialty / Pathway performance meetings. Accurate data on compliance with MCA training specifically is difficult to identify however with current Mandatory Training electronic systems	
			14.10	Review the process for monitoring completion of Mental Capacity training to ensure staff are consistently up to date	Chief Nurse			31 March 2022			
			14.11	Undertake a communications campaign to promote awareness and understanding	Chief Nurse			31 March 2022			

Work in progress:

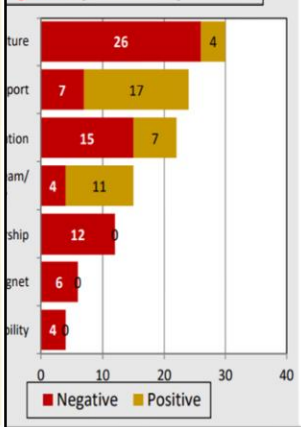
- Nominated leads are developing milestones and outcome measures to make it easier to track progress.
- We are setting metrics against which we can monitor outcomes and benefits.
- We are developing a barometer methodology to give a true picture of progress against plan.

Staff feedback

There were **15** comments about the *Executive Team/Visibility* of which **73%** were positive (e.g. *It's positive that you want to work with staff to make improvements).*

There were most ***Negative sentiments*** *about the* ***Culture*** *theme (**23%** of all comments) such as ...*
"Bullying is happening in the organisation. People have finally had the courage to speak up. We need to make a change ". Another said, *" If I raise a problem you ask me what my solution is - not supportive". "Actions from bullying cases are not being carried out".*
"Don't recognise the bullying but do recognise lack of support ". "I wouldn't feel safe speaking up in nursing".
Another said *"Disappointing but not surprising. Unprecedented number of cases of racial discrimination going to tribunals. "*

Figure 2 Top 7 Themes by sentiment

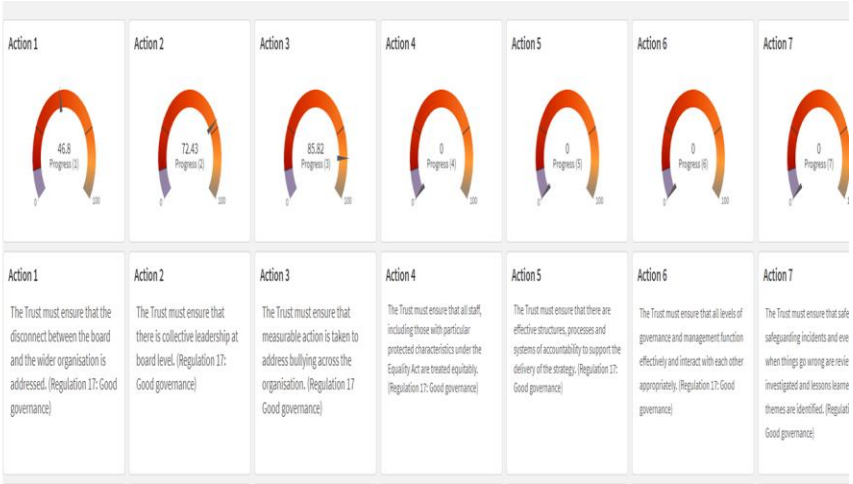


hemes raised in the **116** **Figure 2** shows the Top 7 ach of those into **Positive** were **Negative;** So , for ere **17** positive comments t and **7** negative. The ents about the report v the report **didn't really experience** (eg *"Doesn't perience*). In contrast, the nts about the report said *"Resonates"*. **Altogether unt for 113 comments, comments**. Similarly, as **igure 2**, the top 4 themes e, *Organisation and* ccount for about 70 % of

