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 actions and 10 high and medium actions, and we were placed in special measures. In December 2013, an assurance review was undertaken by the Keogh team, and we were 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. We 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, we 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.

We have commenced our coaching programme and we are now receiving individual coaching. Our second team coaching took place for 2 February 2015, which included personality type indicators. Chair and Non-Executive Directors appraisals have been completed and the Chair's objectives have been agreed at Council of Governors.

Our substantive Chief Financial Officer has commenced on the 23 March 2015, Mr Paul Robinson.

Following the departure of our Director of Operations an interim Director of Operations is in post from 5 January 2015. We have commissioned the Leadership Academy to work with us to recruit to the Chief Operating Officer's post, and they have taken a briefing from the Trust and are developing a timeline for recruitment.

We have appointed a Non-Executive Director, which has been ratified through the Council of Governors on the 16 April 2015.

We have appointed a Turnaround Director, Mr Terry Watson, and we appointed a Programme Director, Mr Adrian Ennis, who commenced on 21 April 2015.

Our Chief Executive left the Trust in April 2015. The Director of Human Resources is the Acting Chief Executive.

We have finalised the management structure review at Newark Hospital, which has been confirmed as an Assistant Director of Operations, and a Matron for Newark Hospital, and the changes commenced from 7 April 2015.

We have created a Newark Hospital Twitter account @ChooseNewark, in order to keep staff, visitors, patients and local people up to date with all the latest news and events from Newark Hospital.

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.

We have rolled out the new recruitment documentation, and recruitment and selection training programme has been revised to reflect the Quality for All values. We have completed the team conversation exercises and these have been shared across the Trust.

We have agreed the Capability policy and toolkit and this will be rolled out with training across the Trust, in conjunction with the Appraisal Policy reflecting the Quality for All values.

Values team conversations have taken place with many of our teams across the Trust and on-going plans for Quality for All conversations are being initiated.

We have completed the Q4 pulse test as planned, and we need to link together the staff and patient Friends and Family Test in the procurement exercise.

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

We have made a decision to undertake a cultural assessment as part of the King's Fund. This is being been tested by other organisations and will be implemented in Quarter 1 2015/16, and the feedback will be in July 2015. Our Director of Nursing continues to participate in the Royal College of Nursing Cultural Alignment Group.

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

We have completed our senior HR Leaders Development Workshop to map existing strategies across to a leadership strategy and identify gaps. We have written in draft our Leadership Strategy and action plan, and this will be completed by the 31 March 2015.

We have undertaken a Medical Engagement Scale in July 2014 and this demonstrated that we had average levels of engagement but marked polarity by age (older Consultants less engaged) and variation between teams. A strategy was developed with an external consultant to foster clinical engagement. The Medical Engagement Scale responds slowly to change and it is not recommended to be repeated for at least 12 – 18 months. However, a new tool has been developed a 'mini- Medical Engagement Scale' for the purpose which can help with regular checks. This tool demonstrated a slight improvement overall. We continue to make progress and we are aware that we have further work to do.

We have enhanced our medical engagement and we have established medical engagement group with Non-Executive Directors, the Medical Director and Consultants to explore mentoring and buddying. We have developed a shadowing programme with Executive, medical staff and Consultants and this has commenced.

We have commenced our third wave of the Trust's Leadership Programme which has 15 clinicians enrolled onto the 12 month programme. Our Medical Director has met with Peter Lees Head of Faulty for Leadership and Management to discuss medical leadership.

We have completed middle and senior manager's focus groups for March and April 2015 to sense check the training needs analysis and to explore leadership developments themes emerging from staff exit interviews. The OD and Workforce Committee will receive feedback in May 2015.

We have commenced the project on the implementation of Allocate to improve Medical Consultant's job plans and operational expectation; all job plans are to be signed off by June 2015.

We have undertaken a review of the quality of the Board Rounds by the Emergency Flow Programme and through this we will re-launch Board Rounds. We have communicated through the iCare2 messages the Trust's expectations of the Board Rounds.

Our Head of Strategic Planning has arranged Service Line Planning meetings with key individuals from within the divisions, and we have developed a Clinical Reference Group for strategy being established to embed strategy development at a service line level. All our service lines have produced plans for 2015/16, and feedback has been received on information that would support better Service Line Management.

We are working towards appointing a substantive Clinical Director for Diagnostic & Rehabilitation. We have established fortnightly meetings between the Clinical Directors, Medical Director and the Director of Operations.

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 has quickly strengthened our risk management work; by January 2015 we had completely rewritten our Risk Management policy, ratified it at Trust Board and disseminated this across the organisation, via various methods of communication to reach the largest number of staff. We have written a risk management and Datix Risk user guide, and this has been introduced. We have developed a new generic risk assessment tool, this has been implemented and feedback has been positive.

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. We can report that there are currently 135 open risks; 15 risks have been closed and archived, 33 risks have been reviewed and we have 24 new risks.

We have cleansed of the data to be transferred to the DatixWeb Risk Management. The risk register is evolving daily providing assurance that risks are being reviewed, archived and re-scored, actions and new risks added.

We established, in December 2014 the first Risk Management Committee which set the agendas and annual work plan. The Risk Management Committee is to receive significant risk with trends in risk scores over the life of the risk, from April 2015. We are reviewing two divisional risk registers monthly as a standing item on the Risk Management Committee agenda.

We have now developed risk reports and these are provided to the local Governance forums for discussion/ action where necessary. We are engaged in regular, robust reporting of significant risks and the risk profile of the Trust is taking place at Trust Management Board, Risk Management Committee and Clinical Quality & Governance Committee on a monthly basis.

We have reviewed the risks on the risk register and mapped to the Five Principal Risks of the Trust, this will enable the Corporate Risk Register/ Board Assurance Framework to be better aligned.

We have added the three levels of risk management to the Trusts Training Needs Analysis. These commenced in January 2015, with 5 sessions per month currently scheduled. We have provided awareness sessions to Ward Leaders and Business Support Units and these have taken place.

We have met with a number of risk owners on a 1:2:1 basis and more meetings have been scheduled. These are proving invaluable from a risk discussion and debate perspective.

