Sherwood Forest Hospitals NHS
NHS Foundation Trust

QUALITY IMPROVEMENT PLAN

Accountability:		
Senior Responsible Officer		Peter Herring Interim CEO
Quality Improvement Plan - Programme Director:		Karen Fisher
Date:		24-Nov-15
Version history:		Version 1.0

Governance arrangements:	
Trust Board	Monthly
Executive Team Meeting	Weekly
Quality Committee	Monthly
Quality Improvement Board	Monthly

		RAG Definitions
(Blue)	0	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by
(Red)	7	Has failed to deliver by target date/Off track and now unlikely to deliver by target date
(Amber)	1	Off track but recovery action planned to bring back on line to deliver by target date
(Green)	277	On track to deliver by target date
(Beige)	0	No BRAG applied
	285	Total number of actions

Governance committees:

Board of Directors	TB
Quality Committee	QC
Organisational Development & Workforce	OD&W
Remuneration & Nominations Committee	RC
Finance Committee	FC
Audit & Assurance Committee	AC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
1. Leadership: **The Care Quality Commission rated the Trust as 'Inadequate' in the Well Led domain which reflects on multiple deficiencies in our leadership throughout the organisation.** **This includes:-** *** exceptional instability and lack of capacity in senior leadership;** *** ineffective processes of holding individuals and teams to account;** *** insufficient focus on developing a clinically led organisation;** *** a vision and strategy which is poorly understood with limited staff ownership;** *** inadequate investment in leadership development and support at all levels.**																					
1.1.1	Trust wide	Refresh and redeploy our vision and strategy, in a way that staff and stakeholders can easily understand and recognise their individual contribution	Refresh the Trust strategy in light of the direction agreed with regulators and stakeholders					X	Foresight Well-Led Review (2014) ST1 Foresight Well-Led Review (2014) EN1		Chief Executive officer - Peter Herring	Director of Strategic Planning and Commercial Development - Peter Wozencroft	31/03/2016		30/09/2016	November 2015 update: Current strategy written and being discussed within the Trust. Discussions ongoing with regulators regarding long term partnerships.	G	Revised strategy agreed by board.		Agreed aligned Trust strategy	TB
1.1.2	Trust wide		Develop a revised compelling strategic narrative.					X			Chief Executive officer - Peter Herring	Director of Strategic Planning and Commercial Development - Peter Wozencroft	29/02/2016		30/09/2016		G	Strategic narrative agreed by board.		Staff can describe their contribution to delivering Trust priorities and can describe key priorities and future direction for the Trust. Patient and public sited on Trust strategic direction.	
1.1.3	Trust wide		Develop and deliver a deployment plan to communicate and engage with staff, patients and visitors, in relation to strategy					X			Chief Executive officer - Peter Herring	Director of Strategic Planning and Commercial Development - Peter Wozencroft	31/05/2016		30/09/2016		G	Strategic narrative and associated deployment plan agreed by board.		Staff can describe their contribution to delivering Trust priorities and can describe key priorities and future direction for the Trust. Patient and public sited on Trust strategic direction.	
1.2.1	Trust wide	Create the appropriate level of leadership capacity to deal with organisational and system wide challenges	Revise our Divisional structure - moving to 5 divisions with Clinical Director accountability, supported by General Manager and Head of Nursing/ Midwife (CD-led triumvirate)		X			X	Foresight Well-Led Review (2014) ST2 Foresight Well-Led Review (2015) BC1		Chief Executive officer - Peter Herring	Chief Operating Officer - Jon Scott	31/12/2015		31/03/2016	Briefing issued advising of proposed change. Recruitment progressing to vacant posts	G	New divisional structures published staff in post		Divisional structures established and posts recruited to.	