Barometer under construction to assess progress against plan

CQC Recommendation Number	Section Completion %	Must Do Action	Agreed Action If an action plan already exists please cross reference here	Status
1	75.0	The Trust must ensure that the disconnect between the board and the wider organisation is addressed. (Regulation 17: Good governance)	Arrangements to be made for Executive team members to attend Departmental Meetings and Staff forums, where required.	50
			Introduce drop-in clinics (e.g. breakfast / tea with the Exec Team), social media engagement e.g. Twitter and Facebook to communicate visits (posted pictures), visual media recognising improvements and good news stories.	75
			Create opportunities for Board, Executive team to be more visible throughout the organisation.	50
			Buddying arrangements to be established place with NEDs to buddy up with an Exec and Execs to buddy up with a DLT member to develop relationships and promote awareness and understanding of key issues and challenges.	100
			Explore a mentorship programme for the wider leadership team.	100
2	48.3	The Trust must ensure that there is collective leadership at board level. (Regulation 17: Good governance)	Develop and implement a Board, Executive and DLT development programme, to include a development session on the Unitary Board, writing papers for assurance, support for NEDs – including further understanding of the NED role, exercising professional curiosity and understanding styles and preference of Board members to develop relationships, build trust and support the creation of a high performing Board.	20
			Develop coaching, mentoring and individual development opportunities for Exec Team.	33
			Develop coaching, mentoring and individual development opportunities for DLTs.	50
			Board to complete a well-led self-assessment to be validated by NHSEI.	11
			Design, commission and implement leadership training package for all leaders across the organisation to include general management training, core skills and tailored training relevant to role.	55
			Refresh and promote our accountability arrangements to include a model of distributed leadership and the empowerment of staff.	79
			Ensure there is clarity on the Trust vision and values.	90

Numbers are illustration only

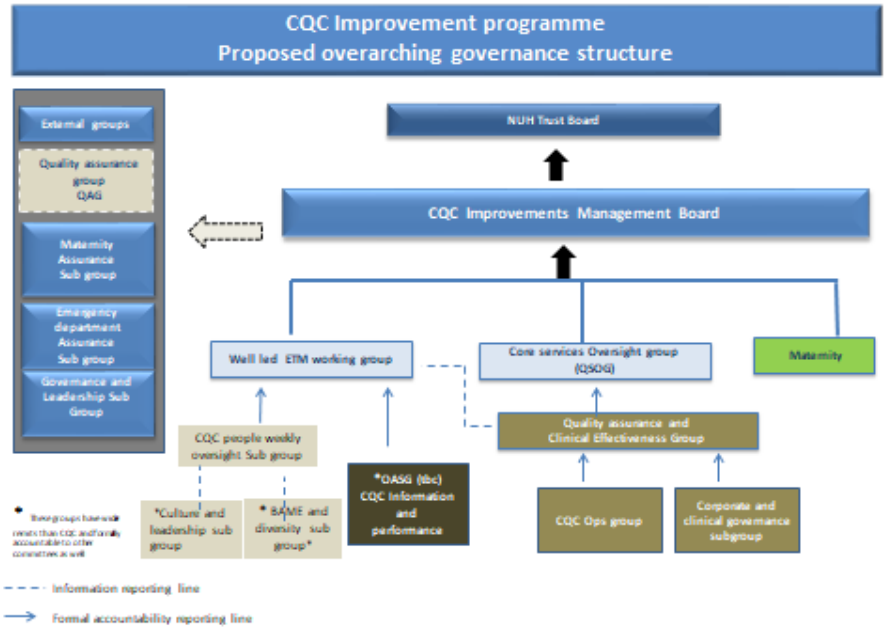


Work in progress:

- The current RAG rating methodology does not allow us to assess a true picture of progress against plan
- The leads are currently assessing % progress against each action and an analysis will be carried out to report overall progress against the relevant MUST Dos
- Progress by exception for “amber-red” and “Red” actions/areas will be reported at the weekly well-led Executive working group together with a forward planning template for the amber green

