Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Location name	The Christie NHS Foundation Trust

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Surgical procedures** **Treatment of disease, disorder or injury**	**Regulation 5** **Fit and proper persons: directors**
	How the regulation was not being met:
	There were gaps in assurance for requirements of the Fit and Proper Persons Requirement (FPPR).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

- Implement a standalone Fit & Proper Persons Policy addressing gaps in assurance.
- Update checklist in line with the Fit & Proper Persons Policy.
- Include in the annual programme of the Audit Committee and Board of Directors.

Who is responsible for the action?	Company Secretary

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Retain records in individual hard copy files.
- Annual audit reporting to Audit Committee for assurance and then to Board.

Who is responsible?	Chair

What resources (if any) are needed to implement the change(s) and are these resources available?

- No additional resources are needed.

Date actions will be completed:	28 July 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?

- No impact on service users.

Completed by:	Executive Chief Nurse & Director of Quality

<table>
<tr><th>Regulated activities</th><th>Regulation</th></tr>
<tr><td rowspan="3">Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury</td><td>Regulation 12
Safe care and treatment</td></tr>
<tr><td>How the regulation was not being met:</td></tr>
<tr><td>Serious incidents and mortality reviews were not always investigated in a timely manner and learning was not always shared across the organisation as required.
Not all patient risk assessments were consistently completed and reviewed in a timely manner for all patients.
The service did not ensure the proper and safe management of medicines, including the completion of antimicrobial documentation for safe prescribing in line with the trust policies.</td></tr>
<tr><th colspan="2">Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve</th></tr>
<tr><td colspan="2">Serious incidents and mortality reviews
Allocation of all incident lead investigators and mortality reviewers for cases reported in the previous 7-days to be confirmed at weekly Executive Review Group and monitored through Risk & Quality Governance Committee.
Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.
Enhance surveillance through the Executive Review Group to ensure compliance with guidance.
Implementation of the new Datix Mortality software to support timely reviews.
Increase frequency of Learning for Improvement Bulletin from every 2 months to every month.
Patient Risk assessments
Align internal policies to national guidelines for falls, nutrition, pressure ulcers and VTE.
Update ward coordinator checklist to reflect daily monitoring of risk assessments.
Introduce an alert for patient risk assessments within our electronic patient records.
Implement ward level view of live risk assessment compliance.
Include nursing risk assessment requirements in the local induction.
Continue to measure compliance through bedside handover quality improvement project.
Proper and safe management of medicines, including completion of antimicrobial documentation
Update of prescriber induction and other training to document clinical indication and duration of all antimicrobials.
Monitor compliance through ward pharmacists undertaking surveillance of completeness of inpatient antimicrobial prescriptions.</td></tr>
<tr><td>Who is responsible for the action?</td><td>Serious incidents and mortality reviews
Associate Medical Director for Quality & Patient Safety
Patient Risk assessments
Associate Chief Nurse for Quality & Patient Safety</td></tr>
</table>

	Proper and safe management of medicines, including completion of antimicrobial documentation • Director of Pharmacy

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
Serious incidents and mortality reviews • Timeliness of incident investigation and mortality reviews to be included in the quarterly patient safety report to Risk and Quality Governance Committee and to Quality Assurance Committee for board oversight. • Internal audit of learning from deaths is included in the rolling internal audit programme. Patient Risk assessments • Monitoring of compliance within Divisions by Lead Nurses. • Assurance to Chief Nurse/Corporate Nurses through Lead Nurse meetings. • Annual review of compliance at Patient Safety Committee. Proper and safe management of medicines, including completion of antimicrobial documentation • Continue a 6 monthly audit programme reporting to the Nosocomial Infection Performance Committee.

Who is responsible?	Serious incidents and mortality reviews • Medical Director Patient Risk assessments • Executive Chief Nurse & Director of Quality Proper and safe management of medicines, including completion of antimicrobial documentation • Chief Operating Officer

What resources (if any) are needed to implement the change(s) and are these resources available?
• Time has been identified within the clinical audit programme.

Date actions will be completed:	29 September 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?
• Risk of not continuing to make timely improvements to patient safety and service quality due to delay in sharing learning.