1.2.2	Corporate		Enhance Divisional clinical governance arrangements and appoint to five clinical governance leads.					X			Chief Executive officer - Peter Herring	Chief Operating Officer - Jon Scott	31/12/2015		31/03/2016	Need for the roles agreed at board of directors. Recruitment to the roles progressing	G	Job Description for clinical governance lead and staff in post		Enhanced governance arrangements within Divisions	
1.2.3	Trust wide		Align corporate functions to support new divisional structures					X			Chief Executive officer - Peter Herring	Director of HR - Graham Briggs	31/03/2016		30/06/2016	-	G	Revised corporate structures		Corporate functions actively supporting divisional activities	
1.2.4	Trust wide		Implement business intelligence systems and revised performance management processes to support service line management					X			Chief Executive officer - Peter Herring	Head of Strategic Planning - Philip Harper	31/03/2016		30/09/2016		G				
1.2.5	Trust wide		Trust Board to agree adequate executive resource to support delivery of internal priorities and proactive contribution to Better Together along with other strategic partnerships					X			Chief Executive officer - Peter Herring	Director of HR - Graham Briggs	31/01/2016		30/06/2016	Strategic/operational proposal developed - proposal to be considered by board of directors by December 15	G	Proposal and board minutes		Additional executive capacity in place	
1.3.1	Trust wide	Implement robust performance management processes that align to delivery of the Trust's strategic, clinical, operational and behaviour standards.	Establish a revised performance management mechanism across all divisions and the corporate function		X	X		X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Director of Strategic Planning and Commercial Development - Peter Wozencroft/ Chief Financial Officer - Paul Robinson	30/11/2015		31/03/2016	New performance management structure implemented - first cycle of monthly divisional performance reviews completed	G	New performance management process documentation		Delivery of internal/divisional targets	TB
1.3.2	Trust wide		Ensure there are performance management systems that address poor standards/performance and support the setting of SMART objectives		X	X		X			Director of HR - Graham Briggs	Director of HR - Graham Briggs	31/03/2016		30/09/2016		G	Disciplinary procedure, capability policy, reward strategy		Performance perceived to be managed consistently across the trust. Staff survey Survey Monkey	OD&W
1.4.1	Corporate	Invest in appropriate leadership development programmes to ensure leaders are equipped and prepared to meet the challenges of the organisation	Undertake leadership capability gap analysis against Trust priorities.					X	Foresight Well-Led Review (2014) ST2 Foresight Well-Led Review (2014) CU1		Director of HR - Graham Briggs	Lee Radford Deputy Director of HR - Graham Briggs L&D	31/01/2016		31/03/2016		G	Leadership capability gap analysis reviewed by OD & workforce committee		Competent leaders delivering trust strategic priorities	
1.4.2	Trust wide		Develop and deliver leadership development opportunities against the identified Gap Analysis findings, utilising our "core values and behaviours"					X			Director of HR - Graham Briggs	Various	31/03/2016		31/03/2017		G	Programme of work developed and reviewed by OD&WF committee		Measures to be developed of uptake of development opportunities amongst targeted staff. Incremental Progress	
1.4.3	Trust wide		Develop and deliver a leadership development programme to divisional management triumvirates					X			Director of HR - Graham Briggs	Lee Radford Deputy Director of HR - Graham Briggs L&D	31/03/2016		30/06/2016		G	Programme of work developed and reviewed by OD&WF committee		Measures to be developed of uptake of development opportunities amongst targeted staff	
1.4.4	Trust wide		Develop an ongoing programme of Medical Leadership					X	913 Legacy QIP Sherwood Forest		Director of HR - Graham Briggs/ Medical Director - Andy Haynes	Lee Radford Deputy Director of HR - Graham Briggs L&D	31/12/2015		30/06/2016		G	Programme of work developed and reviewed by OD&WF committee		Measures to be developed of uptake of development opportunities amongst targeted staff	
1.4.5	Trust wide		Undertake capability review of middle managers					X	914 Legacy QIP Sherwood Forest		Director of HR - Graham Briggs	Lee Radford Deputy Director of HR - Graham Briggs L&D	31/03/2016		31/03/2017		G	Capability review provided to OD&WF committee		Measures of core middle management competences to be developed and assessed.	
1.4.6	Trust wide		Implement required improvement actions to enhance competence and confidence of middle managers in response to outputs from the capability review					X			Director of HR - Graham Briggs	Lee Radford Deputy Director of HR - Graham Briggs L&D	30/09/2016		30/06/2017		G	Programme of development actions developed and approved by OD&WF committee		Measures of core middle management competences to be developed and assessed.	

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1.4.7	Trust wide		Implement a talent spotting and succession planning initiative for key senior leadership roles					X			Chief Executive officer - Peter Herring	Director of HR - Graham Briggs	31/03/2016		31/09/2016		G	Talent spotting process & succession plans in place for key posts		Succession plans for business critical leadership roles	RC
1.4.8	Trust wide		Develop programme of skills workshops to develop effective teams, able to manage continuous change					X			Director of HR - Graham Briggs	Kate Lorenti Deputy Director of HR - Graham Briggs	31/03/2016		31/03/2017		G	Development programme and teambuilding sessions in place		% of staff to have undertaken team-focused learning	OD&W
1.4.9	Trust wide		Strengthen appraisal and supervision process for medical staff	X	X				23 Must do's (2015)	Ensure all staff working in the medical care service receive appropriate supervision, appraisal and training to enable them to fulfil the requirements of their role.	Medical Director - Andy Haynes	Medical Director - Andy Haynes	31/10/2015		31/10/2016	Completed	G	Appraisals are managed and monitored by the medical director's office, doctors are reminded 2 months in advance of appraisal being due to ensure deadlines are hit and everyone is aware of their appointed appraiser and appraisee.			
