Quality *for all*

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Quality Improvement Plan

Working document

Contents:

Our journey so far …

Sir Bruce Keogh, NHS Medical Director, undertook a review of the quality of the care and treatment being provided by those hospital trusts in England which had been persistent outliers on mortality statistics; Sherwood Forest Hospitals NHS Foundation Trust was one of these Trusts.

The initial Rapid Response Review (Keogh Review) took place in June 2013, and resulted in a report and risk summit which identified 13 urgent action and 10 high and medium actions. The Trust was placed in special measures. In December 2013, an assurance review was undertaken by the Keogh team. The Trust was measured as being 'fully assured' in 6 actions and 'partially assured' in 17 actions. No areas were recorded as 'not assured'. The actions identified from this Assurance Review in December 2013 were consolidated with actions from the parallel Care Quality Commission (CQC) inspection and the PwC report in respect of quality governance.

In April 2014 the Trust underwent a subsequent CQC inspection to assess the Trust's progress in relation to exiting special measures. This inspection recommended that the Trust should remain in special measures. The Trust developed an action plan to address the issues raised; the residing Keogh actions were amalgamated into this action plan.

Upon appointment of a new Improvement Director, Gillian Hooper, the Trust developed a comprehensive Quality Improvement Plan (QIP), which pulls together all the issues and concerns that could impact upon our ability to deliver quality care (excluding finance).

The following is an update of the actions included within the Quality Improvement Plan:

1. Recruitment and retention of a credible and competent Board of Directors equipped with the skills to deliver the strategic priorities of the Trust.

The Board Development and Review Programme has been established. The diagnostic has been completed and the board received feedback from Foresight on 4 December, 2014. Planning meetings for the next phase of work scheduled occurred on the 21st January 2015. This work will incorporate Kings Fund Partnership.

The Executive coaching programme has commenced and executive team members are now receiving individual coaching. Team coaching is scheduled for 2nd February 2015.

In December 2014 the Chief Executive recruited a substantive Chief Financial Officer who has accepted the post, and is planned to commence at the Trust on the 23rd March 2015. .

Following the departure of our Director of Operations an interim Director of Operations is in post week. The selection process for substantive appointment is to commence mid-January.

2. Our culture is focussed on delivering 'Quality for All' and staff feel valued and empowered to do an excellent job and proud to work for our Trust.

The new recruitment documentation will be rolled out by the 31st January 2015, and the recruitment and selection training programme will reflect the Quality for All values. Team conversation exercises have been completed and this will be shared across the Trust.

The Capability policy and toolkit have been agreed, and this will be rolled out across the Trust by the 31st January 2015.

Values team conversations have taken place with many teams across the Trust. To date 67 team actions plans have been developed. On-going plans for Quality for All conversations are being initiated.

Procurement arrangements remain on-going in order to secure an external provider for the staff FFT. Robust internal arrangements are in place to secure staff FFT responses until external provider is identified. The staff Friends and Family Test will have internal processes in place for Quarter 4.

The recruitment and selection training programme has been updated to reflect Quality for All Values and Behaviours. The roll-out and training related to the revised recruitment and selection processes is to be completed by 31st January 2015.

The capability policy and toolkit has been agreed with Staff Side – the roll-out will be completed by the 31st January 2015.

The assessment of the benefits of a Listening into Action approach has been undertaken.

3. Implement our leadership strategy with appropriate focus at divisional and service lines to support our leaders to deliver the strategic objectives.

The senior HR Leaders Development Workshop was completed on the 6th November 2014 to map existing strategies across to a leadership strategy and identify gaps. The Leadership Strategy and action plan is in draft, and will be completed by the 31 January 2015.

A revised medical leadership programme has been devised and will commence in February 2015.
Medical engagement has been enhanced and a medical engagement group formed with NED's, MD and Consultants to explore mentoring and buddying has commenced.

4. Ensure Trust Risk Management processes are robust including appropriate identification of risks, incidents, mitigations and learning at all levels in the organisation.

Since the CQC visited in April 2014, we have undertaken a large amount of work to improve our risk management systems and processes. In November 2014, we appointed a Risk Manager who is quickly

strengthening our risk management work; by January 2015 we had completely rewritten our Risk Management policy, ratified it at Trust Board and have started to disseminate across the organisation. Since November 2014 we have undertaken a 'confirm and challenge' exercise of the significant risks and are performing the same exercise for the lower scoring risks. This approach is creating a significant movement in the risk register. Currently there are 128 open risks; 33 risks have been closed and archived, 16 new risks added and 18 risks have had their score reduced. In total over 100 of the risks have now been comprehensively reviewed. The cleansing of the data to be transferred to the DatixWeb Risk Management is underway and will be completed during January, with the training rolled out from February onwards.