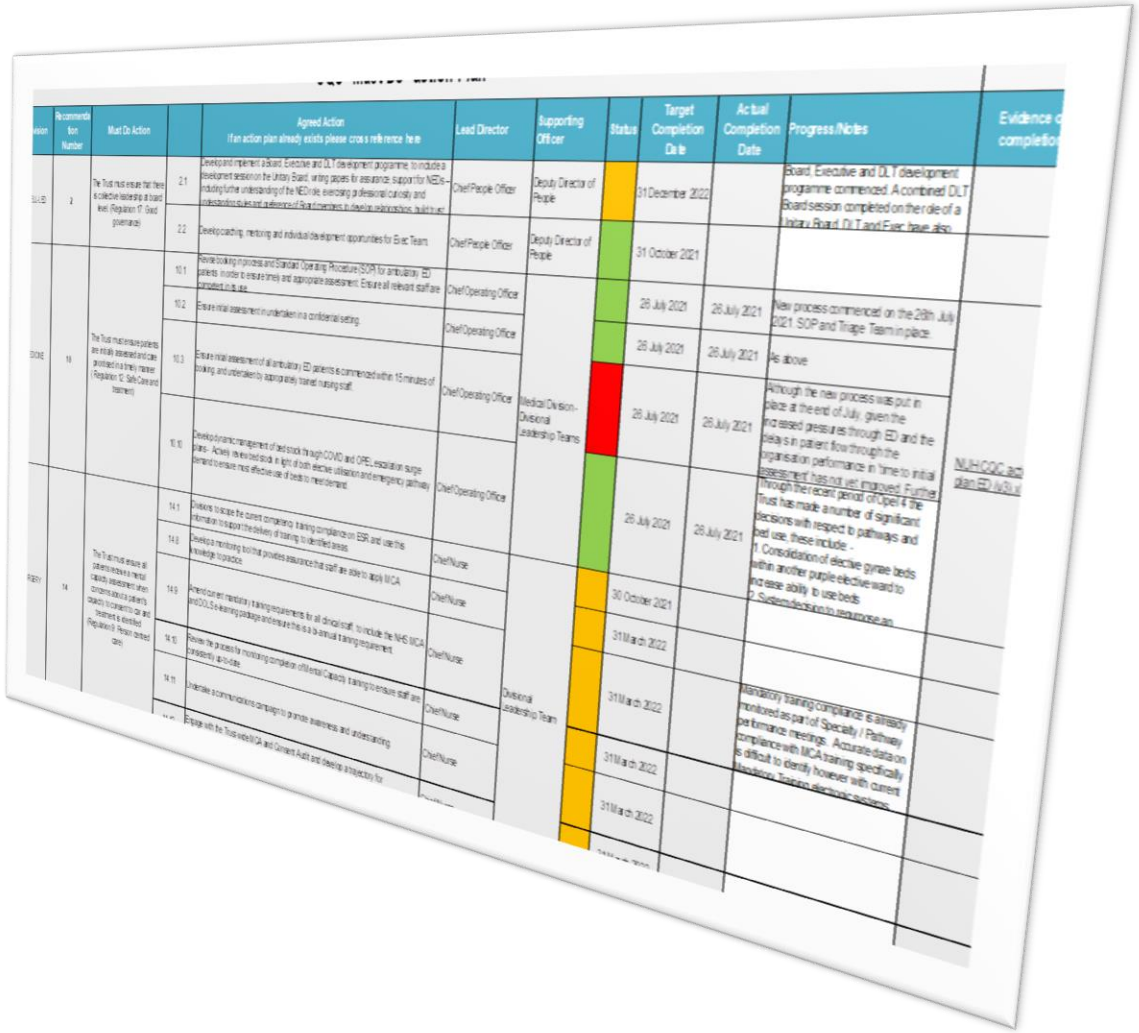
Strengthening governance around the CQC Improvement programme

- We have strengthened our governance to ensure pace and progress around our actions. To this end the Executive Team meet every week to check progress, review actions and provide scrutiny to ensure the changes that have been made are robust, sustainable and making the necessary impact.
- We have established where required delivery groups to take forward the work.
- At each Trust Board meeting we will chart our progress so we can track how far we've come, and how far we have left to go.
- We intend to use some dedicated Management Board sessions to oversee the totality of the CQC programme and our exit from SOF 4.
- We are starting to collect the evidence against the actions



Progress against action Plan

- **Well Led**
- **Core Service's**



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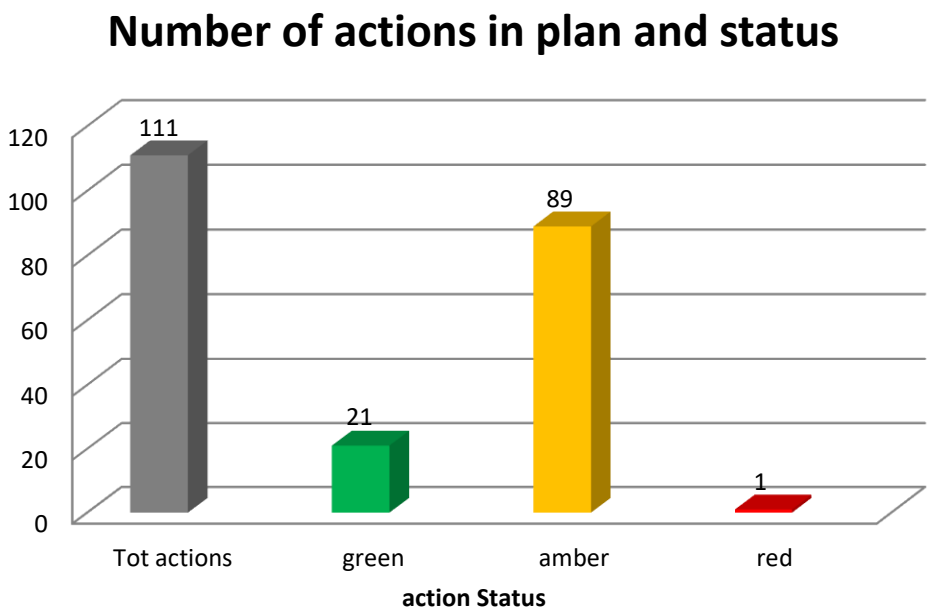
			Engage with the Trust-wide MCA and Consent Audit and clinical effectiveness for							