1.4.10	Trust wide		Ensure robust appraisal data and effective performance managements arrangements to ensure all staff receive an appraisal in a timely manger	X	X				59 Should do's (2015)	Ensure that the nursing and medical staff in the children's and young people's service receive a minimum of yearly appraisals	Director of HR - Graham Briggs	Kate Lorenti Deputy Director of HR - Graham Briggs	31/12/2015		31/03/2017		G			98% of eligible staff to have a appraisal	
1.5.1	Corporate	To ensure the Board has the appropriate skills and abilities to effectively lead the organisation and are visible in doing so	Revised Board Development programme at a collective and individual level which includes effective assurance and governance disciplines and the alignment of NEDs to Execs for effective delivery of sub-committees.					X			Chairman - Sean Lyons	Director of HR - Graham Briggs	31/01/2016		31/07/2016		G	Board development programme approved by board		Programme of work to determine measures	TB
1.5.2	Corporate		Ensure all Board have annual appraisal					X			Chairman - Sean Lyons	Chief Executive officer - Peter Herring	30/04/2016		30/04/2017		G	Appraisal programme approved by board		100% compliance with annual appraisal deadlines	RC
1.5.3	Corporate		Ensure effective personal development process is in place for all board members.					X	873 Legacy QIP Sherwood Forest		Chairman - Sean Lyons	Chief Executive officer - Peter Herring	30/04/2016		30/04/2017		G	Signed off development plan			RC
1.5.4	Corporate		Establish an effective programme for Non-Executive Directors and Executive Directors to gain assurance across the Organisation					X			Chairman - Sean Lyons	Chief Executive officer - Peter Herring	31/12/2015		31/03/2016		G	Joint executive/non-executive portfolios in place and clearly understood		Reports to board from individual exec/non-exec teams	QC
1.5.5	Corporate		Robust utilisation of strategic partners to develop peer support programme for specific Non-executive assurance roles					X			Chairman - Sean Lyons	Chief Executive officer - Peter Herring	31/12/2015		31/03/2016	November 2015 update: Established links with Nottingham University Hospitals	G	Personal relationships with relevant counterparts in place		Non-exec performance against objectives	

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2. Governance: **Our current governance arrangements do not:** **- enable the Board to understand fully what is happening in the organisation;** **- ensure that risks are escalated and managed effectively;** **- support the Trust to be a 'learning organisation' which reports, investigates and learns from incidents openly, honestly and effectively.**																					
2.1.1	Corporate	Changing the Governance framework and architecture and defining leadership roles and responsibilities to deliver the governance plan	Establish a Director of Quality & Assurance role					X	Section 29a Foresight Well-Led Review (2014) AC3 Foresight Well-Led Review (2014) EN2 Foresight Well-Led Review (2014) CG1 Foresight Well-Led		Chief Executive officer - Peter Herring	Chief Executive officer - Peter Herring	31/10/2015	31/10/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	12 October 2015 update: JD agreed and approved by Executive Team - Agreed Job Description		JD approved by Executive Team	TB
2.1.2	Corporate		Recruit to Director of Quality & Assurance	X				X			Chief Executive officer - Peter Herring	Chief Executive officer - Peter Herring	31/03/2016		31/05/2016		G	Director of Quality & Assurance is appointed as a Board member		Director of Quality & Assurance in post	
2.1.3	Corporate		Establish a revised Board Assurance Framework that is aligned to the Quality Improvement Plan		X	X		X			Chief Executive officer - Peter Herring	CEO until the appointment of Director of Quality & Assurance	31/01/2016		30/06/2016		G	BAF which reflects the revised strategic objectives and risks identified in the QIP		Dynamic BAF and process	
2.1.4	Trust wide		Ensure wording of Risk Management Strategy is clear and consistent					X	Section 29a		Programme Director - Karen Fisher	Risk Manager	30/11/2015		To be confirmed per CQC	A revised Risk Management Policy, which includes an outline of the Trust's corporate risk strategy, is scheduled for presentation to the Risk Management Committee for approval on 18th November	G	Clear reporting and escalation processes with regard to risk management		Divisional Managers consistent in approach when escalating risks, enabling trust wide and significant risks to be identified and considered by the executive team and BoDs	
2.1.5	Trust wide		Review the role and operation of the Risk Management and all Governance Committees					X	Section 29a		Chief Executive officer - Peter Herring	External Governance Advisor	31/10/2015	31/10/2015	To be confirmed per CQC	The role of the Risk Management Committee has been reviewed and a revised Terms of Reference is scheduled to be considered alongside the revised policy on 18th November. The role of the committee will be further reviewed as part of the Trust's full governance review, the timescales for which are not yet established.	G	External governance report regarding governance arrangements		External report informs further iterations of the QIP	