In December 2014 the first Risk Management Committee met to agree the Terms of Reference and set the agendas and work plan. A subsequent meeting was held in January 2015. The two largest divisions (Emergency Care & Medicine and Planned Care & Surgery) will have a comprehensive review of their risk register at the February meeting. Risk Management Committee now reports to TMB

Three levels of risk management have been added to the Trusts Training Needs Analysis. These commenced in January 2015, with 5 sessions per month currently scheduled. Awareness sessions to ward leaders and business support units have taken place.

5. Ensure that staff receive appropriate and timely feedback from incidents and complaints and that actions taken and lessons learnt are shared across the divisions to improve quality and safety.

The Trust has now implemented DatixWeb across the whole Trust, with staff receiving training to use the system. Automatic feedback to the reporter is now mandatory.

A task and finish organisational learning group meets weekly. Planned Care and Surgery use a learning board at their Divisional Clinical Governance Committee. This has been incorporated into the new Organisational learning Boards, which have been developed and are on display in Ward 14. All Boards are being rolled out during January 2015.

Nurses and Midwives have attended the Nursing & Midwifery Time Out Days in which practice is shared and shaped around the Trust's new values of CARE. Over 300 have attended these days, which are planned until December 2015.

We have held the first monthly Patient Safety briefing on 'positive patient identification', with 25 minute sessions including a 10 minute presentation, looking at incidents within our Trust.

The implementation of the Nursing and AHP Grand Rounds will commence in January 2015, with the first session on the deteriorating patient presented by ED.

An Innovation Hub is now on the Trust's HQ corridor with plans for moving to the main reception in Q1 2015/16.

The Being Open policy has been circulated through the iCare2 on the 8th January 2015.

Root Cause Analysis training date courses for 2015 have been published on the Trust's intranet.

Ward Leaders forum have received a dedicated session on Organisational learning.

6. Build safe and effective staffing levels with escalation processes to meet unpredicted demand.

Following the Keogh Review in June 2013, SFH committed to invest in nursing. There was an immediate response with an increase in overnight staffing on all inpatient areas. Respective Divisional Matrons have reviewed their nursing establishments in conjunction with the Executive Director of Nursing in order to seek consensus regarding skill mix and registered nurse to bed ratio. The Divisional Matrons are currently in the process of transacting these plans and recruiting to vacancies via a variety of routes in addition to standard recruitment practice; namely appointment of newly qualified staff, international recruitment and return to practice initiatives. We are providing individual preceptor support and development packs for internally recruits who have not been part of our preceptor programme.
Planned Care & Surgery have progressed to a 60:40% RGN: HCA skill mix. Mansfield Community Hospital has also increased its Registered Nurse complement. Night nursing in ED has been increased and ward leadership in EAU has been strengthened.

The current information which is reported monthly on UNIFY and NHS Choices, demonstrates that the Trust achieves 100% or greater for Registered Nurses and Healthcare Assistants day and night average fill rate, overall. The Healthcare Assistant has an increase in the average fill rate, and this demonstrates the utilisation of Healthcare Assistants to support the additional support required to some patients in 1:1 care.

There have been successful recruitments to the Acute Physicians post; one commenced in December 2014, and the second is to commence in February 2015. Two further posts will commence in March 2015, giving us a total of 6 Acute Physicians. This is the highest number the Trust has recruited. The recruitment of an Interventional Consultant Radiologist with Nottingham University Hospitals is underway and this appointment will provide the Trust with 5 day interventional service.

7. Ensuring equipment maintenance programmes are fully compliant and operate systems to identify, assess and manage risks relating to the health, welfare and safety of service users and others.

The actions for equipment management are all in place and are being executed for the end of January 2015.

The Medical Device Management Policy has been updated and approved. This policy is currently being communicated across the trust.

The Trust has introduced a standardised electronic medical device reporting systems. This ensures there are no discrepancies between reporting arrangements. The roll out of this system will be through the distribution of posters (w/c 19 January 2015), through the staff bulletin and onto the Learning Boards in all the clinical areas.