Completed by:	Executive Chief Nurse & Director of Quality

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Surgical procedures** **Treatment of disease, disorder or injury**	**Regulation 16** **Receiving and acting on complaints**
	How the regulation was not being met:
	The trust did not ensure there was an effective process to manage complaints, in particular, ensuring the timeliness of responses.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

- Report as required by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.
- Enhance surveillance through Executive Review Group to ensure compliance with national guidelines.
- Immediate learning to be identified through Executive Review Group and shared with divisional governance leads and through Friday Focus.

Who is responsible for the action?	Associate Chief Nurse for Quality & Patient Experience

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Monitor through the weekly Executive Review Group.
- Continue to provide executive oversight through quarterly report to Patient Experience Committee and Risk & Quality Governance.
- Continue to provide board assurance via the Quality Assurance Committee.
- Internal audit of complaints management is included in the 2023/24 internal audit programme.

Who is responsible?	Executive Chief Nurse & Director of Quality

What resources (if any) are needed to implement the change(s) and are these resources available?

- No additional resource requirements.

Date actions will be completed:	29 September 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?

- Risk of not making timely improvements to patient experience and service quality due to delay in sharing learning.

Completed by:	Executive Chief Nurse & Director of Quality

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Surgical procedures** **Treatment of disease, disorder or injury**	**Regulation 17** **Good governance**
	How the regulation was not being met:
	Not all policies were reviewed and ratified in a timely manner.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
• Review all trust policies against expiry dates. • Review Trust Procedural Documents policy and policy template. • Develop and implement a Document Management Standard Operating Procedure.	
Who is responsible for the action?	Associate Chief Nurse for Quality & Patient Safety
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Validation of all policies on the trust document management system (HIVE). • Monthly reports of "soon to be expired" policies to be managed via the trust Risk & Quality Governance Committee. • Regular auditing of points within the Document Management Standard Operating Procedures, once developed.	
Who is responsible?	Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
• Support from the digital team agreed.	
Date actions will be completed:	29 September 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?
• Risk of staff employing out of date practice as a result of using a policy past its review date.

Completed by:	Executive Chief Nurse & Director of Quality

<table>
<tr><th>Regulated activities</th><th>Regulation</th></tr>
<tr><td rowspan="3">Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury</td><td>Regulation 18
Staffing</td></tr>
<tr><td>How the regulation was not being met:</td></tr>
<tr><td>Not all staff had completed mandatory training in accordance with the relevant schedule including safe guarding training. Not all staff had received relevant training, supervision and appraisal to perform their duties competently.</td></tr>
<tr><td colspan="2">Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve</td></tr>
<tr><td colspan="2">Mandatory Training
Allocate dedicated time for all new starters to attend induction and complete mandatory training before commencing duties.
Allocate dedicated time for all staff to refresh mandatory training.
Align our mandatory training including safeguarding training to the Core Skills Training Framework.
Review and update our Mandatory Training Policy.
Communicate our mandatory training requirements to all staff.
Implement a mandatory training dashboard to improve visibility and monitoring of compliance with the mandatory training policy.
Appraisal
Review our PDR policy, training, tools and processes to improve accessibility.
Implement a PDR dashboard to improve visibility and monitoring of compliance with the PDR policy.
Pilot Talent Tool as an alternative approach to PDR.
Supervision
Align supervision requirements to professional standards for Agenda for Change roles / Postgraduate medical training grades / local employed doctors (SAS + Consultants).</td></tr>
<tr><td>Who is responsible for the action?</td><td>Mandatory Training & Appraisal
Deputy Director of Workforce
Supervision
Head of Workforce Education</td></tr>
<tr><td colspan="2">How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?</td></tr>
<tr><td colspan="2">Regular reporting and review of compliance with the policies at the service and operational review meetings.</td></tr>
</table>

• Executive oversight through Workforce Committee. • Continue to provide board assurance via Workforce Assurance Committee. • Commission internal audit (MIAA) to review our processes.	
Who is responsible?	Director of Workforce
What resources (if any) are needed to implement the change(s) and are these resources available?	
• Prioritise resources to release staff to meet training requirements. • Additional resources required for the MIAA audit will be identified.	
Date actions will be completed:	31 October 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?
• Risk of staff not having the full skills and development needed to undertake their roles effectively.

Completed by:	Executive Chief Nurse & Director of Quality