2.1.6	Trust wide		Secure external expertise to support the Trust in identifying and making the necessary structural changes					X	Section 29a		Chief Executive officer - Peter Herring	Chief Executive officer - Peter Herring	31/10/2015	31/10/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Additional capacity and capability secured. 14 October 2015 update: Director of Assurance from Tameside Hospital NHS Trust is supporting the Trust		Approved changes to governance structures implemented	
2.1.7	Trust wide		Develop enhanced Quality Improvement Plan which reflects identified risks	X	X	X	X	X	Section 29a		Chief Executive officer - Peter Herring	Programme Director - QIP - Karen Fisher	31/10/2015	30/11/2015	To be confirmed per CQC	31 October 2015 update: QIP in development and to be presented to the Trust Board on the 26 November 2015. Quality Improvement Plan includes actions directly identified to mitigate recognised risks	R	Quality Improvement Plan includes actions directly identified to mitigate recognised risks		Quality Improvement Plan known and understood across the Trust	QC
2.1.8	Trust wide		Review the role and operation of all governance committees and implement new Governance Committee arrangements, including the review of NICE guidance			X		X	Section 29a		Chief Executive officer - Peter Herring	CEO until the appointment of Director of Quality & Assurance	31/12/2015		To be confirmed per CQC	Additional capacity and capability has been secured to review the existing governance framework	G	Informed decision making at Board of Directors and Committees through improved governance and assurance. Clear line of sight from Ward to Board. Escalation of risks to enable focus on achievement of strategic objectives and improvements in quality of care to patients		Risks and performance issues mitigated and escalated appropriately	TB
2.1.9	Trust wide		Review guideline update process and develop plan for updating all past review date guidelines in to updated format	X	X	X			57 Should do's (2015)	Ensure acute paediatric clinical guidelines are reviewed and follow best practice guidance	Medical Director - Andy Haynes	Colin Dunkley	31/03/2016		30/09/2016	Admin support needed to kick off getting review of past-review date documents. Overlap with 2.1.10 to be monitored.	G				QC
2.1.10	Trust wide		New Quality Governance Unit established					X	Section 29a		Programme Director - Karen Fisher	CEO until the appointment of Director of Quality & Assurance	31/12/2015		To be confirmed per CQC		G				TB
2.1.11	Corporate		Appoint QIP – Programme Director					X	Section 29a		Chief Executive officer - Peter Herring	Chief Executive officer - Peter Herring	30/11/2015	30/11/2016	To be confirmed per CQC	Appointment Made to 31/03/2016	G	Single Quality Improvement Plan with clear lines of accountability.		SMART KPI's to demonstrate improvements achieved.	TB
2.1.12	Corporate		Resource PMO support					X	Section 29a		Programme Director - Karen Fisher	Chief Executive officer - Peter Herring	30/11/2015		To be confirmed per CQC		G	Identified actions delivered on time. All completed actions monitored until sustained and embedded			TB
2.1.13	Trust wide		Establish Quality Improvement Board	X	X	X	X	X	Section 29a		Programme Director - Karen Fisher	Programme Director - QIP	30/11/2015	30/11/2015	To be confirmed per CQC	Quality Improvement Board established	G				QC
2.1.14	Trust wide		Strengthen external scrutiny of Quality Improvement Plan through Oversight Group			X		X	Section 29a		Chief Executive officer - Peter Herring	Chief Executive officer - Peter Herring	30/11/2015		To be confirmed per CQC	Oversight group established and meeting regularly	G				TB
2.1.15	Trust wide		Establish monthly Confirm and Challenge meetings with Improvement Director and QIP Programme Director					X	Section 29a		Chief Executive officer - Peter Herring	Programme Director - QIP	30/11/2015		To be confirmed per CQC		G				QC
2.1.16	Trust wide		Identify and secure 'Best in Class' expertise/capacity to support delivery of QIP		X	X		X	Section 29a		Chief Executive officer - Peter Herring	Programme Director - QIP	31/12/2015		To be confirmed per CQC		G				TB
2.1.17	Trust wide		Agree and implement process for developing and approving localised clinical pathways		X	X			907 Legacy QIP		Medical Director - Andy Haynes	Medical Director - Andy Haynes	30/04/2015		31/05/2016	Completed	G	Clinical pathway development and implementation process established.	Review of pathway documentation and compliance with process (see below)		QC
2.1.18	Trust wide		Develop and agree a mechanism for ongoing review and refinement of localised clinical pathways		X	X			908 Legacy QIP		Medical Director - Andy Haynes	Medical Director - Andy Haynes	31/03/2016		31/05/2016		G				QC
2.2.1	Urgent & Emergency Care	Integrated governance and risk assurance processes to ensure that risks are systemically identified and responded to appropriately	Governance framework in the emergency department clearly identifies risks, responsibilities and actions			X		X	8 Must do's (2015) Foresight Well-Led Review (2014) AC1 Foresight Well-Led Review (2014) AC2 Foresight Well-Led	Ensure the governance framework in the emergency department clearly identifies risks, responsibilities and actions required to manage those risks within a stated timeframe	Chief Operating Officer - Jon Scott	Clinical Director - Emergency and Urgent Care	31/12/2015		31/03/2016		G				QC
