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).

We have had our CQC inspection week commencing 15 June 2015, which we have received an initial feedback. We have a Quality Summit in September 2015.

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 in December 2014.

We have commenced our coaching programme and we are now receiving individual coaching. Our second team coaching took place in 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.

We have commenced the recruitment process for the Deputy Director of Finance, and the Deputy Chief Operating Officer. We have an Interim Deputy Director of Finance in post currently, and our current Deputy Chief Operating Officer remains in post until the end of August.

Following the departure of our Director of Operations an Interim Director of Operations is in post from January 2015, and our current arrangements will be extended until we have recruited substantively to the post. We have commissioned the Leadership Academy to work with us to recruit to the Chief Operating Officer's post.

We have appointed a Non-Executive Director, Mr Neal Gossage, which has been ratified through the Council of Governors on the 16 April 2015. Our exiting Non-Executive Mr Gerry McSorley remains in post currently.

We have appointed a Turnaround Director, Mr Terry Watson, a Programme Director, Mr Adrian Ennis, and a Recovery Director, Ms Helen Flear.

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 will commence at the end of June 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.

We are reviewing the 'Freedom to Speak' following the Francis Report and we are developing an action plan. We will report and monitor this action plan through the OD & Workforce Committee.

We recognise the importance of enabling staff to raise concerns at work to embed a culture of openness, and we have held Listen Events during the week of 20 April 2015.

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 has 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, which was presented to the Executive Team on the 18 May 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 an 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 Consultant and this has commenced.

We had 28 applicants for the Faculty of Medical Leadership Management Programme and 15 have been chosen to join the first cohort in July 2015.

We have commenced the project on the implementation of Allocate to improve Medical Consultant's job plans and operational expectation, all job plans to be signed off by June 2015. The Project Manager for the Allocate Project has commenced on the 22 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. The Emergency Flow Programme continues to observe Board Round to reflect with the team how these could have been undertaken. The next step is to link Board Rounds with long length of stay patients.

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 have appointed to the Clinical Director for Diagnostic & Rehabilitation Division, Dr Sharif Gill.

The Executive Team visited Royal Bath Hospital NHS FT in April 2015 and the two Medical Directors spent a morning discussing a variety of topics including medical engagement and the journey Royal Bath Hospital had made. A group of clinicians from SFH attended the Clinical Outcomes Group at Royal Bath Hospital in May 2015.

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 have started to disseminate 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 has received significant risks 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.

All Central Alerting System Alerts are being addressed prior to their deadline action dates and no alerts are open beyond these dates.

We are reviewing total or partial gaps in NICE guidance and we are risk assessing and adding to the risk register for the first time.

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.

Our Datix Incident reporting system is being upgraded to Version 14.0.2 after some technical issues identified by Datix Ltd.

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 June 2015.

We are triangulating risks, claims and incidents which will be a key focus in the coming months, this will embed effective escalation and learning from lessons.

We have recruited and appointed a new Risk Manager, and we are awaiting a start date and we have interim arrangements from within the divisions. We have recruited to the Head of Governance role and we are awaiting the successful candidate to commence.

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.

Our Datix system is being upgraded to Version 14.0.2 after some technical issues identified by Datix Ltd. We will now be able to implement the Patient Experience module of Datix and the reporting functionality and dashboards have been agreed.

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 Learning Boards are being updated with new themes and trends to ensure information is current. 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. Our Good Ideas Group continues to meet fortnightly.

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. The second quarterly report is due to be produced in July 2015.

We have planned a further nurse, Allied Healthcare Professionals Grand Round on Revalidation.

We held our first Organisational Learning Event on the 17 March 2015, and the attendance was good and the feedback positive. We have further shared learning events planned for 25 June and September 2015.

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 places 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.

We have produced a CQC Newsletter and posters which display key messages and these have been distributed from throughout the Trust. We have developed a CQC intranet site and CQC hub in Suite 2.4.

We have celebrated nurse's week, with a stand within the Kings Treatment Centre concourse. We have held our annual Nurse of the Year awards on the 15 May 2015, and Valett Brown, Deputy Ward Leader from Ward 14 is our Nurse of the Year, and the Director of Nursing Award went to Sarah Addlesee, Patient Safety Lead.

We have recently held a Maternity Quality Summit to review Maternity incidents and data.

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

Following the Keogh Review in June 2013, we have 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 have 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 for nursing on the 1 April 2015, and we have held an open day on the 25 April 2015 and a clearing house event on 30 April 2015, which was successful.