To support the maintenance of equipment an Amnesty Day is being planned for the end of January. This will enable us to identify the remaining equipment that is past its maintenance date, which will then help support the MEMD staff in the planned maintenance programme. It is currently difficult to manage the bed maintenance programme due to the current inpatient capacity, but plans are in place to hasten this programme once ward capacity is made vacant (Ward 21).

The Cardiopulmonary Resuscitation (CPR) Procedural Policy was reviewed and approved in August 2014. The Appendices section (referenced 'NEW') illustrates where additional information was added to the existing appendix, e.g,.Trolley Content List/Additional equipment list. Once approved, a significant amount of work had to be undertaken with regard to mapping the location of trolleys across all 3 Trust sites. The replacement of the Resuscitation boxes to new Resuscitation trolleys is currently in the awarding stage of the procurement process, and once this has been completed an implementation plan can be developed, which is estimated to take 4 – 5 months to implement. A programme of implementation has been agreed by MEMD and Resus staff and dates will be inserted when the delivery date of trolleys is known, subsequent to completion of the procurement process.

The daily resuscitation checklist is monitored through the Nursing Metrics and is demonstrating 98% compliance.

8. Improve the systems and processes for the storage and administration of all medicines. Reduce the incidence of medicine omissions.

An operational group, chaired by the Director of Nursing, meets weekly to drive the improvements required for medicine safety. Many initiatives have been implemented including; informative posters, use of red aprons and a red apron campaign, new Trust Wide prescription chart, new e-learning opportunities in relation to medicine safety, introduction of 2 nurse check at the bedside, trials of a 'unrequired stock boxes' and 'swipe action' bedside lockers and the development of a medicines error policy.

The Pharmacists are working with the Ward Leaders and the nursing teams to provide safe administration and storage of medicines. The Pharmacists and nurses are undertaking twice monthly missed/omitted drug audits, which are being reported back to the Divisional Matrons to develop an action plan to improve and reduce the number of missed doses of drugs. December results were the best recorded results since data collection commenced. Ward Sisters are challenging the data which demonstrates an ownership of wanting to improve. The audit is now being refined to identify which parts of the system are causing medicine omissions - to enable focused action. ED are introducing 'named nursing' which is expected to provide greater responsibility for medicine management.

Training is currently being undertaken by the Pharmacist on Patient Group Directives and ward based discharges, which will be an on-going training exercise as staff are recruited to the wards.

The Practice Development Matrons have focussed on medication safety and this has demonstrated a reduction in medication errors and missed/omitted doses. We have included eLearning module for insulin safety into the preceptor programme

9. Ensure patient records are appropriately maintained in line with Trust policy and legislative requirements.

The WHO surgical checklist was established as an area of good practice which had not been embedded within the organisation. Following the Keogh Review in 2013, Theatres have embraced the WHO surgical checklist, and it is now championed by a Trauma & Orthopaedic Consultant. The Trust is currently one of the better performers within the East Midlands, and the audits continue to demonstrate high levels of compliance.

The Practice Development Matrons have a dedicated focus week on 'Record Keeping', in February 2015. There is ongoing delivery of weekly record keeping training sessions for nursing staff and bespoke sessions for those requiring additional support e.g. overseas nurses. A new record keeping session is now included within the nursing induction to ensure all new staff are captured upon entering the Trust. We are currently trailing the development and delivery of a specific record keeping training session for HCA staff. The bedside record keeping folders are being standardised across the Trust – currently at the printers. Areas using prototype dividers have evaluated positively.

The implementation of Care & Comfort Rounds and Accountability Handovers are currently being audited to provide a baseline and to ensure that the Ward Leaders can be sighted of an improvement. These will be reported on the Key Performance Indicators in February 2015.

This section is currently RAG rated AMBER, and it is recommended that it remains AMBER for further monitoring and assurance.

10. Ensure the processes for the recognition of deteriorating patients are robust and appropriately acted upon.

VitalPac has been rolled-out across Kings Mill Hospital with an upgrade due prior to April 2015 and a planned upgraded roll-out to Newark and Mansfield Community Hospitals in January and February 2015. Training for staff at Newark and Mansfield Community Hospitals has been planned with support from the VitalPac trainers.

The implementation of VitalPac has improved the escalation rates of deteriorating patients, as in December 95% of patients were escalated appropriately and timely.