We received the 360 Audit Feedback Report on the 9 February 2015, and this concluded that **'significant progress'** had been made to address areas of weakness identified within the original audit report. The audit team are not proposing undertaking any further follow ups in this area.

The platform for Datix has migrated on the 3 March 2015 in readiness for uploading of version 12.3. The version 12.3 allows the automatic feedback functionality to be enabled and the Datix co-ordinator is currently considering the specific section to be agreed for feedback.

We have reviewed the new Never Event list and Serious Incidence reporting guidance and have developed a gap analysis. We are working with CCG colleagues to review the implication of these changes. The Serious Incident policy is being updated to reflect these changes, recommendations will be presented to Clinical Quality & Governance Committee in May 2015.

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.

We have implemented the Patient Experience module of Datix and the reporting functionality and dashboards has been agreed. We have completed the training, in order to utilise this module's functionality we need to upgrade to Version 12.3, which is awaited from Datix.

We have established a task and finish organisational learning group which meets weekly and from this meeting a 'good ideas' tracker has been developed and Learning Boards are informed and developed. The group looks at Serious Incidents and takes themes and lessons learnt from these and develop the themes for the month. Our ward teams have embraced the Learning Boards, and this was highlighted at a recent Senior Nurse workshop.

We have developed a learning template that is being used in all the Divisional Clinical Governance meetings. We are implementing Organisational Learning as a standing item on group/committee agendas and this has been added to Clinical Quality & Governance Committee the demonstration of learning and connections between complaints, incidents and feedback

Our three clinical divisions and Newark Hospital produced their first divisional quarterly learning report which was presented to the Clinical Quality and Governance Committee in March 2015. The content of these will be used to produce a themed learning report, and these are a good platform from which to start to triangulate the learning for future reports. The Quality Committee received the first quarterly Learning Report in March 2015, which was presented to the Clinical Quality & Governance Committee on the 8 April 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. Our second Patient Safety briefing was held on record keeping in March 2015.

We have established the multi-disciplinary Grand Rounds and these are themed on a Serious Incident within the Trust, and presented by staff who were involved in the incident, the themes have been:-

January 2015	Deteriorating patient
February 2015	Serious fall
March 2015	Medicine Safety
April 2015	Adult safeguarding

We held our first Organisational Learning Event on the 17 March 2015, and the attendance was good and the feedback positive.

We have developed a two day lead investigator Root Cause Analysis training. We have encouraged medical staff to attend, and the response has been good, and the Divisional Matrons have been asked to ensure that staff are nominated for the course. Our feedback was excellent and will help us develop future courses. All the placed for the remainder of 2015 have been booked.

All our divisions now hold their divisional governance meetings in the fourth week of the month. The meetings were moved from earlier in the month to provide more time for leads to produce the relevant data for the divisional governance packs. The data packs do contain the required level of data to facilitate discussion of the priorities, the risks, for best practice to be discussed and for themes and trends to be shared with service lines.

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

Following the Keogh Review in June 2013, we 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 our 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 have established a 60:40 Registered Nurse: Healthcare Assistant skill mix in Planned Care & Surgery moving towards 70:30 RN: HCA. Mansfield Community Hospital has also increased its Registered Nurse complement. We have increased night nursing in Emergency Department by one Registered Nurse and ward leadership in EAU has been strengthened with the employment of a second Ward Charge Nurse. We proposed the staffing for 2015/16 and this has been agreed by the senior nurses and submitted for financial costing.

We have established that Emergency Care & Medicine will move to 60:40 (RN: HCA) ratio, with specialty wards already on 60:40 and moving towards 70:30. We have launched our new Recruitment Strategy on the 1 April 2015, and we have planned an open day on the 23 April 2015 and a clearing house event on 30 April 2015.

We have agreed another tender exercise to recruit a further two cohorts of 20 international nurses within this financial year.

We have closed our additional winter ward capacity on the 6 April 2015, and have sustained the capacity within the division. Plans to reduce beds in correlation with the improvements in the Emergency Flow Programme are in progress with plans to reduce capacity in June 2015.

We have responded to the Emergency Department NICE staffing guidance, and we have undertaken a gap analysis against the recommendations, this has informed the budget setting process. We discuss the medical and nursing gaps and skill mix in Emergency Department and Emergency Assessment Unit (and any other areas) at every bed meeting which is three times a day, seven days a week.

We have reported the current information monthly on UNIFY and NHS Choices, and the Trust achieved 100% or greater for Registered Nurses and Healthcare Assistants day and night average fill rate in March 2015. The Healthcare Assistant has an increase in the average fill rate, and this demonstrates the utilisation of Healthcare Assistants to support the additional enhanced care needs required to some patients require 1:1 care. We have submitted our 6 monthly nurse staffing report to the April 2015 Trust Board.

We are undertaking a snapshot audit on the acuity and dependencies on Sconce Ward at Newark Hospital and Ward 11 to understand the potential acuity and dependency changes. We have utilised the Safer Nursing Care Tool (SNCT) in January which informed the Divisional Matrons for the next six months. There continues to be a large need for 1:1 enhanced support still required.

We have successfully recruited to the Acute Physicians posts and all six Acute Physicians are now in post, this is the highest number the Trust has recruited. The Acute Physicians are offering additional support to the Emergency Department to see General Practitioner referrals and medical admissions. We have interviewed for the 8th Emergency Department Consultant and appointed a long term locum Consultant. We are trying to attract Consultants to the 'hard to fill' vacancies by offering recruitment and retention premium payments.

We have added additional resources into End of Life team (Band 7 nurse), Falls team (Band 7 nurse) and an additional junior doctor to the Hospital at Night team following the Hospital at Night review.

We have advertised for three substantive Radiologists and a Breast Radiologist in April 2015, we continue to work with Nottingham University Hospitals in the recruitment of an Interventional Radiologist in a joint appointment. We have successfully recruited three substantive Orthopaedic Consultants in April 2015.

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.

We have updated the Medical Device Management Policy and the policy has been approved. This policy has been communicated across the trust via various methods in order to reach the widest audience. We have utilised the Learning Boards to display posters promoting choosing the right equipment, 'Choose Right: Using Right: Keeping Right'.