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 from June 2015. We have made the decision when the bed capacity was tight to not open additional capacity ward, and we have reduced the bed base at Newark Hospital to support the vacancy gap on Sconce Ward (8 beds closed) and on Ward 33 (8 beds closed) at Kings Mill Hospital.

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 four 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 April 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 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, who commenced in June 2015. We are trying to attract Consultants to the 'hard to fill' vacancies by offering recruitment and retention premium payments.

We have increased the Consultant support to the Geriatric team, and this Consultant has senior Consultant experience and an interest in End of Life care. We are looking to jointly recruit with Nottingham University Hospitals a Neurology Radiologist. We did not have a positive response to the advertisement for Radiologist, and we have recruited to the Breast Radiologist post.

We have added additional resources into End of Life team (Band 7 nurse) which has been extended to December 2015, Falls team (Band 7 nurse) and an additional junior doctor to the Hospital at Night team following the Hospital at Night review.

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.

We have all our emergency equipment maintained across all sites of the Trust, and the maintenance of the remaining equipment is continuing. All ward leaders have received a personalised report of items missing maintenance.

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 weekly 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 will include a section on storage and safety of medicines from April 2015.

We have audited medication storage and this has been undertaken across the Trust, which is being used to improve storage and understanding on the wards.. We have introduced secure waste bins on the wards; this will prevent access to waste at the ward level. We are driving medicine security and this is now being audited daily.

We have reviewed the patient lockers to ensure that the drug security at the bedside is paramount, and we have re-circulated the Standard Operating Procedure for what to do when the patient's drug cabinet is broken.

Our electronic cabinet project will be operational by July 2015. These cabinets will be in the Emergency Department and the Emergency Assessment Unit, which are high patient turnover areas and had issues highlighted by the CQC in April 2014.

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 have now submitted three data sets which demonstrates that we are performing better than the mean in most areas.

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 week commencing 1 June 2015 was 100% (stage 1) and 98.6% completed (stage 2) which demonstrates that there is good compliance.

Our new Emergency Care documentation is being audited monthly using our Healthcare records audit to ensure that we are compliant with GMC standards of documentation. We will be undertaking in June 2015 a pre and post new Emergency Care documentation audit to ensure that the new documentation is adding value to the patient's outcomes. We are undertaking a weekly audit of the co-morbidity section of the new documentation to ensure completion and to improve coding.

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.

We have procured standardised bedside patient record folders, which have been implemented in all ward areas and will improve record keeping.

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

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. We have trained staff at Newark and Mansfield Community Hospitals in preparation of VitalPac commencing.

The Learning Clinic continues to work towards the next big release of VitalPac which will be in July 2015. The VitalPac project team continue to work with Newark and Mansfield Community Hospitals to prepare the nursing and medical staff for the roll out of VitalPac following this release.

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

Our HSMR figures demonstrate a fall but this remains higher than other Trusts in our region. We have discussed and shared our mortality results with Royal Bath Hospital.

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. We are reviewing our escalation processes and ensuring that we acknowledge ceilings of care as part of these discussions. We will develop and implement an action plan to improve our escalation processes.

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.

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 have improved the emergency flow and as a consequence this has now moved to AMBER. The Emergency Department access standard has been met for the last 3 months.

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 Chief Operating Officer 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. This is being audited daily by the Duty Nurse Managers for compliance.

We have developed a comprehensive Emergency Flow Programme to integrate the clinical and quality improvements required, alongside the operational processes to embed best practice. We are continuing to target reduction of Delayed Transfer of Cares agreed with the CCGs.

We have had a staff engagement and changing behaviours time out session with an independent facilitator for all Emergency Department Consultants. We have arranged a staff engagement event to listen to and thank staff for changes over the last few months, this was held on the 14 May 2015.

We have visited Royal Bath Hospital NHS and we have returned on the 14 May 2015 and have observed their Performance Management meetings with our divisional teams.

Our teams are continuing to review all outstanding Outpatient appointments and work closely with the Interim Chief Operating Officer to monitor for improvement.

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 section has been reviewed by the action owner in June 2015 and we will review in September 2015.

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. 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. 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. Our Medical Director continues to meet monthly with the Trauma and Orthopaedic Head of Service and Consultants with significant progress against the HEEM action plan.

The Consent audit demonstrated marked improvement and junior doctors comments were positive, PROMS outcomes have improved, best tariff performance has improved and daily consultant ward rounds across the week will be implemented from August 2015.

We have revised and agreed the Appraisal Policy, which now reflects Quality for All Values and Behaviours. This was communicated on the Staff Bulletin in 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 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 are 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.