The issues identified are:

- Poor WiFi at Newark Hospital which has caused some delays;
- Deliverability by the Learning Clinic to supply the system in a timely manner;
- The Fluid Balance module has been trialled and the clinical team at the Learning Clinic are not currently satisfied with the usability and therefore have withdrawn this module, and are hoping to trial again in April at Sherwood Forest Hospitals. This impacts upon our fluid balance work which we are addressing.

Infection Prevention and Control is currently RAG rated as RED within this section, as we are currently over the trajectory (54 cases) for the C-diff target of 37 cases. The Nurse Consultant for Infection Prevention and Control

is working in partnership with the local CCGs and a Task & Finish group has been established to review C-diff. This currently remains a concern and it is not recommended that the RAG rating changes (please refer to the Trust Board Quality & Safety Report).

11. Ensure safe, appropriate and timely flow of patients from admission to discharge, with the support of good bed management and discharge processes. Achieving sustaining all three 18ww pathways.

The discharge lounge was opened in October 2014, utilising space within Clinic 9. This area is to support SFH in maintaining patient flow for emergency admissions, and ensure that there is good flow throughout the day. Week commencing 12th January 2015 saw the highest utilisation of the discharge lounge in the ten weeks of the lounge being operational.

Improve the flow of emergency pathway with timely access to relevant services and discharge remains RAG rated RED, as there remains significant bottlenecks within the patient flow system, which is reflected in the monthly four hour trolley wait (95%) not being achieved.

The Hospital @ Night audit and review has now been completed, and the draft copy is to be discussed with the Medical Director.

The Medical Outlier Policy has now been ratified at the January's Clinical Quality & Governance Committee, and the compliance monitoring is agreed. The Outlier Decision Tool will be audited monthly with January's audit to be reflected within the Key Performance Indicators next month.

The Refer To Treatment (RTT) 18 weeks continues to be monitored monthly, and a Trust-wide achievement of 'admitted' 90.2% (target 90%) and 'non-admitted' 95.5% (target 95%) in Q3.

12. Improve delivery of mandatory and targeted training for staff.

The Mandatory training e-learning workbooks have been developed and following a successful pilot in four areas will be launched by the 31st January 2015. Data review discussions have taken place with Managers across the Trust. No significant data issues have been identified.

Personalised letters to all staff which identifies their mandatory training requirements and compliance have been issued. Improved uptake of mandatory training course bookings noted

Launch of supervisor self-service completed for January 2015 to enable Managers to have real time mandatory training information

13. Strengthen the processes to enhance staff performance, ensuring the availability of skilled and competent staff.

A detailed action plan has been developed as a result of the HEEM visit. All actions are being progressed through the OD & Workforce Committee, with good progress.

The Appraisal Policy has been revised and agreed which now reflects Quality for All Values and Behaviours.

Incremental Progression Protocol was approved on the 6th January 2015.

Stress Management Focus Groups have been taking place across the Trust regarding approaches to Stress Management in relation to staff. Interim update considered by the Health & Safety Committee on the 8th January 2015. Detailed requirements to be considered by the OD & Workforce Committee in February 2015.

This section is currently RAG rated as GREEN, and it is recommended that this remains GREEN for further monitoring and assurance.

14. Improve the effectiveness and responsiveness of services through the use of evidence based clinical pathways.

The Clinical Pathways have been discussed by the Executive Medical Director at the Medical Managers meeting in January 2015, and the Clinical Directors for Emergency Care & Medicine and Planned Care & Surgery are engaged in their developments. A review of pathways has been completed by the Heads of Service which includes transfer protocols and Newark. These are being collated into a standard format but some have required revision and approval has been delayed.

Director for Newark Hospital is in place to review and design integrated services.

The DNA texting service is in place for outpatients and implementation planned in radiology by March.

The Urology telehealth monitoring is in implementation.

The Hip/Knee Schools and combined physio clinics for Orthopaedics will be implemented by March. The Nurse led cystoscopy clinic requires nurse training which will take six months to complete.

15. Increase patient feedback by collating a higher level of Family and Friends responses.

The Trust has recently met with the current provider following an unsuccessful procurement activity, in order to discuss ways in which the Trust can increase the Friends & Family response rates in ED. Increased support continues to be provided to increase the uptake of this test response (please refer to the Trust Board Patient Experience Report).

16. End of Life is responsive to the needs of our patients (and their carers), delivered by competent, knowledgeable staff who respect and meet individual preferences.