We have introduced a standardised electronic medical device reporting systems. The roll out of this system has been through the distribution of posters, through the staff bulletin and onto the Learning Boards in all the clinical areas. iCare2 communications have been issued to support this new reporting method.

Our Medical Equipment Maintenance Department (MEMD) has prioritised the servicing of the Trust's equipment, and April 2015 they have serviced (across the Trust) the following:-

Kings Mill Hospital	77%
Newark Hospital	81%
Mansfield Community Hospital	67%.

We have currently serviced 72% of the hospital beds and 97% of the infusion device pumps, which is an improvement from reporting in March 2015. This demonstrates that there has been a prioritisation of essential emergency equipment undertaken.

We are planning an Equipment Day on the 1 July 2015 to highlight the importance of maintenance and safe use of medical devices.

We are in the process of ordering from Beaver Healthcare (the company who has been awarded the tender) six resuscitation trolleys (with a further 75 trolleys being ordered, as per the procurement process) so that staff can become familiar with the trolleys and for training purposes. We have established weekly implementation meetings to support the roll out programme of the resuscitation trolleys. We have developed an implementation plan for the new resuscitation trolleys from April 2015.

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

We have an operational group, chaired by our Director of Nursing, which meets fortnightly to drive the improvements required for medicine safety. We have tested many initiatives to improve medicine safety including; informative posters, use of red aprons and a red apron campaign which is now mandatory across the Trust, new Trust Wide prescription chart, new e-learning opportunities in relation to medicine safety which has been successfully used in other local Trusts, and the introduction of 2 nurse check at the bedside.

Our Executive Director of Nursing and Medical Director have advised all nursing and medical staff to carry out the Virtual College e-learning package on Missed and Delayed doses of Medicines and Safe Use of Insulin.

We have developed a medicines error policy to standardise the management of staff who make medication errors, and is now in use in the clinical environment. We have developed a flow chart to guide nursing staff on what action to take if a drug is omitted or delayed.

The Pharmacists are working with the Ward Leaders and the nursing teams to provide safe administration and storage of medicines. Our mandatory training workbooks include a section on storage and safety of medicines from April 2015.

We are auditing medication storage and this has been undertaken across the Trust, which is being used to improve storage and understanding on the wards. Our medication safety and storage audit did not

demonstrate good compliance and this was discussed within the divisional governance forums. We have introduced secure waste bins on the wards; this will prevent access to waste at the ward level.

We are trialling the electronic key fobs for staff and patients access to bedside lockers, this will also support self-administration of medication.

We are introducing electronic storage cabinets in ED and Emergency Admissions Unit, both these areas have high patient turnover and had issues highlighted by the CQC.

The Pharmacists and nurses are undertaking twice monthly missed/omitted drug audits, which are being reported back to the Divisional Matrons. We have refined the audit to identify which parts of the system are causing medicine omissions - to enable focused action. We continue to improve on the missed and delayed doses audit, having reduced from 4% to 2.5%. Our critical medicine missed or delayed has also reduced from 5% to 1.75%. All critical medicines missed are reported on Datix.

We have participated in the Medicines Safety Thermometer and although the sample size was small (46 Trusts) we have results better than the national average.

We are training nursing staff to work towards Patient Group Directives and ward based discharges, which will be an on-going training exercise as staff are recruited to the wards, this training is being undertaken by the Pharmacists.

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 compliance for March 2015 was 97% (stage 1) and 88% completed (stage 2) which is an improvement from the previous month.

We have developed new admission documentation which is currently being trialled and will be audited in May 2015.

We have developed a new monthly documentation audit which reflects qualitative elements to the nursing record keeping. We are providing regular teaching and awareness sessions on record keeping. We support all new registered and international nurses to the Trust with 1:1 support sessions from a Practice Development Matron, in order to set the standard and expectation of the Trust for record keeping and documentation. We have produced a 'Record keeping guidance' for the nursing staff at Sherwood Forest Hospital, to support their practice.

The Practice Development Team are working with the operational teams to ensure there is a clear process for reviewing Core Care Plans. A 'How to Guide' has been produced to help authors of Core Care Plans and documentation to support their responsibilities.

A procurement exercise is underway to source a company to undertake work to standardise bedside folders, which will improve record keeping.

The Practice Development Matrons have commenced delivery of weekly revalidation awareness, portfolio building and reflective writing sessions.

We have implemented of Care & Comfort Rounds on all wards at Sherwood Forest Hospitals, this is planned to be audited this month. We have implemented Accountability Handovers this has been audited and 98% of the patients audited had accountability handover sheets present in their nursing documentation. This is a significant improvement from the last audit.

We are monitoring the number of missed case notes in Outpatient and this is being monitored across the divisional teams, however this is demonstrating good practice with only 0.26% of case notes missing week commencing 27 March 2015. We are also monitoring the number of clinics cancelled at short notice, and this has significantly improved and is being managed by a cross divisional team.

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

We have rolled VitalPac out across Kings Mill Hospital and there will be an upgrade due prior to April 2015 and a planned upgraded roll-out to Newark and Mansfield Community Hospitals in January and February 2015. We are training staff at Newark and Mansfield Community Hospitals in preparation of VitalPac commencing.

The new software to upgrade VitalPAC is on site and this will be signed off week commencing 20 April 2015. This will ensure that the devices can be updated to IOS 8.0, thereby allowing new activities to be available.

VitalPAC Obstetrics module has been agreed and we will be implementing when this is released from the Learning Clinic.

We have undertaken a Fluid Balance internal audit which has demonstrated that we have further work to do, albeit 80% compliance.

Our HSMR mortality variation for November 2014 demonstrated that the weekday and weekend mortality figures are similar; however our mortality numbers remain high. We have reviewed December 2014 (most current) and there is a slight improvement in these figures.

Our Medical Director has reviewed Dr Foster alerts for Upper GI Endoscopic Procedures and Sepsis in October and November 2014. There were no deaths related to endoscopy procedures and there were

four deaths in the sepsis group which have triggered further review, but in the majority the sepsis care was good.