Overall position against plan

Of the 14 Must dos the overall status position using the existing RAG rating system is illustrated in the chart below

Must do actions A summary	Number of actions by area
Board disconnect	5
Board collective leadership	7
Culture and diversity	17
Governance, quality , risk and safety and incidents	29
Information and performance	9
Comms and engagement	2
Core services (UEC and surgery	23
Corporate governance	11
Strategy	8
Total	111



Disconnect between the Board and the wider organisation

Our Improvement plan aim:
Significant improvements in the functioning of the board and healthier inter-personal and supportive relationship between members of the Board and leadership teams

Progress to date:

- Staff feedback was used to inform our plan and presented to Management Board, then wider staff (CE Update).
- Executive visit areas across our sites and attending meetings we have been invited to. Over 100 areas visited since July.
- We are compiling a list of issues staff raise so that we can do all it takes to address them.
- Executive team members are also attending Departmental Meetings and Staff forums, where required.
- Board, Executive and DLT development programme.
- DLT and Exec sessions on leading with an outward mindset, in October, December and one is planned for January 22.
- Joined forces with Clever Together who have extensive experience and a great track record of helping NHS organisations to harness ideas from their staff . Developed an engagement plan for the organisation. Sessions booked for small staff groups in December and on into January. Big Conversation will take place at the end of January to allow maximum participation.

Future priorities:

- Buddying arrangements are being established to place a NEDs to buddy up with a divisions to develop relationships and promote awareness and understanding of key issues and challenges.
- Finalise Visibility plan

Impact to date:

- Board members report greater clarity of purpose and understanding of key issues.
- Staff engaged in various sessions.
- Follow up emails directly to Executives, e.g. 14 emails Themes predominantly bullying cases (past and current). Will be followed up to ensure each issue closed
- Follow up on staff feedback and themes (next slide)

Risks:

- Staff do not engage fully with the process
- That despite measures being introduced the team fail to bridge the disconnect.

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Our NUH – co-creating our plans with our staff

- OurNUH, a new approach to staff engagement was launched in early December
- Started with personal conversations (small groups of staff engaged in conversation around our three challenges, plus bullying, harassment and racism) during December and January
- Launch of Big Conversation at the end of January and will run for 2-3 weeks
- Big Conversation uses a crowd-sourcing platform that will allow every member of staff to share ideas and feedback on addressing our three tough challenges anonymously
- The platform is hosted and managed by an external partner with expertise in this area, and every idea/ comment will be analysed

These are the tough challenges that staff have told us underpin a lot of our barriers to progress…

We need to live our values at all times with consistent positive, supportive behaviour from our board to our wards

Our people have said: "NUH is not, yet, a place that is entirely free of bullying, embracing of everyone's differences, open to ideas and innovation, where people can talk openly about challenges and get involved in solutions. And it could be if we all consistently lived our values everywhere."

We need to build psychological safety - helping everyone to ask questions, speak up and say sorry

Our people have said: "There are too many places where people do not safe feel to ask questions, to speak up or raise concerns if something could or has gone wrong, or to feel safe to say sorry. Too many of us fear we won't be treated respectfully or worse, an adverse impact on our careers or working lives, if we were to question or speak up."

We need to understand "Why NUH?" to better attract and retain great employees

Our people have said: "Our staff experience is not, yet, consistently good enough. We want NUH to be a place where people choose to work, want to do their best work, and yet we don't always understand why NUH can be such a special place to work. We want everyone to embrace the fact that individuals make organisations and that our experience of Our NUH is a collective effort."