There has been a lot of progress with End of Life following the visit of the CQC. Since April, 2014 the Trust has:

- Developed an end of Life Strategy which is strongly linked to the six-steps within the National End of Life Care Pathway NEoLCP (2010)
- Developed a network of Ward Champions and Clinical Leaders within each speciality who will facilitate the processes necessary for good quality care for EOLC patients and their families, and encourage a culture of compassionate care by staff caring for individuals approaching end of life.
- Produced guidelines and care plans to support patients in the Last Days of Life Care. This was launched at the beginning of September and was implemented by the end of December 2014.
- Ensured end of life care education and training is either delivered or being developed in a number of ways: Implementation of the Last Days of Life Care guidelines and care plans, Multi-disciplinary Induction Programmes, End of Life Care module within Mandatory Training Workbook, End of Life Care study days and communication skills training for staff who are involved in difficult conversations on end of life care
- Commenced a bereavement survey to capture patient / carers experience during their last days/hours of life.

Additional resources to deliver this programme of work has been provided y the Divisional Matron for Emergency Care & Medicine. The Lead Nurse with the additional resource is now charged with writing the two supporting policies to End of Life care, and embedding the Gold Standard Framework for Acute Hospitals to the wider inpatient areas, along with the Amber Care Bundles.

The Practice Development Matrons have a plan of work which focuses on key areas, one of which is End of Life. This consists of a self-assessment by the Ward Leaders and their teams, followed by a week with the Practice Development Matrons focussing on key areas to create improvements. The self-assessment for the End of Life demonstrated a positive understanding of the documentation and the principles of End of Life.

Adult Safeguarding and Staff engagement (including medical engagement) will be part of the Quality Improvement Plan from February 2015

Key Performance Indicators:

Key Performance Indicators:	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14
All Board posts are filled on substantive basis by competent individuals	Full Board	Full Board	Full Board	Full Board	Full Board	Full Board	Interim CFO	Interim CFO	Interim CFO	Interim CFO	Interim CFO	Interim CFO CFO apt
Staff FFT positive response rate improves from 52% to 62% by 30 June 2015						31.3%			35.8%			TBC
Staff survey question 8G from 36% to 46% from 14/15 results to 15/16	36%											
Staff survey question 9C from 54% to 64% - results from 14/15 to 15/16	54%											
Staff survey question 12C from 52% to 62% - results from 14/15 to 15/16	52%											
Mandatory training compliance rates at 90% or more					78%		79%	79%	80%	81%	82%	83%
Staff appraisal completion rates for AfC staff at 98% or more				82%	84%	81%	83%	84%	82%	84%	83%	85%
Evidence of performance being managed – number of capability hearings				0	0	0	0	0	0	0	0	0
All inpatient wards record >85% nurse staffing levels on UNIFY return					**T – 100.8% UT – 109.7%**	**T – 104.9% UT – 111.6%**	**T – 105.7% UT – 111.8%**	**T – 103.2% UT – 107%**	**T – 102.2% UT – 109.3%**	**T – 100% UT – 110.2%**	**T – 101.1% UT – 110.0%**	**T - 101.1% UT – 110.3%**
ED patient 4 hour wait – 95% target				93.4%	93.42%	95.96%	92.97%	**95.78%**	93.37%	91.26%	87.92%	84.46%
Infection Prevention and Control – number of C-diff – target 37 cases				**5**	**6**	**5**	**7**	**5**	**7**	3	7	9
Deteriorating patient escalation >95% compliance				78%	84%	**92%**	83%	73%	78%	**92%**	84%	**95%**
Increase family & friends response rate to 50% overall (inpatient response)				32.8%	32.2%	31.3%	38.1%	34.3%	35.8%	40.5%	36.6%	36.6%
RTT 18weeks – admitted 90% and non-admitted 95%				A - **90%** NA – 94.5%	A - **91.1%** NA – 94.1%	A - **92.1%** NA – 94.7%	A - **90.2%** NA – 92.6%	A - 89.4% NA – 91.8%	A - **91.6%** NA – **95%**	A - **91.3%** NA – **95.7%**	A - **90.2%** NA – **95.5%**	TBC

Abbreviations:
T = trained/registered nurse
UT = untrained/ healthcare assistant
A = admitted pathway
NA = non-admitted pathway

Future Key Performance Indicators to be included:

- WHO surgical checklist compliance;
- Accountability Handovers – from February 2015;
- Care & Comfort Rounds – from February 2015;
- End of Life documentation audit – from February 2015;
- Missing notes;
- Clinic short notice cancellations;
- Complaint responses within 25/40 days;
- Outstanding pathways;
- Discharge lounge utilisation;
- Medical Outlier Decision Tool audit;
- Medical Appraisal data;