We are focussing on the National Early Warning Score (NEWS) triggering to recognise the deteriorating patients, escalating to the Critical Care Outreach Team and following the Sepsis Six, which will continue to be audited monthly. The escalation of deteriorating patients to the Critical Care Outreach Team was 96% in March 2015.

The Medical Director from Derby Teaching Hospitals NHS Foundation Trust has reviewed an independent sample of our mortality case note reviews and has validated our findings and processes.

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.

We opened the discharge lounge 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. We have utilised the Discharge Lounge consistently well, and this will be monitored as one of the Key Performance Indicators for this section, in March 263 patients were discharged through the Discharge Lounge which was an increase on the previous month by 18 patients.

We have improved the emergency flow and as a consequence this has now moved to AMBER. The Emergency Department access standard was met in March 2015, and we achieved 96.38%, this is the first time that this standard has been met since August 2014. This is a tremendous achievement considering that March was the third busiest month of the financial year 2014/15, with 12,530 attendees to the Emergency Department / Minor Injuries Unit. .

We have increased our focus in improving streaming in the Emergency Department, and a focus on ensuring patients are appropriately and safely discharged with the assistance of the community teams. We are concentrating on ensuring that the time waiting to be seen in the Emergency Department does not exceed 60 minutes, and we are ensuring that there is always empty beds on the Emergency Assessment Unit, this will ensure that flow improves through the Emergency Department.

Our Emergency Care & Medicine division have seconded two Matrons to improve the Emergency Flow for the Trust, and review the patients who are in hospital for 14 days and over. A reduction of 30% in the number of patients who are in hospital for 14 days and over, will enable the Trust to close medical wards. We are regularly reviewing the 14 day length of stay patients, with daily reporting and challenge at the Board Rounds via the Matrons. Our next focus is linking the Board Round review and individual ward Length of Stay.

Our Director of Operations continues to work collaboratively with stakeholders and partners in the health economy to improve patient flow and reduce overcrowding in the Emergency Department.

The Medical Outlier Policy was ratified at the January's Clinical Quality & Governance Committee, and the compliance monitoring is agreed. The Outlier Decision Support Tool has been audited in January 2015, which was 19% compliant. We have re-audited in March, and the results will be reported to Clinical Quality & Governance Committee in May 2015. The provisional results from the March 2015 audit, is that we are 39% compliant which is an improvement, but we know that we require further education with the staff to improve the compliance.

We are continuing to monitor the Refer To Treatment (RTT) 18 weeks monthly, and a Trust-wide achievement of 'admitted' 90.2% (target 90%) and 'non-admitted' 95.5% (target 95%) in Q3. Our RTT for February 2015 was 'admitted '82.5%' (target 90%); 'non-admitted'91.1% (target 95%).

We are planning for phase 2 of PAS implementation of off-target due to work to necessary to stabilise the core system implementation. It is expected that work on phase 2 will be largely a 2015/16 project , with the main focus being on improving and further developing the integration of PAS with other systems internally and externally and the implementation of portal technology, to safely and appropriately share electronic patient records more effectively between the Trust, General Practitioners and other organisations.

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

We have developed the Mandatory training e-learning workbooks and following a successful pilot in four areas this was launched in January 2015, giving staff 24/7 flexible access to complete their mandatory training requirements. This new system includes an app for staff that can be used on a mobile phone and tablet device, to access mandatory training information and to promote greater engagement with the completion of mandatory training. This new system will begin to be rolled out in April 2015.

An evaluation report was presented to the OD & Workforce Committee in January 2015 on the impact that mandatory training has on patient care. This reporting mechanism will form part of the routine quality infrastructure of the Training Department and we will receive further feedback every six months.

The Medical staff mandatory training for C-diff and MRSA remains above 90% compliant.

We have provided staff with personalised letters which identifies their mandatory training requirements and compliance have been issued. We have noted that this has improved uptake of mandatory training course bookings.

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

We have completed this section, and this will now be monitored three monthly with the action owners.

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

We have developed detailed action plan as a result of the HEEM visit, which is on track with significant improvement noted on the re-visit. All actions are being progressed through the OD & Workforce Committee, with good progress. In February 2015 we had a further two HEEM visits where further issues were identified. We have developed and formulated an additional action plan to address the issues raised and the oversight for this will be with the OD & Workforce Committee. Our OD & Workforce Committee has received the action plan in April and will continue to monitor the progress. The findings and the actions were presented to the Quality Committee in March 2015 (sub-committee to the Trust Board chaired by a Non-Executive Director).

As part of our first HEEM action plan we have worked to improve the relationship between the medical teams in the Emergency Department and Trauma & Orthopaedics. The Head of Service for Emergency Care and the Trauma & Orthopaedic team meet monthly to address issues and the Head of Service for Emergency Care attended the meetings to develop and implement the Trauma Assessment Unit. The Clinical Director for Emergency Care and Medicine will be attending the next Junior Doctor's forum in Trauma and Orthopaedics to improve relationships.

We have revised and agreed the Appraisal Policy, which now reflects Quality for All Values and Behaviours. This was communicated on the Staff Bulletin on 13 February 2015, and there are guidance notes available for staff and managers on the Trust's intranet site.

We have established Stress Management Focus Groups and these are taking place across the Trust regarding approaches to Stress Management in relation to staff. We have reported an interim update to the Health & Safety Committee on the 8 January 2015. The report was considered by the OD & Workforce Committee in February 2015 and further work was requested to triangulate the results with the outcomes from the staff survey.

We have completed our Training Needs Analysis for Middle Managers and was presented to the OD & Workforce Committee in April 2015. Our Managers Focus Group has continued to meet with a scheduled meeting in April 2015.

We have above 90% of our Medical staff appraisals completed and this will be monitored on the Quality Improvement Plan's Key Performance Indicators.

Our Occupational Health team provide a developing resilience education session in addition to the stress awareness education session to either groups in the workplace or individual staff. The resilience training has been embedded into the Trust Leadership and Management course since December 2014, and from March 2014 to March 2015, 76 staff have attended this session.

We have a ratified Clinical Supervision Guideline and the Clinical Supervision website is live. We have a data base of clinical supervisors and we have trained 12 clinical supervisors to date, we are working with individuals who have undergone training in other organisations, to establish a data base for the Trust with external Clinical Supervisors. We have added train the trainer clinical supervisor education' to the Training Needs Analysis so we can become self-sufficient as an organisation.