Our Programme Management Office will be implementing a programme of testing the clinical pathways for Gastro-intestinal bleed, fractured neck of femur and one of the ambulatory care pathways – suspected pulmonary embolism. We have developed a programme of audit for the next year to demonstrate the standardisation of care and outcomes. This audit reports will be presented at the Service Clinical Governance meeting monthly.

Our Medical Director has visited Royal Bath Hospital and has reviewed with their Medical Director their clinical pathways implementation and auditing.

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

We have completed our assessment of the NICE guidelines backlog and we have updated the risk register to reflect this.

The Hip/Knee Schools and combined physiotherapy clinics for Orthopaedics has reviewed patients 4 week pre-operatively to enhance recovery and rehabilitation post operatively. The patients on this pathway will have their length of stay and PROMS outcomes audited. Our pathway changes in joint replacement have seen a fall in Length of Stay from over 6 days to under 4 days with PROMS satisfaction scores over 89%.

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 patients onto the telemedicine follow up for prostate specific antigen measurement follow up. These patients have been followed up 3 monthly in clinic, so 60 slots have been released to improve capacity in the consultant clinics. Our Urology pathway changes have seen a fall in new:follow-up ratio from 2.5 to 1.7.

We are auditing the Sepsis 6 bundles monthly across the Trust, and this is undertaken by the Lead Nurse for Sepsis. This report will be received by the Medical Director, the Patient Safety Team and the Divisional Clinical Governance meetings from May 2015.

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. Our inpatient response rates for March 2015 was above 50%.

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.

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, until December 2015. 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 Geriatric Consultant with significant management experience, with 4 sessions a week for End of Life Care, and he has already attended the End of Life Strategy Group. The Medical Lead for End of Life care has reviewed all the key actions and has reviewed lessons learnt and has provided assurance to the End of Life Strategy Group.

We have continued 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 have held our first training session and we have further other 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 are collecting monthly data and reporting quarterly on Fast Track audit. We are monitoring through the End of Life Strategy Group and reporting quarterly to Clinical Quality & Governance Committee.

We have attended Ward 24 Clinical Governance meeting and presented an introduction to Amer Care Bundle.

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

We have held teleconference with Royal Bath Hospital in May 2015 and have discussed End of Life strategies.

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 received the review of our Safeguarding services from the external Consultant, Professor Mandy Ashton, and this report contains an action plan. We have arranged a further session for the 15 May 2015 to develop a medium term action plan with the team. This is being monitored through the Safeguarding Board, and Clinical Quality & Governance Committee.

Our Deputy Director of Nursing & Quality attended the Nottinghamshire Adults Safeguarding Board in April 2015. We are meeting with the local CQC team fortnightly and they have reported that the concerns around safeguarding have reduced.

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

Our Clostridium Difficile target for 2015/16 is 48 cases (4 per month), and in May 2015 there were 8 cases. Our ward metrics will incorporate information about the number of C-diff cases per month, the number of days since the last case at ward level and results of ward hand hygiene audits.

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 have celebrated ‘World Health Organisation’s – Saving Lives Hand Hygiene’ on the 5 May 2015 with Infection Prevention & Control team having a stand in the King’s Treatment Centre concourse,

educating staff, patients and relatives on hand hygiene. We have held 'Hand Hygiene' campaign for May 2015 which will include Glow and Tell sessions for staff.

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.

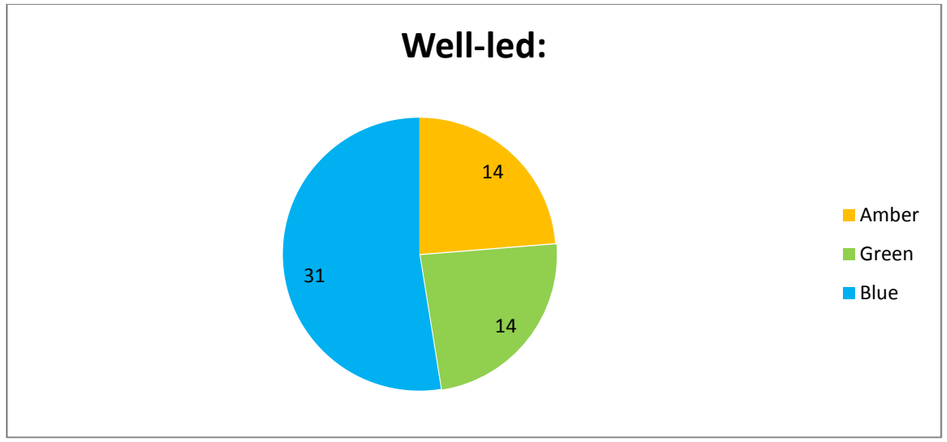
We have procured 14 hand hygiene stations which will be placed in areas such as the main reception, outpatients, the lift lobbies, outside Costa and the Voluntary Coffee Bar and in the Emergency Department