Assurance Dashboard

Dec-14

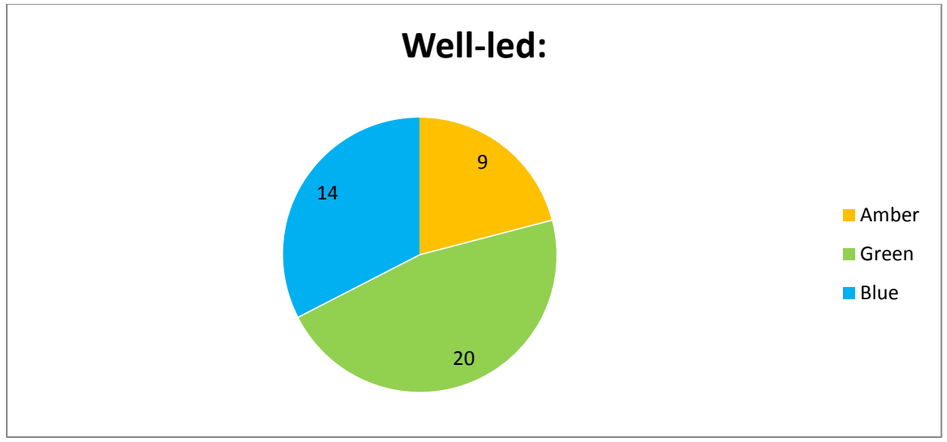
Whole Trust

<< dashboard

	Storage	Omissions	Critical Meds	Fluid Balance/Hydration	Observations	Escalation	BBE Compliance	2 stage test & best interests	Resus Trolley Checks
Data Source	NMetrics	MD audit	MD audit	NMetrics	VitalPac	NMetrics	Nmetrics	Nmetrics	Nmetrics
Ward / Dept									
11	100%	96%	98%	80%	84%	n/a	100%	n/a	100%
12	100%	97%	99%	100%	92%	80%	100%	50%	100%
14	100%	98%	98%	100%	89%	100%	100%	100%	100%
22	100%	98%	100%	60%	90%	100%	100%	100%	100%
23	100%	100%	100%	100%	86%	100%	100%	100%	84%
24	100%	97%	100%	100%	94%	100%	90%	67%	100%
25	90%	100%	100%	86%	nd	nd	nd	n/a	nd
31	100%	94%	99%	100%	95%	100%	100%	100%	100%
32	95%	98%	100%	100%	93%	n/a	90%	100%	100%
33	100%	99%	99%	33%	90%	100%	100%	n/a	94%
34	100%	98%	97%	75%	95%	100%	100%	50%	100%
35	100%	98%	98%	n/a	96%	n/a	100%	67%	100%
36	100%	99%	99%	17%	89%	100%	100%	nd	94%
41	100%	100%	100%	100%	94%	100%	100%	100%	100%
42	100%	98%	98%	100%	94%	n/a	100%	n/a	100%
43	100%	98%	99%	67%	80%	100%	100%	n/a	94%
44	100%	97%	94%	n/a	90%	n/a	100%	100%	97%
51	100%	97%	98%	29%	91%	100%	100%	100%	100%
52	100%	97%	98%	100%	90%	100%	100%	57%	100%
53/4	95%	98%	98%	60%	93%	100%	100%	100%	100%
Daycase	95%	nd	nd	n/a	94%	n/a	100%	n/a	100%
Maternity	nd	98%	100%	nd	nd	nd	nd	n/a	nd
EAU	100%	88%	86%	83%	88%	67%	90%	n/a	100%
ED	100%	nd	nd	100%	nd	100%	nd	n/a	nd
Chatsworth	100%	99%	100%	100%	nd	100%	100%	100%	100%
Lindhurst	100%	99%	99%	n/a	nd	100%	100%	50%	100%
Oakham	100%	100%	100%	100%	nd	100%	100%	100%	100%
Sconce	100%	100%	100%	100%	nd	n/a	100%	80%	100%
Minster	100%	nd	nd	n/a	nd	n/a	100%	100%	83%
Total Avg	99%	98%	98%	82%	91%	97%	99%	85%	98%