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Board working effectively together to achieve its full potential

Our Improvement plan aim: Significant improvements in risk management and A stronger line of sight from floor to Board on risks at a Speciality and Divisional level

Progress to date:

- Session on Business Assurance Framework (BAF) delivered at the October Board session
- Report on BAF presented at the Board development session on risk management and BAF
- Session with divisional directors on the role of the Unitary board
- Individual board support on BAF risks
- Board development programme underway
- Away Day between Corporate Quality Team and DQDs to agree priorities and next steps on 4th October. Outcomes report to be presented to Execs end December 2021.

Future priorities:

- Explore a mentorship programme for the wider leadership team.
- Board to complete a well-led self-assessment to be validated by NHSEI.
- Clarifying the governance structure from ward to Board specifically focusing on the meetings and how they flow up and the value that they add.
- Datix system commissioned to be completed Jan 22.

Impact to date:

- Maturing understanding of risk management from Ward to Board.
- BAF quality content improving with performance oversight in place.
- Staff actively engaged in risk sessions.

Risks:

- That the organisation is slow or unable to embed new systems of accountability and processes.

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Culture of Bullying, Diversity and Inequality

Our Improvement plan aim:
A culture of compassion and civility…. Staff feel they are treated fairly …diversity is celebrated. An environment of mutual respect … A culture which is owned and developed by staff.

Progress to date:

- Culture and Leadership programme developed which provides a framework for many actions in relation to Culture. It includes specific workstreams on Just Culture and Civility which focuses on how our values and behaviours are embedded and are consistently demonstrated within the Trust.
- Re-launched our Resolution of Employment Concerns Policy and Conduct, Behaviour and Disciplinary Policy. All re-written through a Just Culture lens.
- Analysed staff survey information and HR metrics to identify potential areas of concerns and triangulated this data with intelligence from key stakeholders in a sharing event on 12th November. Follow up meeting happened on the 5th January.
- Specific conversations on Bullying as part of the #Our NUH engagement. This may provide further information on themes for action.
- Reviewed/reviewing historic concerns raised by ex-employees to capture learning.
- Launched new starters and leavers surveys including feedback on the well led themes.
- Trained 15 mediators to support individuals and teams in conflict
- Mapped all current management and leadership development offers relevant to managing bullying to produce a joined up offer for managers.

Future priorities:

- A ‘cultural dashboard/diagnostic tool’ to gather quantitative and qualitative data to identify areas of concerns at an early stage on an ongoing basis.
- EDI specific development session for Trust Board
- An Multi Disciplinary Team approach to identifying and supporting areas of concern
- Introduction of conflict facilitators to support teams in difficulty across NUH.
- Supporting the introduction of BAME cultural ambassadors for investigations including scoping a pilot in nursing.
- Culture and Leadership Programme and workstreams continue including launch of the Big 6.

Impact to date

- Joint understanding of the areas of concern which need support
- Employees and ex-employees having their concerns acknowledged with a process for review.
- Conduct, Behaviour and Disciplinary Policy training well received by staff side and managers.

Risks to delivery

- Lack of data analyst to develop the dashboard. Recruitment commencing within next week.
- Resource to undertake cultural reviews in areas of concerns and to investigate increased number of concerns. Plan in place to utilise specialist agencies and to recruit additional staff to the HR Operations team
- Failure to release Trust staff to attend training sessions due to operational pressures, this may delay the adoption of new ways of working.

Wider work in relation to EDI 1/2

Progress to date:

- We have a 3 year BAME staff strategy and a dedicated project team for delivery. The strategy was signed off in October 2020 but COVID pressures and delays with the recruitment and availability of the project team meant that implementation properly commenced in August 2021 (although valuable work was going on the background).

- Year 1 of the strategy has 8 key areas for action:
  1. Increase BAME representation within senior posts at NUH
  2. Increase membership and utilisation of the BAME network
  3. Positively impact the recruitment process for BAME candidates
  4. Creation of Local Metrics
  5. Progression Programmes
  6. Mentoring
  7. BAME Staff and HR processes
  8. BAME staff health

- We have three staff networks in place - BAME staff, Staffability (staff with a disability) and LGBTQIA+. We have recently committed to funding for our staff network chairs to be released for one day a week to undertake their duties

Wider work in relation to EDI 2/2

Progress to date:

- The National Equality, Diversity and Inclusion Team have identified six high impact actions that they believe every organisation should implement as part of the effort to improve recruitment and promotion pathways. This contributes to the delivery of the diversity and inclusion priorities as set out in the East Midlands Regional Race Equality strategy and in the NHS People Plan. We have mapped these areas of action against the NUH strategy and all are covered in our strategy and are being progressed. Key highlights:
  - We have developed a reciprocal mentoring programme for BAME staff and senior leaders
  - We have appointed/are appointing BAME ambassadors in each Division and Corporate Department
  - We are complimenting our staff wellbeing toolkit with information specifically for BAME staff
  - We have appointed a new chair for the BAME staff network who is connecting with members on how to make the network more effective
  - We have established a group which is looking at how we address the concerns of BAME staff regarding HR processes (this links to the bullying work)
- We have BAME COVID Ops group which meets regularly to consider operational issues. We have BAME representatives on key Trust groups including our COVID leaders groups and working groups around risk assessments, vaccinations etc.
- As part of the CQC response, we have met with Clive Clarke from the national EDI team and Kuvy Seenan from the Regional team to review our BAME strategy. Initial feedback on content and progress was good. We are now working with Kuvy to map the NUH BAME strategy with the regional strategy to assess any gaps.

Impact to date:

- Greater time to support network with dedicated time for the networks Chairs
- We have 27 individuals who have signed up for the reciprocal mentoring programme so far, including 4 Executive Directors
- Recruitment improvement group created with representatives from EDI

Future priorities:

- BAME cohort of staff to be included within the Scope of Growth talent management programme that we are a national pilot for
- Awaiting for start date for a reciprocal mentoring programme from Leadership Academy .
- Actions against the BAME Strategy continue

Risks to delivery

- Availability of staff to commit time to supporting delivery in the context of significant operational pressures

Effective structures and systems to deliver strategy

Our Improvement Plan aim: Strengthen systems and processes that support delivery of the strategy.

Progress to date:

- Work has started with our Divisional Leadership Teams to co-produce a multi-year roadmap for each clinical pathway to get to our Trust vision of 'outstanding' by 2028.
- The process developing the pathway roadmaps will have clinical involvement so they are better connected with the long-term strategy and provide the headline direction for 3-year speciality plans to be developed.
- Increased QSIR training for staff (over 800 NUH staff now trained in QSIR)
- Commenced work on the first of the organisational processes to be reviewed – minor new works
- Changed recruitment processes to enable more timely authority for recruitment to replacement posts

Future priorities:

- Planned a cross divisional virtual workshop on 19th Jan 2022, to outline NUH 2021-28 Trust strategy with clear short, medium and long term deliverables (estates, people and digital); aligned to our 3 year annual planning cycle.
- Update to Management Board on 1-February 2022 ahead of the Trust Board Development Session on 10-February 2022.
- Agree a communications and engagement plan to ensure that Heads of Service have the opportunity to engage in developing the 2022/23 priorities and that staff have been consulted and are kept abreast of delivery
- Ensure priorities are aligned with the refreshed Trust Accountability arrangements

Impact to date:

- Held 4 workshops with Medicine, Ambulatory, Surgery and Family Health DLTs to discuss strategy roadmaps for elective, ambulatory, women's and children's services and urgent emergency care pathway
- Engaged and updated HOS in Dec 2021 on overall strategy roadmap process.
- Aligned to 3 year planning cycle- The planning templates have been issued to all DLTs (10-Dec) in order to give c.6 weeks for the development of speciality plans (4-Feb 2022) – this will be iterative as detailed national expectations emerge – and will involve Divisional and Executive review of proposed plans and areas for escalation

Risks:

- DLT Capacity to engage with the process (unable to hold workshops with CAS and Clinical Support before Christmas due to tight timescales and operational pressures)

Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements

Our Improvement plan aim:
A more integrated governance system which incorporates all elements of corporate and clinical governance
A stronger line of sight from floor to Board on risks at a Speciality and Divisional level

Progress to date:

- Support plan to reduce open overdue incident numbers enacted
- Incident management training commissioned to embed ongoing management of incidents
- Change in leadership of Governance. New (interim) Director of Corporate Governance in place.
- Regular meeting between Corporate and Quality Governance Teams.
- Revision of serious incident management process to ensure SIs are appropriately identified and method of investigation focusses on the greatest opportunities for learning.
- Additional resource to support the head of patient safety and the patient safety nurse to embed learning.
- Strengthening of clinical risk oversight and escalation.
- Patient Safety Fellow in post working on a number of projects including safe handover
- Patient Safety Team reorganised and expanded to create incident investigation team
- Triangulation of data from incidents, claims, complaints and mortality review to identify top themes for learning – will form 2022/23 Quality priorities and QI resource allocation.
- Revised Quality Governance meeting structure and Quality Dashboard now in place

Future priorities:

- Clarify governance arrangements and divisional accountability and responsibility with regards to adopting good governance.
- Design and deliver a comprehensive training and development package for all governance leads.
- Revision of Corporate and Divisional Quality Governance structures.