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 received the Patient Safety Collaborative report which has independently reviewed the internal assurance measures particularly with respect of outcomes and action. Our Infection Prevention & Control Consultant Nurse and our Clinical Lead have developed an action plan in response to this and the implementation and monitoring of this action plan will be through HCAI and Clinical Quality & Governance Committee.

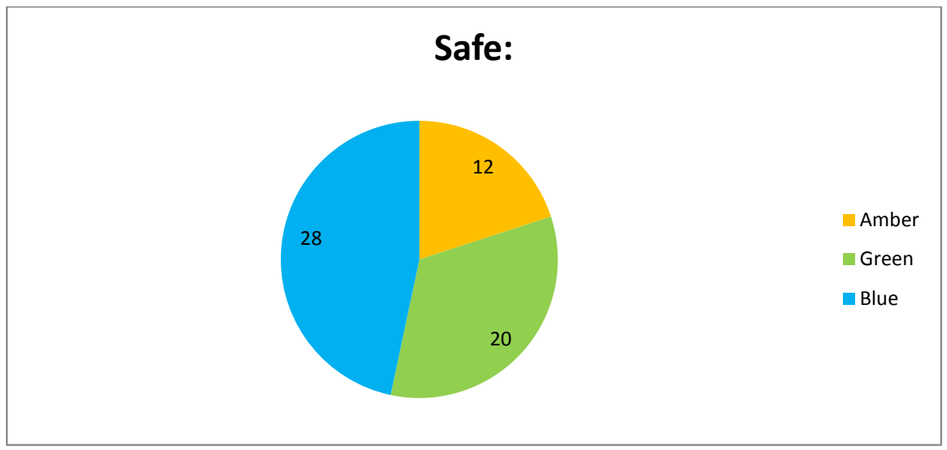
Domains:

Are we well-led?



This domain has 58 actions with 31 actions completed (52%) and 14 actions on track (24%) to be completed within the timeframe. There are 14 actions (24%) 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.

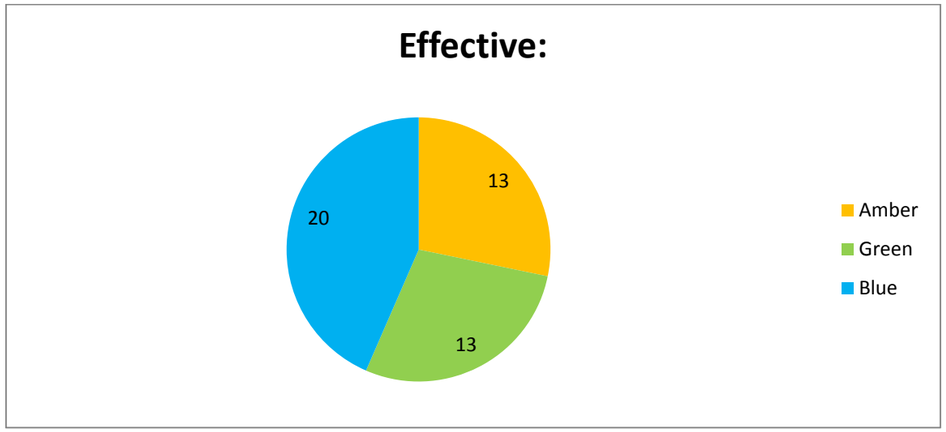
Are we safe?



This domain has 60 actions with 28 actions completed (47%) and 20 actions on track (33%) 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.

