This Action Plan was agreed by executive team the week commencing 4 October 2021.
This plan will be presented to the Quality Panel for BRAG rating on the 21 October 2021, following this work will commence on compiling evidence against each action.

Completed	**0**	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice
Overdue	**0**	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.
Off Track with actions to deliver	**0**	Action is off track and plans are being put in place to mitigate any delay
On Track	**0**	Action is on track with progress noted and on trajectory
Total Number of actions		0
Percentage of actions completed/on track		To be confimed

No	Recommendations 2020/2021 Inspection	Self Assessment RAG Status	Providers must have regard to the following guidance	Well Led/Core Service Area	Operational Leads Statement of current position
MD01	The Trust must assess, monitor and improve the quality and safety of the services provided in the carrying-on of the regulated activities (including the experience of	Not Rated	Regulation 17 - Good Governance CQC report states: Page 3 - There were clear lines of accountability from the department to the board through the directorate governance structure, but these were not always effective. There was a lack of oversight of issues identified as a risk to patient and staff safety which had not been identified or addressed by the leadership team until we raised them during our inspection. For example, on the temporary coronary care unit, there was a lack of infection prevention and control compliance and the environment was inappropriate creating many risks. • Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. The audits should be baselined against Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and should, where possible, include the experiences people who use the service. The systems and processes should be continually reviewed to make sure they remain fit for purpose. Fit for purpose means that: - systems and processes enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. - providers have access to all necessary information.	Well Led/Trust Wide	
		Not Rated	• Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken.		

	service users in receiving those services) - Regulation 17	Not Rated	• Providers should have effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review. • Providers should actively seek the views of a wide range of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, about their experience of, and the quality of care and treatment delivered by the service. Providers must be able to show how they have: - analysed and responded to the information gathered, including taking action to address issues where they are raised, and - used the information to make improvements and demonstrate that they have been made • Providers must seek professional/expert advice as needed and without delay to help them to identify and make improvements. • Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected. • Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.		
		Not Rated	• Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	Well Led/Trust Wide	
MD02	Assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk which arise from the carrying on of regulated activities - Regulation 17	Not Rated	Regulation 17 - Good Governance • Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. • Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. • Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	Well Led/Trust Wide	
		Not Rated	• Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students	Well Led/Trust Wide	
MD03	The Trust must ensure that all mandatory training records are updated promptly via the electronic systems to accurately reflect percentages of staff trained in each subject - regulation 12	Not Rated	Page 49 - We were informed that health and safety training figures were low because two electronic recording systems were not compatible and that the actual figures were above 85%. *Whist this action was identified in the Children and Young Peoples Core Service review, it is a Trust wide recommendation.*	Children & Young Services	
MD04	The trust must ensure that medicines brought in by patients are recorded at admission and stored securely - regulation 12	Not Rated	Service area Page 3 - Medicines brought in by patients were not always recorded at admission and there had been several incidents were medicines had gone missing across a number of wards.	Specialist Medicine	

MD05	The trust must ensure paper patient records are completed in full and are contemporaneous to reflect care provided - regulation 12	Not Rated	Page 3 - Paper records were still in use and not always fully completed or filled contemporaneously in line with trust policy.	Specialist Medicine	
MD06	The trust must ensure that where medical care service risks are identified, mitigation is put in place in a timely manner - regulation 17	Not Rated	Page 3 - There were clear lines of accountability from the department to the board through the directorate governance structure, but these were not always effective. There was a lack of oversight of issues identified as a risk to patient and staff safety which had not been identified or addressed by the leadership team until we raised them during our inspection. For example, on the temporary coronary care unit, there was a lack of infection prevention and control compliance and the environment was inappropriate creating many risks. *Relates to overarching question - Regulation 17*	Specialist Medicine	
MD07	The trust must ensure that there are sufficient numbers of appropriately skilled staff to keep patients safe from avoidable harm	Not Rated	Page 3 - The service did not always have enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to meet the needs of the patients including using locum and bank staff to help keep patients safe.	Specialist Medicine	
		Not Rated	Page 24 - Medical staff reported the service did not have good skill mix of medical staff on each shift		
SD01	Review its oversight of clinical incidents and embed an effective system to learn from such incidents.	Not Rated	Page 11 - A learning culture was not embedded within the trust, and the lack of effective governance around serious incidents, mortality and mental health (as well as an inability to effectively learn from complaints and patient experience) showed there had been little appetite for organisation learning.	Well Led/Trust Wide	
SD02	Review its mortality governance processes.	Not Rated	Page 9 - Mortality governance was immature with no clear approach for reporting issues. Structured judgement reviews had not happened as required and there was a backlog to be completed. Mortality meetings were meant to be held monthly but there had been months when these had not taken place	Well Led/Trust Wide	
SD03	Review and act upon its governance of the Mental Health Act.	Not Rated	Page 9 - There had not been a proactive approach to the governance of the Mental Heath Act and reporting to committees and the board has been on an ad-hoc basis. The trust's lead in this area said that the trust had not focused on this issue effectively. There was an outstanding gap analysis to be carried-out in response to the Care Quality Commission's Assessment of Mental Health Services in Acute Trusts report, published in October 2020. Page 10 - The approach to governance around mental health was concerning reactive. The trust had seen a significant increase in incidents related to mental health including missing patients and young people waiting for specialist placements elsewhere, and remaining under the trust's care for long periods prior to placement. There was an admitted absence of assurance on whether trust relationships with external partners, local authorities and the police were effective Page 10 - In the absence of a Mental Health strategy, a proactive review of polices and standard operating procedures needed to be carried-out, with assurance that staff use these to follow procedure.	Well Led/Trust Wide	
SD04	Review and act upon the reasons underpinning the Head of Internal Audit's 2021 opinion.	Not Rated	Page 10 - There was a risk that management information was not reliable; leading to the potential for misleading reporting in turn potentially impacting on the efficacy of decision making. The head of internal audit opinion indicated that the trust cannot rely on the quality of its data. Page 12 - The trust subsequently updated us on this position, and upon completion of the work the trust had five reviews rated as significant assurance with minor improvement opportunities and four reviews rated as partial assurance with improvements required. This led to a final Head of Internal Audit opinion of significant assurance with minor improvements.	Well Led/Trust Wide	