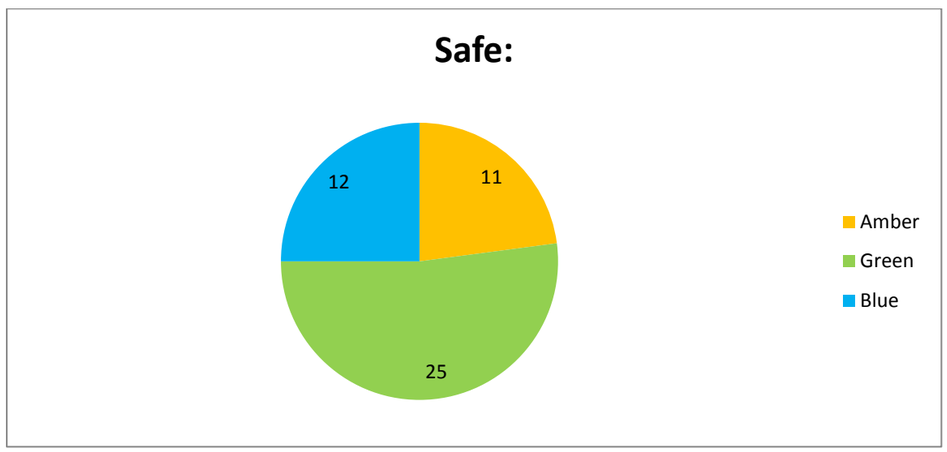
Domains:

Are we well-led?



This domain has 43 actions with 14 actions completed (32.5%) and 20 actions on track (46.5%) to be completed within the timeframe. There are 9 actions (21%) showing amber, indicating that progress is being made towards completion but is likely not to be within he completed date. This domain has no red actions.

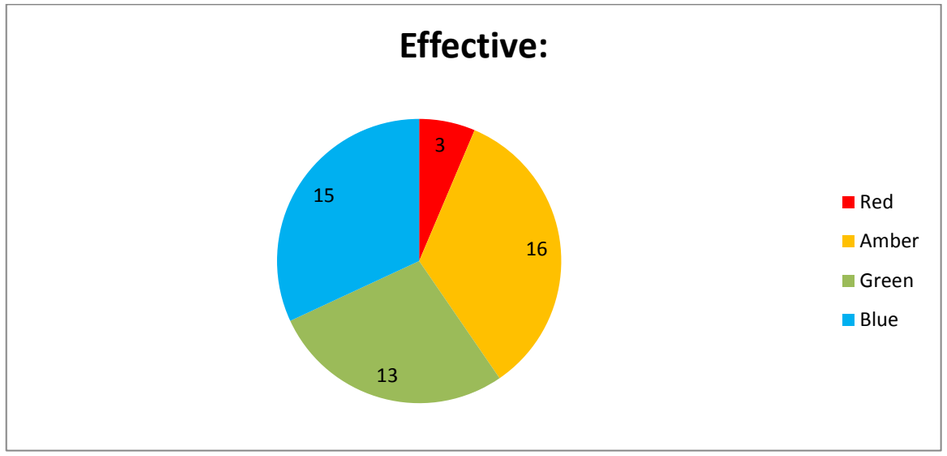
Are we safe?



This domain has 48 actions with 12 actions completed (25%) and 25 actions on track (52%) on track to be completed within the timeframe. There are 11 actions (23%) showing amber, indicating that progress is being made towards completion. This domain has no red actions.

The majority of the amber actions relate to recruitment of nursing and medical staff which is being addressed through international and newly qualified registered nurse recruitment. The Trust maintains its commitment to the nursing strategy and its three year implementation plan to increase staffing across the inpatient areas, in line with the Keogh recommendations in 2013.

Are we effective?

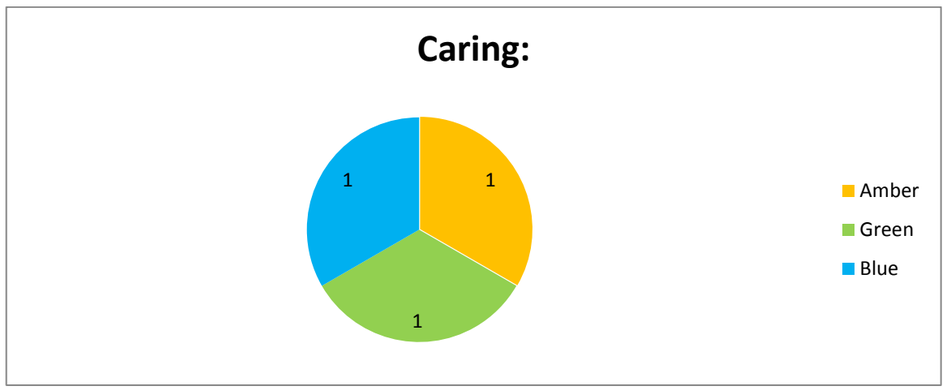


This domain has 47 actions with 15 actions (32%) are completed and 13 actions (27.5%) are on track to be completed within the timeframe. There are 16 actions (34%) which are amber, indicating that there is progress but the action will not be completed within the original timeframe.