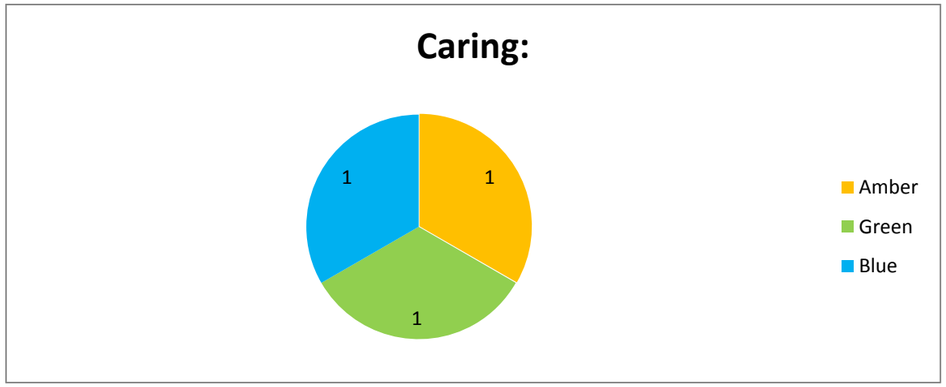
The majority of the amber actions relate to recruitment of nursing and medical staff which is being addressed through international and newly qualified registered nurse recruitment. The Trust maintains its commitment to the nursing strategy and its three year implementation plan to increase staffing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

Are we effective?



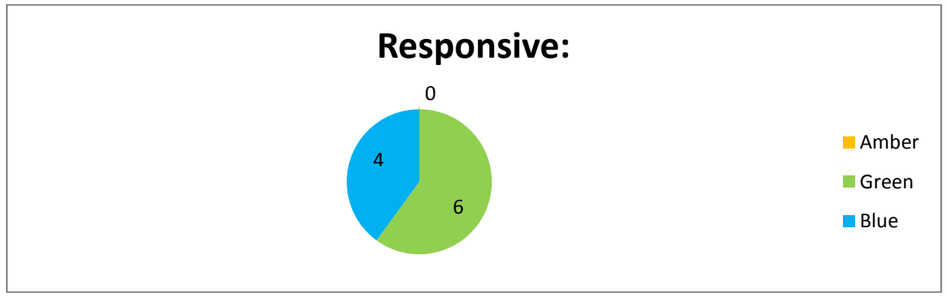
This domain has 46 actions with 22 actions (44%) are completed and 13 actions (28%) are on track to be completed within the timeframe. There are 13 actions (28%) which are amber, indicating that there is progress but the action will not be completed within the original timeframe.

Are we caring?



This domain has 3 actions with 33.3% (1) showing that the action has been completed, 33.3% (1) action is on track to be completed within the timeframe, and 33.3% (1) is demonstrating amber, indicating that progress is being made towards completion, but not within the timeframe. This domain has no red actions.

Are we responsive?

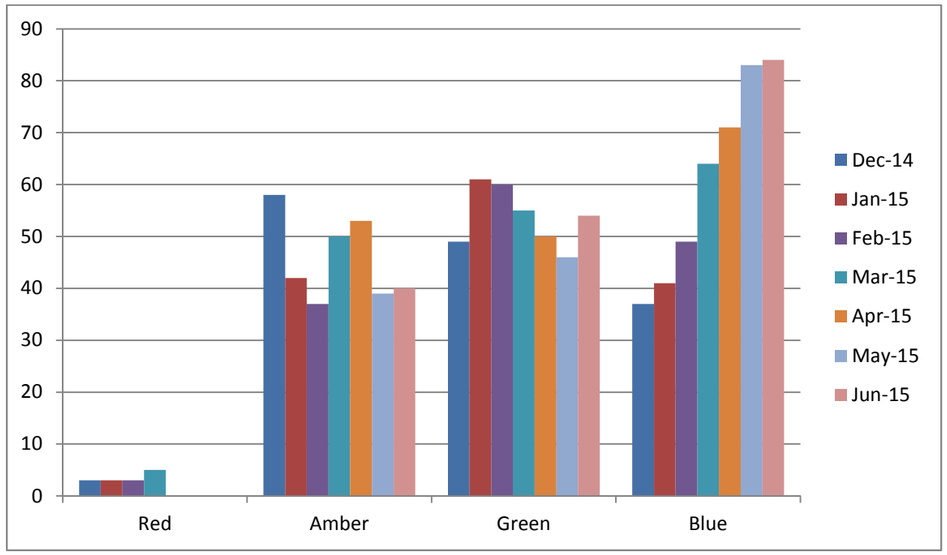


This domain has 10 actions with 20% (4) actions demonstrating that the actions have been completed 40% (6) actions demonstrating that they are on track. This domain has no ambers or red.

What has changed since May 2015?

- There is an improvement in the number of actions completed;
- The Quality Improvement Plan continues to be updated regularly by the action owners.

Have we improved?



The comparison of the position of the actions in May 2015 has continued to improve, there remains no RED rated action, and the number of AMBER ratings has reduced. There is a slight increase in the number completed this month, and an increase in the number of actions on tract to deliver.

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