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

We have discussed Clinical Pathways at Medicine's, Anaesthetics and Orthopaedics' junior doctors forum. Our Clinical Pathways are in a standard format with version control which is uploaded to a single point of access on the Trust's intranet. These pathways will provide optimised management for common presentation which is consistent. These pathways were developed from discussions with Heads of Service at the Medical Managers weekly forum. We have developed a communication plan to target junior doctors, Heads of Service and divisions over the next 9 weeks. We will review the uptake of the clinical pathways in May 2015.

We have agreed the new NICE guidelines policy and this is available on the Trust's intranet site. The implementation of relevant new NICE guidance will be traced at 12 weeks after publication and monitored via the Clinical Audit and Effectiveness Committee. We are in the process of arranging the 360 Assurance audit to be undertaken to review the NICE Guidance processes. In Q4 there were 14 new NICE clinical guidelines were completed and reviewed with a further 3 awaiting review. These are being monitored via the Clinical Audit and Effectiveness Committee on a monthly basis.

The Hip/Knee Schools and combined physiotherapy clinics for Orthopaedics has reviewed patients 4 week pre-operatively to enhance recovery and rehabilitation post operatively. There were 23 patients through the pathway in March 2015 who will have their procedures in April their length of stay and PROMS outcomes will be audited.

A new Trauma lead Consultant has been appointed and in March 2015 a 6 bedded Trauma Assessment Unit was created on Ward 12. This will improve performance against Best Practice Tariff which is tracked monthly and supports a revised pathway for fractured neck of femur.

We have enrolled 15 patients onto the telemedicine follow up for prostate specific antigen measurement follow up. These patients have been followed 3 monthly in clinic, so 60 slots have been released to improve capacity in the consultant clinics. We will be enrolling a further 15 patients throughout April 2015.

The Nurse led cystoscopy clinic requires nurse training which will take six months to complete, and is in progress.

We have standardised how Newark Hospital Minor Injuries Unit and King's Mill Hospital's Emergency Department operate and ensured that a single pathway.

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

We are currently exploring a number of procurement options to support the Friends and Family Test (FFT) moving forward (the current service provider is due for renewal in January 2016), however no decision has been made as yet.

We have recently redeployed a CQUiN Support Worker to support FFT, whereby they collate and monitor completed surveys from all relevant wards and departments in the Trust. Staff have demonstrated a positive response in the introduction of the worker, ensuring training and support issues are addressed and resolved in a timely manner to ensure eligible patients are asked to complete the FFT.

All completed FFT surveys are analysed prior to forwarding onto the external provider to identify positive and negative feedback, areas of negative feedback are reported to the relevant ward/departments and addressed given the limited anonymised information provided.

We have commenced the Customer Service Excellence Training with 65 places for our ward hostesses and reception staff. Customer Service Excellence Training has been delivered to 9 Emergency Department staff to date.

We are continuing to use Android App for FFT in Emergency Department and Outpatients from February 2015, and this has proven to be successful.

Our Friends and Family Test response rates have shown an improvement in the returns during March 2015:

Inpatients	February – 29.6%	March – **53.2%**
ED	February – 6.7%	March – 17.2%
Maternity	February – 36%	March 38%

We commenced our bereavement relative experience survey in October 2014, and the Lead for End of Life has produced the first quarterly report which was positive. We have presented the Bereavement survey at the Safety and Patient Experience Governor meeting on the 1 April 2015.

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.

We have increased the resources to deliver this programme of work, and this has been provided by the Divisional Matron for Emergency Care & Medicine. The Lead Nurse has reviewed the Discharge Policy and has updated the Fast Track/ Continuing Health Care and Rapid Discharge home to die section of the policy. Our Medical Director has appointed a Deputy Medical Director with 4 sessions for End of Life Care.

April 2015

We will continue to embed the Gold Standard Framework for Acute Hospitals to the wider inpatient areas, along with the Amber Care Bundles, with a further two wards being enrolled into the programme in 2015. We are working to ensure that the Amber Care Bundle will have a phased roll out and be fully rolled out by April 2016. We have developed plans to deliver the Gold Standard Framework to two additional wards, Ward 34 and Ward 52. We held our first training session in March and we have further 2 training sessions planned.

We are continuing, as an End of Life team to provide ward and individual training, and support both the nurses and doctors at their induction training. We have provided induction training to 83 staff in Q4 on End of Life care, and we have provided End of Life care education at the preceptorship induction in January 2015.

We have attended Ward 24 Clinical Governance meeting and presented an introduction to Amer Care Bundle, we are planning training sessions for all ward staff throughout April and May.

We have an End of Life Champion identified on all wards and we are holding two training days for the Champions.

We have updated the End of Life intranet site to reflect the new documentation, strategy and the team.

17. On-going concerns from different sources about our existing safeguarding arrangements

We are delivering Safeguarding training within mandatory training, as targeted specialist training to particular staff or areas and supplementary additional support. Mandatory training for adult safeguarding is at 92%; mental capacity training at 94%; learning disabilities is at 96% and Prevent awareness is at 80% in Q3. In addition, 75 of our staff have attended supplementary vulnerable adults study days this year and over 200 additional staff have been trained on consent, deprivation of liberty and mental capacity. Our Planned Care & Surgery division have asked us to provide additional level 3 Children Safeguarding training, for their team.

We have identified and trained clinical champions for Adult Safeguarding and established resource packs for all inpatient clinical areas to assist with local knowledge and expertise to raise awareness. The establishment of these roles is to assist with organisational learning, audit and supporting safeguarding referrals.

Our Serious Incident investigation process has been reported by the Coroner to be exemplary in the East Midlands. We have aligned our safeguarding investigation process to this to ensure consistency, Duty of Candour, legal review, and an executive sign off process. This will be tracked on the divisional action plan and be monitored for organisational learning. We have shared with our colleagues in the local Clinical Commissioning Groups and the Care Quality Commission, our Serious Incident investigation process.