2.2.2	Trust wide		Review and improve risk management processes including risk escalation and information flows			X		X	104 Section 29A letter		Programme Director - Karen Fisher	Risk Manager	30/11/2015		To be confirmed per CQC		G	Clear understanding of risk process and escalation		Policy approval and implementation	QC

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2.2.3	Trust wide		Enhanced risk escalation process implemented	X		X		X	Section 29a		Programme Director - Karen Fisher	Risk Manager	31/12/2015		To be confirmed per CQC		G	Clear reporting and escalation processes with regard to risk management		Divisional managers consistent in approach when escalating risks, enabling trust wide and significant risks to be identified and considered by the executive team and Board of Directors	QC
2.2.4	Trust wide		Develop an appropriate suite of report formats for reporting on risk management			X		X	Section 29a		Programme Director - Karen Fisher	Risk Manager	30/11/2015		To be confirmed per CQC	New format reports have been designed and will be presented to the Risk Management Committee alongside the revised policy for approval before being adopted for routine use.	G	Clear reporting to committees detailing purpose of report – assurance, escalation, delegation, communication		Consistent information within reports. Risks are reported, communicated and escalated in line with the new structure. 6 month review of effectiveness of reports and information	QC
2.3.1	Trust wide	Improve information to be provided to the board to ensure visibility of risks	Engage with divisional managers and trust staff through the governance review to mitigate and clarify their confusion regarding escalation and clarify flowchart for escalation going forward		X	X		X	Section 29a Foresight Well-Led Review (2014) ST3 Foresight Well-Led Review (2014) AC1 Foresight Well-Led		Chief Executive officer - Peter Herring	Risk Manager	30/11/2015		To be confirmed per CQC	Engagement has taken place as part of consultation of revisions to the Risk Management Policy; the escalation process is clearly describe within the revised policy, and a process flow chart is attached as an appendix.	G	Clear 'simple process for escalation		All staff follow defined approach when escalating risks, enabling trust wide and significant risks to be identified and considered by the executive team and Board of Directors	QC
2.3.2	Trust wide		Understand and analyse the strategic risk register to the principal risks identified on the BAF					X	Section 29a		Programme Director - Karen Fisher	Deputy Director of Corporate Services	31/10/2015		To be confirmed per CQC	A board development session is scheduled for 16th December 2015 to review the current principal risks in light of the revised strategic objectives, strategic risk register and outcomes of QIP. The revised BAF document will be presented to the Board of Directors at its December meeting. Once the links between the strategic risk register and the BAF have been established the Datix Risk Register will be updated to enable clear links between strategic objectives and individual risks in order to inform robust decision making.	R	Clear understanding of linkage between operational and strategic risks		Operational risks inform the strategic risks identified on the Board Assurance Framework Document	TB
2.3.3	Trust wide		Implement a single integrated performance report			X		X	Section 29a		Chief Executive officer - Peter Herring	Chief Executive officer - Peter Herring	31/10/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Integrated performance report which identifies risk, challenges risk and informs the risk register		Fully Integrated Performance Report	TB
2.3.4	Trust wide		Enhance and review DATIX system and improved processes implemented			X		X	Section 29a 874 QIP 2014/15 86 Should do's (2015)	Ensure all staff are adequately and appropriately trained to use the trust incident reporting system.	Programme Director - Karen Fisher	Head of Governance	31/12/2015		To be confirmed per CQC		G	Escalation of risk to enhance informed decision making		Swift response to downward trending of KPI's	QC
2.3.5	Trust wide		Implementation of the Patient Experience module (Datix) to improve recording of complaints and learning opportunities		X	X			898 Legacy QIP		Chief Nurse - Suzanne Banks	Head of Governance	30/04/2016		31/07/2016		G	Appropriate reporting		Learning from complaints across all sites	QC
2.4.1	Urgent & Emergency Care	Develop an open and transparent culture that supports good governance to enable the trust to be a learning organisation	Develop a Duty of Candour Strategy for the Organisation which is aligned to Governance and risk work plans so that open and transparency is business as usual	X	X	X	X	X	7 Must do's (2015) Foresight Well-Led Review (2014) CU2 Foresight Well-Led Review (2014) BC1	Ensure learning from complaints is shared with staff in the emergency department which leads to improvement in care	CEO until the appointment of Director of Quality & Assurance	CEO until the appointment of Director of Quality & Assurance	31/03/2016		30/09/2016		G	Emergency Department staff share and learn from complaint to improve the quality of care in the Emergency Department		Reduction in reoccurrence of incidents	QC