SD05	Review the terms of reference and membership of the audit committee.	Not Rated	Page 12 - The audit committee's terms of reference required three non-executive members for quoracy, but over the recent months had met with two only. In addition, one of the members was the trust chair, which is not in line with recommended practice.	Well Led/Trust Wide	
SD06	Share with the Care Quality Commission recommendations resulting from the findings of the NHS England and NHS Improvement Intensive Support Team review work.	Not Rated	Page 2 - The trust had been subject to significant intervention from NHS England and NHS Improvement across several areas of trust service delivery, including support for the trust's executive being provided by their Intensive Support Team. Page 6 - We had not received the necessary assurance from the trust following our December 2020 inspection of the trust's emergency department - when we issued the trust with a section 29A warning notice	Well Led/Trust Wide	
SD07	Agree a process of regular ongoing assurance with the Care Quality Commission through information returns - in order to provide assurance on progress against the findings of the well led summary report and progress against the ECIST recommendations and its own Patient First workstream.	Not Rated		Well Led/Trust Wide	
SD08	The trust should improve the rates of mandatory training completion for both medical and nursing staff	Not Rated	Page 18 - Nursing staff met the trust target in six of the 10 mandatory training modules. This was the same as reported at the last inspection in December 2019. Unregistered and administrative staff groups also met the trust target in six of the 10 modules they were eligible for.	Trust wide/Specialist Medicine	
		Not Rated	Page 18 - Medical staff performed slightly worse than the other staff groups, achieving the 85% target in five of the nine mandatory training modules. However, this was a significant improvement on the last inspection where the target had been met in only one module.		
SD09	The trust should ensure patients are referred to the correct patient pathway at the earliest opportunity.	Not Rated	Service area Page 3 - Patients were not always put on the correct patient pathway which delayed the start of their treatment and increased the risk of deterioration.	Specialist Medicine	

SD10	The trust should improve the timeliness of incident investigations.	Not Rated	Page 28 - Managers reviewed accidents and incident reports, but these were not carried out in a timely way. The trust reported that they had a large backlog of serious incidents to investigate. At the time of our inspection records showed medical care had 330 incidents that were overdue by 45 days and a further 203 incidents overdue by 60days. This meant the service could not in a timely manner, learn from the incidents or take action to prevent the incidents from happening again. The service had a back log of serious incidents that were overdue for investigation.	Trust wide	
SD11	The trust should embed its new complaints process to respond to patient complaints about the service/s effectively, and in compliance with timelines set in the trust's complaint policy.	Not Rated	Page 43 - The service did not always meet their target for responding to complaints. The target response time for all complaints was 30 working days and 60 days for complex complaints. At our inspection the specialist medicines care group had 27 outstanding complaints, 23 of which had breached their target date. Staff told us there had been an increase in patient complaints and minutes from the care group board meeting showed that some complaints were breaching their target as they needed to be signed off by the executive team. *Whist this action was identified in the Specialist Medicine Core Service review, it is a Trust wide recommendation.*	Trust wide	