We have reviewed 7 'unexplained' fractures between June 2014 and January 2015 which have been initiated from incident reporting. There were no consistent themes, and the wards have received feedback and staff awareness raised. The report has been discussed at Clinical Quality & Governance Committee and the Quality Committee, and share with the CCG.

We have appointed an external Consultant, Professor Mandy Ashton, an external Consultant to undertake a strategic review of safeguarding which will include the impact of training, evidence of learning into practice and how best practice is disseminated. The strategic review of safeguarding will include safeguarding governance and safeguarding leadership capability and capacity. This will produce an action plan for short, medium and long term goals. We have held a team building and objective setting workshop with all safeguarding teams on the 10 April 2015, and this was facilitated by Professor Mandy Ashton.

18. Infection Prevention & Control (Key Action 18 – Quality Improvement Plan)

We remain over our trajectory for the C-diff target of 37 cases, we have had 67 cases in 2014/15. Our 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, and improve our performance in the forthcoming year. Our Clostridium Difficile target for 2015/16 is 48 cases (4 per month).

We know that the simplest ways to combat the spread of infection is hand hygiene, and we are communicating across the Trust the importance of the 5 moments of hand hygiene, compliance with Bare Below the Elbows, and ensuring all staff know the correct and appropriate use of soap and water and hand gel.

We are actively involved in the writing of a new community anti-microbial prescribing policy, with our Consultant Microbiologist and Nurse Consultant. We have reviewed our anti-microbial prescribing and the community team are to review their practice too. We have undertaken a peer review of anti-microbial prescribing and the review suggests that our practice is good.

Our Antibiotic Pharmacist has met with the community counterpart to share intelligence; practice which increased the risk of C-diff has been highlighted and together with the community C-diff guidelines will be fed back by the community Pharmacists to GPs in education sessions. A system wide campaign for European Antibiotic Awareness day on 19 November 2015 is planned.

We are improving the Root Cause Analysis documentation in order to record clinical input which will include medical presentation. This will strengthen the 48 hour rapid review reporting.

We are reviewing with the Nurse Consultant for Infection Prevention & Control and the Medical Director the Terms of Reference for the Infection Prevention & Control Committee to strengthen clinical involvement and engagement in the meeting. We have changed the dates of our HCAI and IPPC meetings to allow clinical representation, and there are now no clashes with other sub-committees.

Our Infection Prevention & Control Team now attends Emergency Care & Medicine and Diagnostics and Rehabilitation's clinical governance meeting. Infection Prevention & Control are now standing agenda items on these divisional clinical governance meetings.

We have procured 14 hand hygiene stations which will be placed in areas such as the main reception, outpatients, the lift lobbies, outside Costa and the Voluntary Coffee Bar and in the Emergency Department. These have been rolled out, and awareness sessions on hand hygiene are planned in the main concourse. We have launched a twitter account for infection prevention and control, and this being viewed by many outside organisations, ie, East Midlands Ambulance Service, senior members of the CCG, NHS England, patients and visitors - #handhygiene.

We have had a review by the Patient Safety Collaborative, who independently reviewed the internal assurance measures particularly with respect of outcomes and action. This was completed on the 19 March 2015 and a report is expected.

Key Performance Indicators:

Key Performance Indicators:	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
All Board posts are filled on substantive basis by competent individuals	Full Board	Full Board	Full Board	Interim CFO	Interim CFO	Interim CFO	Interim CFO	Interim CFO	Interim CFO CFO apt	Interim CFO Interim DofOps	Interim CFO Interim DofOps	Interim DoOps Interim Turnaround Director
Staff FFT positive response rate improves from 52% to 62% by 30 June 2015			31.3%			35.8%			52%			
Mandatory training compliance rates at 90% or more		78%		79%	79%	80%	81%	82%	83%	81%	82%	83%
Staff appraisal completion rates for AfC staff at 98% or more	82%	84%	81%	83%	84%	82%	84%	83%	85%	87%	86%	88%
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%	T – 105.5% UT – 109.3%	T – 102.5% UT – 110.2%	T – 100% UT – 106%
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%	89.45%	90.45%	96.38%
Infection Prevention & Control – number of C-diff – target 37 cases	**5**	**6**	**5**	**7**	**5**	**7**	3	7	9	3	6	4
Deteriorating patient escalation >95% compliance	78%	84%	**92%**	83%	73%	78%	**92%**	84%	**95%**	82%	87%	96%
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%	38%	29.6%	53.2%
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%	A – 90.2% NA – 94.3%	A – 86.4% NA – 91.5%	A – 82.5% NA – 91.1%	TBC
Medical Outlier Decision Support Tool compliance										19%		33%
Medical staff appraisal – 90% compliance	92%			93%			97%			98%		
Missing Notes in clinic										0.19%	0.21%	0.26%
WHO surgical checklist compliance										87% (S1) 66% (S5)	88% (S1) 67% (S5)	97% (S1) 88% (S5)
Discharge Lounge utilisation number of patients										218	245	263
Medical Outlier Decision Support Tool audit (% compliance)										19.1%		33%
Accountability Handover audit – two signature handover										54.4%		98%

Abbreviations:

T = trained/registered nurse

UT = untrained/ healthcare assistant

A = admitted pathway

NA = non-admitted pathway

April 2015

Mar-15

Assurance Dashboard

Whole Trust

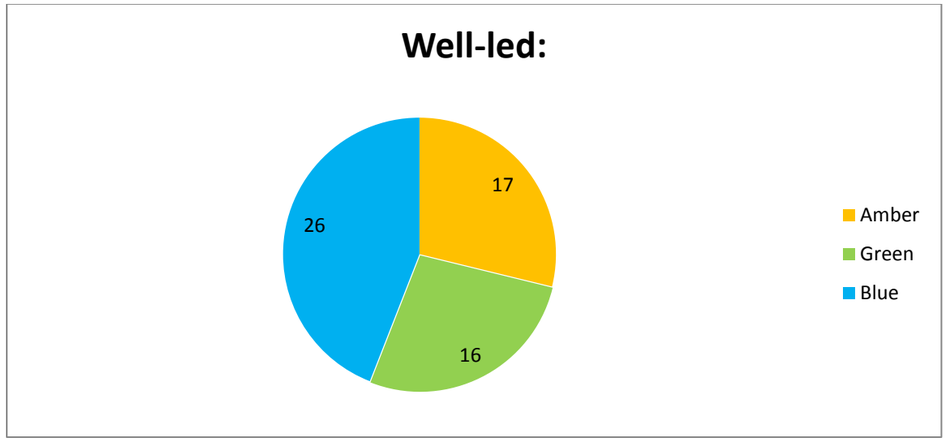
<< dashboard

nd = No Data

	Medicines			Fluid Management	Deteriorating Patient		Infection Control	Safeguarding	Equipment	Capacity/Flow
	Storage	Omissions	Critical Meds	Fluid Balance	Observations on time	Escalation	8 hr VIPs	2 stage test & best interests	Resus Trolley Checks	Pre-Noon D/C
Data Source	NMetrics	MD audit	MD audit	NMetrics	VitalPac	NMetrics	Nmetrics	Nmetrics	Nmetrics	Info Team
Ward / Dept										
11	100%	100%	100%	100%	90%	nd	100%	nd	100%	14%
12	100%	74%	97%	60%	92%	100%	100%	100%	nd	14%
14	100%	nd	nd	100%	93%	nd	nd	nd	100%	12%
21	100%	100%	100%	nd	94%	88%	100%	50%	100%	7%
22	93%	100%	100%	0%	90%	100%	50%	40%	100%	19%
23	100%	93%	91%	57%	88%	100%	100%	nd	0%	10%
24	100%	91%	100%	60%	94%	50%	17%	100%	100%	29%
25	100%	94%	100%	67%	nd	100%	nd	nd	nd	nd
31	100%	91%	100%	100%	92%	100%	100%	nd	95%	24%
32	100%	100%	100%	100%	94%	100%	100%	100%	0%	18%
33	100%	100%	100%	33%	92%	100%	100%	100%	0%	19%
34	100%	100%	100%	33%	95%	100%	100%	100%	100%	25%
35	100%	88%	93%	100%	94%	nd	nd	100%	100%	47%
36	100%	nd	nd	17%	90%	100%	100%	100%	0%	15%
41	100%	96%	100%	90%	92%	50%	100%	nd	100%	26%
42	100%	89%	100%	100%	95%	100%	67%	88%	50%	18%
43	93%	95%	99%	83%	86%	100%	75%	100%	100%	35%
44	100%	70%	98%	0%	92%	100%	100%	nd	100%	10%
51	100%	92%	97%	60%	92%	nd	100%	100%	0%	14%
52	86%	67%	100%	100%	91%	100%	100%	100%	100%	35%
53/4	100%	80%	93%	67%	92%	100%	100%	nd	100%	21%
Daycase	93%	nd	nd	nd	92%	nd	100%	nd	0%	nd
Maternity	100%	nd	nd	0%	nd	nd	67%	nd	100%	nd
EAU	100%	nd	nd	60%	89%	100%	100%	50%	100%	nd
ED	100%	nd	nd	nd	nd	nd	100%	nd	nd	nd
Chatsworth	100%	100%	100%	78%	nd	nd	nd	57%	100%	nd
Lindhurst	100%	96%	100%	nd	nd	nd	100%	100%	100%	nd
Oakham	nd	96%	100%	nd	nd	nd	nd	nd	nd	nd
Sconce	100%	100%	100%	100%	nd	nd	100%	50%	100%	nd
Minster	100%	nd	nd	nd	nd	nd	nd	nd	50%	nd
Total Avg	99%	92%	99%	65%	92%	94%	91%	84%	73%	21%

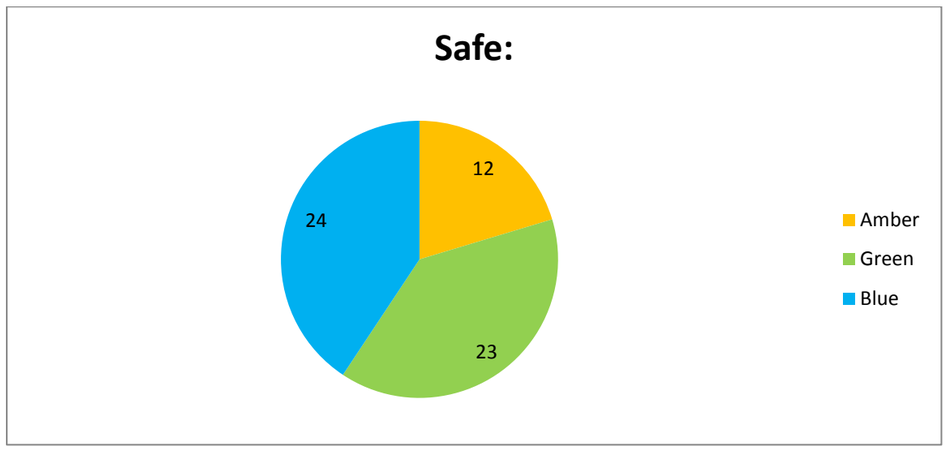
Domains:

Are we well-led?



This domain has 59 actions with 26 actions completed (44%) and 16 actions on track (27%) to be completed within the timeframe. There are 17 actions (29%) showing amber, indicating that progress is being made towards completion but is likely not to be within the timeframe. This domain has no red actions.

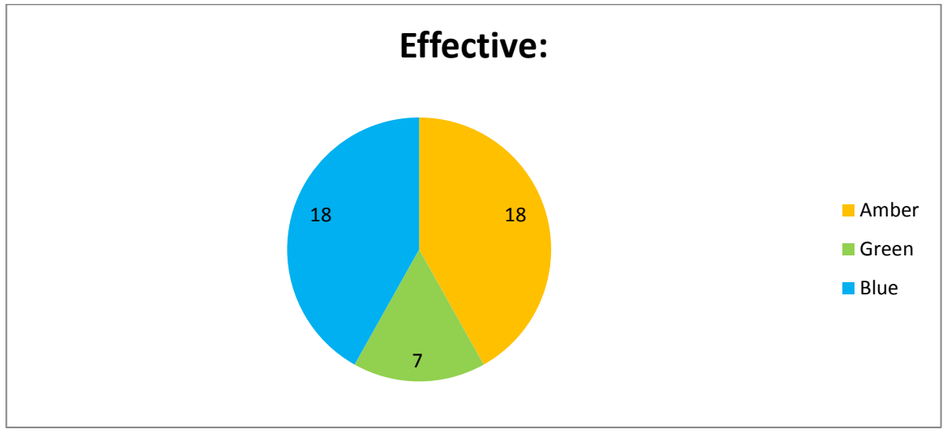
Are we safe?