Impact to date

- Significant reduction in open overdue incidents
- Improved relationship between Corporate and Quality governance – shared agenda
- Significant increase in number of SIs being declared and investigated
- Greater understanding of themes, issues and risks related to quality and patient safety

Risks to delivery

- Conflicting demands
- Pace of change – cultural aspects may impact of timescale to deliver
- Availability of staff to deliver and embed new structures and processes

Learning from Incidents

Our Improvement Plan aim:
A continual learning and improvement environment and safety and learning culture where safety always comes first and we all continually seek to improve.
support and underpin delivery of safe, high quality of care and use QSIR to drive improvement

Progress to date:

- Support plan to reduce open overdue incident numbers enacted
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- Revised Quality Governance meeting structure and Quality Dashboard now in place

Future priorities:

- Develop guidance for staff on learning events such as Safety Huddles.
- Strengthen use of Human Factors approach to learning from incidents and repeat harm incidents through improved links with Sim Centre, creation of a Human Factors Practitioner post and launch of Human Factors Forum.
- Strengthen links between Patient Safety agenda and Quality Improvement
- Establish Academy of Learning
- Raise profile and visibility of Patient safety team, adopting a Just Culture approach to learning from incidents and create opportunities to share learning through a multi-media approach.
- Review Duty of Candour process to reflect National guidance.

Impact to date

- Significant reduction in open overdue incidents
- Improved relationship between Corporate and Quality governance – shared agenda
- Significant increase in number of SIs being declared and investigated
- Greater understanding of themes, issues and risks related to quality and patient safety

Risks to delivery

- Conflicting demands
- Limited divisional governance resources

We Care

Risk, Issue and Action management

Our Improvement plan aim:
Robust arrangements for identifying, recording and managing risks, issues and mitigating actions.

Progress to date:

- Change in leadership of Governance. New (interim) Director of Corporate Governance in place. Regular meeting between Corporate and Quality Governance Teams.
- Revised Quality Governance meeting structure and Quality Dashboard now in place

Future priorities:

- Clarify the arrangements at Trust level for MCA and DOLs safeguarding training and undertake an communications campaign to promote awareness and understanding.
- Comprehensive review of risk management group including risk management processes particularly in relation to escalation of risks, clinical risk management and oversight and ensuring that there is a clear differentiation between risks and issues. Make any revisions needed to streamline the process and make it more effective. Deliver a communications campaign so staff are made aware of any changes to the risk management process.
- Ensure that there is a process in place for reviewing all risks and ensuring that they are contemporaneous and that the mitigating actions are sufficiently robust.

Impact to date

- Greater understanding of themes, issues and risks related to quality and patient safety

Risks to delivery

- Staffing capacity due to operational challenges to sustain changes

We Listen
We Care

Quality of information and professional curiosity and challenge

Our Improvement plan aim:
A stronger performance framework that has a golden thread from ward to board. improve the quality of Information to turn it into insight by triangulating disparate information to support decisions making.

Progress to date:

- Established a 10 point programme for resetting our ambition around analysis and performance to ensure a high quality and impactful contribution to patient care, overseen by OASG, attended by divisions, corporate areas and relevant external partners
- Established a working group of 30 clinicians and to discuss their contribution to supporting the agenda for Insight and analysis.
- Held a workshop on 26th October between 4 key areas working on predictive modelling (UoN, AHSN, ICS and PA Consulting) to ensure wide sharing of techniques and methods for future applicability.
- Reviewed the Quality data during Sept-November resulting in a new the implementation of a new Quality Dashboard (QD) at Trust and Divisional level.
- Visited some exemplar sites at three trusts.

Future priorities:

- Review the internal information capacity and capability to deliver these improvements.
- Ensure the flow of information from ward to board to provide effective governance and assurance and that the Board is sighted on areas of concern.