	Trust wide			X	X	X	X	X	40 Must do's (2015)	Ensure staff have opportunities to learn from incidents across the trust								All staff will have opportunities to learn from incidents to improve care		Reduction in reoccurrence of incidents	
				X	X	X	X	X	46 Should do's (2015)	Ensure there are effective and consistent systems for learning from incidents to be shared across the trust at all locations.								All wards and department will have up to date learning boards		All staff will be able to articulate the themes and trends for their ward or department and the trust	
						X		X	85 Should do's (2015)	Ensure systems to share learning from incidents include learning from incidents at all trust locations								All wards and department will have up to date learning boards		All staff will be able to articulate the themes and trends for their ward or department and the trust	
								X	174 Must do's (2014)	The trust must ensure actions taken and lessons learned are shared with staff at all levels											
				X	X				91 Should do's (2015)	Ensure leaders within the minor injuries unit understand their responsibilities under Regulation 20 Duty of Candour.								Duty of Candour policy is understood		Improved reporting of incidents and understood by the MIU team	
									899 QIP 2014/15	Deliver in-house 1-2 day RCA training workshops								All managers are trained and competent to the trust's standard		Root Cause Analysis documentation will be consistent	
2.5.1	Surgery - Trauma & Orthopaedics	Ensure Corporate oversight and response to external agencies and regulatory reports to ensure co-ordinated Clinical Governance approach	Support the junior doctors in trauma and orthopaedics and Implement action plan to respond to concerns raised by HEEM in October 2014.						Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for T&O - Paresh Kotari	31/07/2015	31/07/2015	To be confirmed per CQC	Completed - Subject to confirmation from HEEM/CQC	G	Improved communication with Junior doctors to understand and rectify issues raised.		Various measures as contained in the action plan, including: • Ensure there is a good balance of appropriate training opportunities. • Ensure there are good supervised training opportunities in theatre, particularly trauma lists. • Ensure interactions between Consultants are not having an adverse effect on learners and if it is, to address the issue. • Ensure the trauma meeting is well structured as a good learning opportunity.	QC
2.5.2	Surgery - Trauma & Orthopaedics Urgent & Emergency Care - Emergency Care		Develop a new set of pathways to support the improved interaction and decision making processes between these departments and publish on the intranet.	X					Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for ED - Richard Clarkson and T&O - Paresh Kotari .	31/01/2015	31/01/2015	To be confirmed per CQC	Completed - Subject to confirmation from HEEM/CQC	G	Improved communication and decision making processes established. New ED and T&O pathway protocols have been established to provide clear decision making processes.		Minutes of meetings to confirm attendance.	QC

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2.5.3	Surgery - Trauma & Orthopaedics Urgent & Emergency Care - Emergency Care		Poor communication within and between the Emergency Department and Trauma & Orthopaedics department resulting in unclear decision making. The Head of Service for Emergency care to attend PC& S divisional team meetings.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for ED - Richard Clarkson and T&O - Paresh Kotari .	31/01/2015	31/01/2015	To be confirmed per CQC	Completed - Subject to confirmation from HEEM/CQC	G	Improved communication and decision making processes established.		Minutes of meetings to confirm attendance.	QC
2.5.4	Surgery - Trauma & Orthopaedics		The Trust must investigate the concern raised relating to lack of consent forms and site markings. To provide assurance through audits that appropriate site marking and consent processes are being carried out.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for T&O - Paresh Kotari	31/03/2015	31/03/2015	To be confirmed per CQC	Completed - Subject to confirmation from HEEM/CQC	G	Subsequent audit undertaken following consent training improvement to 90%. Plans for prospective audit of ten cases ongoing audit every month including Newark to be undertaken. These results will be fed into divisional governance meetings for monitoring commencing in January 2015. Audits in February and March have been undertaken and shown improvement but will continued to be monitored until August 2015		Audit results	QC
2.5.5	Surgery - Trauma & Orthopaedics		Lack of senior clinical support for junior doctors in Trauma & Orthopaedics and poor staffing levels at night. Each junior doctor will be paired with two supervisors to provide appropriate clinical support at all times.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for T&O - Paresh Kotari	31/03/2015	31/03/2015	To be confirmed per CQC	Completed - Subject to confirmation from HEEM/CQC	G	Improved supervision for junior drs.		Copies of rotas confirming access to two lists.	QC