This domain has 59 actions with 24 actions completed (41%) and 23 actions on track (39%) on track to be completed within the timeframe. There are 12 actions (20%) showing amber, indicating that progress is being made towards completion, but not within the timeframe. This domain has no red actions.

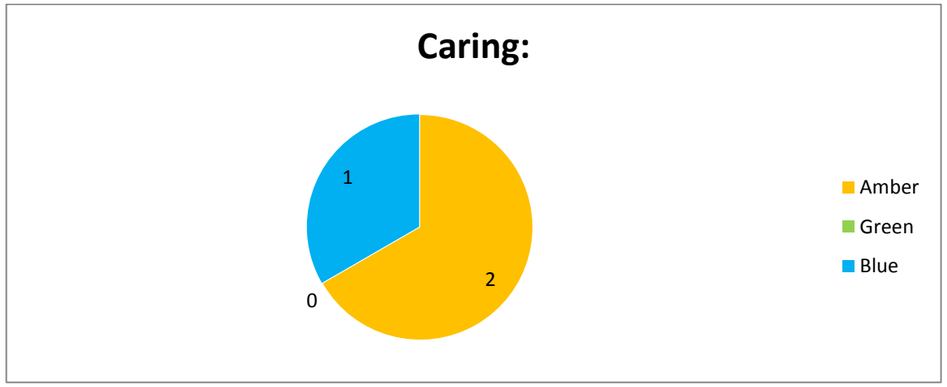
The majority of the amber actions relate to recruitment of nursing and medical staff which is being addressed through international and newly qualified registered nurse recruitment. The Trust maintains its commitment to the nursing strategy and its three year implementation plan to increase staffing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

Are we effective?



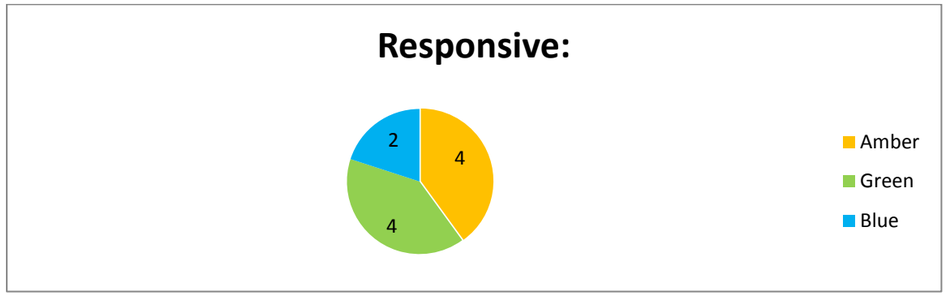
This domain has 43 actions with 18 actions (42%) are completed and 7 actions (16%) are on track to be completed within the timeframe. There are 13 actions (42%) which are amber, indicating that there is progress but the action will not be completed within the original timeframe.

Are we caring?



This domain has 3 actions with 33.3% (1) showing that the action has been completed, 66.6% (2) action is on track to be completed within the timeframe.

Are we responsive?

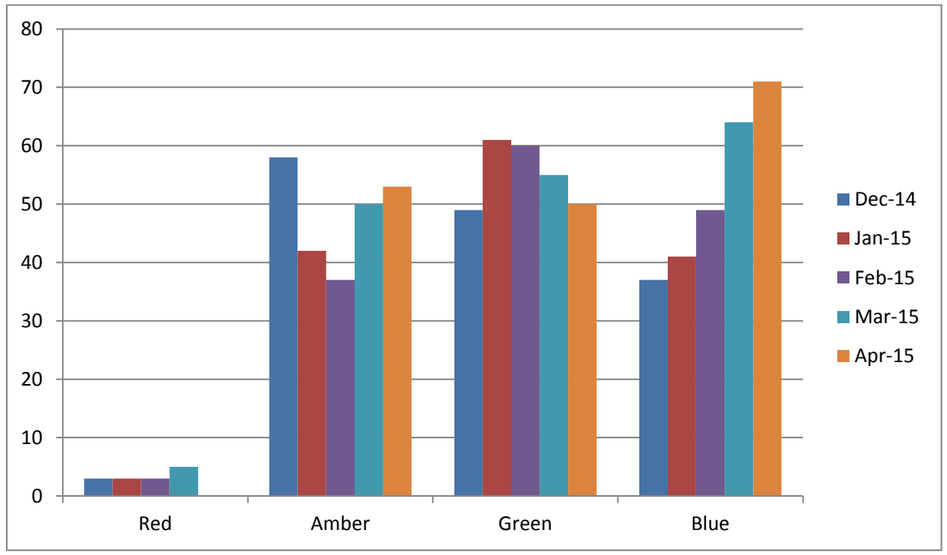


This domain has 10 actions with 20% (2) actions demonstrating that the actions have been completed 40% (4) actions demonstrating that they are on track, and 40% (4) actions which are amber, indicating that there is progress on the actions, but the actions will not be delivered within the original timeframe.

What has changed since March 2015?

- Mortality has moved from RED to AMBER;
- Emergency Flow has moved from RED to AMBER;
- HEEM visit has moved from RED to AMBER;
- Safeguarding has moved from RED to AMBER;
- Infection Prevention & Control has moved from RED to AMBER
- Therefore, we have no RED RAG rating in April 2015.

Have we improved?



The comparison of the position of the actions in March 2015 has significant improvement, there are no RED rating actions in April, and the number of AMBER ratings has increased as the RED have now become AMBER. There were 8 more actions completed this month, and therefore the BLUE rating actions has increased.

The graph above demonstrates the on-going improvements being made against the Quality Improvement Plan from December 2014 to April 2015.