Impact to date:

- Full new Quality Dashboard in place
- IPR redeveloped
- QLIK reporting changes
- Clinical group established increasing buy-in
- Information shared
- Adoption work delivered for PA Consulting scheduling models

Risks:

- Staffing capability and capacity
- Ability to recruit to essential positions
- Staff engagement and buy into a performance culture

Core Services
(Urgent and Emergency Care)

Our Improvement plan aim:
To deliver high quality care that is safe effective and focused on patients experience and the people we employee have the education training and development to deliver this care compassionately.

Progress to date:

- Revise booking in process and Standard Operating Procedure (SOP) for ambulatory ED patients in order to ensure timely and appropriate assessment. Ensure all relevant staff are competent in its use.
- Work has commenced with City PCN regarding the establishment of a UEC primary care service withing the ED. Initial meetings have been positive.
- Created interim pathway 1 support for patients requiring restarts of Package of Care on discharge.
- Developed dynamic management of bed stock through COVID and OPEL escalation surge plans - Actively review bed stock in light of both elective utilisation and emergency pathway demand to ensure most effective use of beds to meet demand.
- Worked with HR Business Partners to deliver an on-going rolling recruitment programme for all levels of ED support, nursing and medical staff.
- 'Launched 'Putting Patients First' campaign to support flow of patient out of ED to specialty beds and effective allocation of patients to appropriate specialty.
- Updated the risk management process and ensured regular review at Divisional Governance meetings
- Rolling recruitment programme in place in medicine and business case for additional medical workforce has been approved at Trust Board

Future priorities:

- Work with ECIST on 6 workstreams focusing on front door and flow
- Develop business case for nursing establishment review in ED
- Relocate fracture clinic to create additional space for ED
- Focus on MCA across staff groups

Impact to date:

- additional pathway 1 support has been put in place and additional bed capacity secured to provide interim care whilst packages of care are sourced
- A plan to deliver further reductions in the supported discharge patients who are medically fit for transfer has been agreed by system partners
- Working with commissioners and NEMS to develop primary care service provision within ED -service has had rotas to deliver the current agreed capacity model since August
- The medical workforce business case has been progressed and has been signed off at Trust Board
- A review of the nursing establishment within ED has been completed
- Divisional Quality report to Quality and Safety Oversight Group covering quality and patient safety issues within ED to the October meeting

- **Risks:** ongoing operational pressures, including winter and Covid, creating further capacity challenges. Ability to recruit to new posts. Impact of Booster programme on Primary Care capacity.

Core Services

Our Improvement plan aim:
To deliver high quality care that is safe effective and focused needs of patients where capacity to consent to care and treatment is a concern

Progress to date:

- MCA compliance audits now forms part of the Tendable app, a baseline audit was done in December for reporting in mid – January 2022
- MCA policy is currently being reviewed to support delivery over the next 12 months
- MCA compliance is now part of the divisional DLT leadership pounds
- Revised ToR of safeguarding committees to improve governance and accountability structure
- Mental Health Matron started in December 2021 to support the Safeguarding team

Future priorities:

- National eLearning package is available for all staff to complete annually. Current Trust figures 69%, Nursing and Midwifery 70%, Medical Staff 63%
- We need to develop a communications campaign to promote awareness and understanding. Safeguarding Team to increase use of Twitter to promote changes, updates
- MCA compliance will be built into the new Board2Ward visits

Impact to date:

- MCA training on induction is part of the BigLec action plan
- MCA training compliance is now a metric being reported at safeguarding committees and is reflected in the updated adult safeguarding committee ToR

Risks:

- Ongoing issues with the National ESR database continue and confidence in the reporting of data is poor
- Staffing capacity due to COVID19 (4th Wave) and operational challenges will impact on training in Q4 and potentially into Q1 (2022/23)

We Listen
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Summary and concluding messages

- The CQC report gives us an opportunity to make the improvements required.
- It has been shared with our staff and the findings used to inform improvement plan.
- We know we are at the start of a an 18 month journey to take us beyond solely meeting the regulatory requirements and building an organisation to be proud of.
- We have created a plan that incorporates issues raised by the CQC, our staff and comments from our regulator and put the necessary governance arrangements in place provide the rigour and discipline we need to ensure we implement our improvement plan and have the make it happen.
- We have began to make changes in our organisation that address culture, engaging with our staff in ways we did not try before and strengthening our governance systems and processes.
- We recognise some of the changes we need to make will take time to do and take time to embed in our organisation.

We welcome your comments and views on the style and level of detail of reporting on our progress to date and the work in progress