2.5.6	Surgery - Trauma & Orthopaedics		Lack of senior clinical support for junior doctors in Trauma & Orthopaedics and poor staffing levels at night. The Hospital at Night to be re-designed to include an onsite surgical registrar on call to provide additional cover at night.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Director of Post Graduate Medical Education. – Giles Cox	31/07/2015	31/07/2015	To be confirmed per CQC	Completed - Subject to confirmation from HEEM/CQC	G	Increased support now in place through revised Hospital at Night team which now includes a resident on call surgical registrar.		Increase levels of support through Hospital at Night has increased senior support.	QC
2.5.7	Surgery - Trauma & Orthopaedics		Lack of opportunities for Trauma & Orthopaedics trainees to get experience. The rotas to be redesigned to ensure trainees are given greater exposure to lists to increase their experience.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for T&O - Paresh Kotari	31/03/2015	31/03/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Trainees in Trauma and Orthopaedics benefit from having two lists as part of their training. One trainee from Derby even changed his rotation in April in order to come to Kings Mill hospital.		Copies of rotas confirming access to two lists.	QC
2.5.8	Diagnostics & Rehabilitation - Pathology		Difficulty with blood test reporting IT system, ensure that the ICE blood results IT system is modified to make the screens more user friendly.	X	X	X		X	Section 29a HEEM		Medical Director - Andy Haynes	Patient Safety Fellow and NHIS. – Jo Richardson	30/11/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	NHIS and Patient Safety Fellow have made ICE modifications have been implemented to make certain screens more user and trainees have been informed of these changes.		Sense check revised screens with new trainees to ensure they are fit for purpose.	QC
2.5.9	Surgery - Trauma & Orthopaedics		Poor management of out of hours rota and access to mandatory training, ensure that rotas are revised and to ensure that mandatory training is clearly identified			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Rota Co-ordinators	30/04/2015	30/04/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Rota co-ordinators have revised rotas and mandatory training is clearly identifiable		Rotas to be sense checked by the Medical Education and Quality Manager for compliance.	QC
2.5.10	Surgery - Trauma & Orthopaedics		Undermining and inappropriate behaviours towards junior doctors in Trauma & Orthopaedics. Ensure an investigation into the behaviours reported and take appropriate action to ensure values and behaviours are conducive with the NHS Code of Conduct and Trust values are being applied.		X			X	Section 29a HEEM		Medical Director - Andy Haynes	Medical Director - Andy Haynes - Andrew Haynes	31/03/2015	31/03/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	CEO and Medical Director have attended T&O Departmental meetings to address the behavioural issues. Medical Director has scheduled in 6 weekly meetings to ensure that behavioural and team developments are being progressed through an action plan.		Junior dr forums will be used to sense check improvements in behaviours. Next HEEM report	QC
2.5.11	Urgent & Emergency Care		Inappropriate patient care in the Emergency Department, such as where patients had had an interventional procedure in the department for fractures but had not had an x-ray. Trainees felt that the patients were not always properly assessed and were being sent to Trauma & Orthopaedics to 'rule out' a fracture. Ensure that correct x-ray protocols are in place and are being followed					X	Section 29a HEEM		Medical Director - Andy Haynes	Head of Service for ED - Richard Clarkson	31/12/2015		To be confirmed per CQC		G	The Trust investigated the claim made in relation to patients not having x-rays for post intervention procedures and could find no evidence of this practice. There is a very clear x-ray process in place and patients do receive post procedural x-rays.			QC
2.5.12	Surgery - Ophthalmology		To address concerns relating to lack of trainees supervision, over booking of clinics and absence of local protocols. Ensure that the trust develops and implement detailed action plan for concerns raised in Ophthalmology			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Medical Director - Andy Haynes / Head of Service for Ophthalmology - Sushma Damunshi	31/12/2015		To be confirmed per CQC		G	Address concerns raised by trainees in Ophthalmology during HEEM visit May 2014.		Ophthalmology action in place and progressed on a monthly basis.	QC
2.5.13	Trust wide		Create a new and standardised approach to Junior Doctors Forums. Ensure trainees are able to raise concerns quickly and safely and feedback to trainees actions taken on any issues raised.					X	Section 29a HEEM		Medical Director - Andy Haynes	Director of Post Graduate Medical Education - Ben Owens	30/11/2015		To be confirmed per CQC		G	New standardised junior doctor forums were launched in September 2015 and are currently working well. The success of the new format will be reviewed in December 2015.		Minutes of meetings from junior doctor forums and divisional governance meetings.	QC