There are three actions (6.5%) showing red, these actions are:

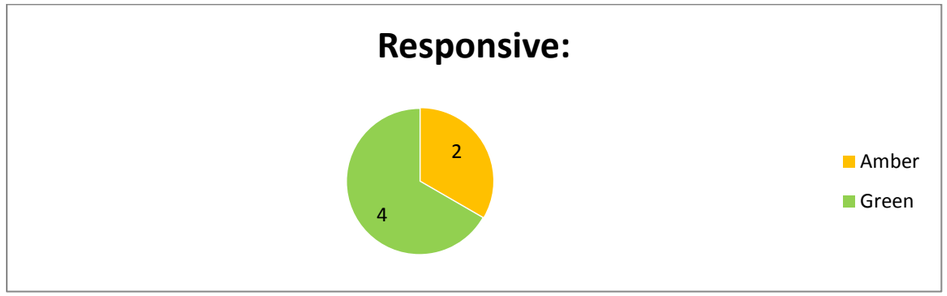
- Infection Prevention & Control – this will be reviewed at the next Quality Improvement Meeting on the 26 January where the Nurse Consultant will provide the group with evidence of the actions being undertaken;
- Improve patient flow of emergency admission – this action will remain red as the flow and capacity remains an issue for the Trust;
- Implementation of a Medical Day Case facility.

Are we caring?



This domain has 3 actions with 33.3% (1) showing that the action has been completed, 33.3% (1) action is on track to be completed within the timeframe, and 33.3% (1) action is showing amber indicating that there is progress but the action will not be completed within the original timeframe.

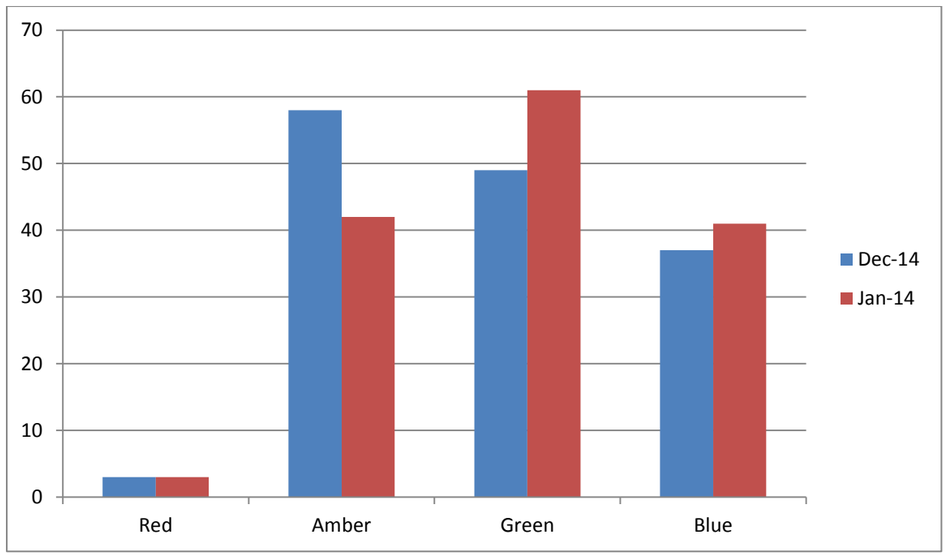
Are we responsive?



This domain has 6 actions with 67% (4) actions demonstrating that they are on track, and 33% (2) actions which are amber, indicating that there is progress on the actions, but the actions will not be delivered within the original timeframe.

All the amber actions are related to End of Life care, which has been identified as a resource issue, which has not be supported with a whole time equivalent post supporting End of Life care.

Have we improved?



The comparison of the position of the actions in December 2014 has improved. The number of actions which are in progress but will not be delivered within the timeframe has reduced (Amber). The number of actions which are now on track to deliver in the timeframe has increased (Green), and the number of actions which have been completed has increased.