2.5.14	Urgent & Emergency Care		With support from the Post Graduate Dean of HEEM develop a bespoke support package for Emergency Department to address issues on lack of leadership out of hours, disconnect between in ED and the rest of the trust, and inappropriate e-referral from the ED. In June 2015, the Trust met with the Post Graduate Dean of HEEM to develop a bespoke support package for the ED Department which will utilise the expertise within HEEM and other specialists to help improve a range of issues, including the quality of referrals, communication between the ED Department and other specialties and cultural behavioural issues.					X	Section 29a HEEM		Medical Director - Andy Haynes	Clinical Director for ECM/ Service Director for ED and Director of Post Graduate Medical Education. Ben Owens	31/03/2016		To be confirmed per CQC		G	Improve quality of referrals, communication between ED and other specialties and cultural behavioural issues.		Improved feedback from junior doctors on appropriate referrals and behaviours of staff. This will be sense checked at junior dr forums.	QC
2.5.15	Urgent & Emergency Care - Cardiology		Lack of senior review of patients particularly in the areas of medicine, surgery, Obs & Gynae and Urology. Cardiology consultants job planned to perform 2 ward round/week of their patients and the on call cardiologist attends Ward 23 for a daily board round. Consultants split into two teams of three allowing them to cross cover each other's patients when they are absent. If the juniors have concerns about patients then they can call the relevant consultant or the on call cardiologist.. HoS is now jointly covered by consultant and nurse. As per all specialties there is the drive to move to a daily consultant review 7 days a week by 2017 which will require a complete review of job plans.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Heads of Service Cardiology & Urology Mel Bulgin & Ashok Bhojwani	31/03/2016		To be confirmed per CQC		G	Registrar started 25 March 2015. The two speciality doctor started 5 May 2015. During HEEM visit 7th May 2015 trainees reported that 2 consultant ward rounds per week were taking place and additional registrar ward rounds taking place in between.		Improved feedback from junior dr's and on-going sense checking at junior doctor forums.	QC
2.5.16	Trust wide		Ensure that learning and lessons learnt from the external visits are disseminated across all services. To hold combined junior dr forums 3 times a year from all divisions to share learning and best practice.			X		X	Section 29a HEEM		Medical Director - Andy Haynes	Director of Post Graduate Medical Education and Medical Education and Quality Manager - Sue Elliott	31/08/2016		To be confirmed per CQC		G	Quick implementation of improvements to other services.		Outputs and lessons learned from combined junior doctor forums.	QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
2.6.1	Corporate	Ensure that there are proper processes to enable the trust to make the robust assessment required by the Fit and Proper Person Requirement	Revise Fit and Proper Person Policy in discussion with, and support from, our Improvement Director					X	105 Section 29A letter Sherwood Forest	You are not ensuring that there are proper processes to enable you to make the robust assessment required by the Fit and Proper Persons Requirement (Warning Notice Sections 3.1, 3.2, 3.3 and 3.4)	Chief Executive officer - Peter Herring	Director of Human Resources	24/09/2015	24/09/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	A consistent process with clear accountability for roles and individual responsibilities between the Human Resources Department and Directors. This will include consideration of FPPR for deputies when they act up, interims and risk assessment process for incomplete information		Communication of policy to all relevant parties and inclusion in appointment process for new substantive and interim roles Quarterly review of status by Executive Team	TB
2.6.2			Audit all current Executive Director and Non-Executive Director personal files and identify gaps with compliance.					X			Chief Executive officer - Peter Herring	Director of Human Resources	14/09/2015	14/09/2015	31/12/2015	Completed - Subject to confirmation from CQC	G	All current Directors are compliant with the new policy		All files compliant and signed off appropriately	TB
2.6.3			Place appropriate restrictions on any Directors where documentation is incomplete					X			Chief Executive officer - Peter Herring	Chairman - Sean Lyons	26/08/2015	26/08/2015	31/12/2015	Completed - Subject to confirmation from CQC	G			Evidence of restrictions on file Reported to Board of Directors monthly until restrictions lifted	TB
2.6.4			Independent audit of 20% sample of all new starters (297), randomly chosen from all grades of staff, who were recruited between 1/01/15 to 30/06/15 re DBS clearance					X			Chief Executive officer - Peter Herring	Director of Human Resources	29/10/2015	29/10/2015	31/12/2015	Completed - Subject to confirmation from CQC	G	Assurance that the issue is not organisational wide	Internal Audit report to Board of Directors 29.10.15	Audit of the HR recruitment process to establish consistent practice.	TB

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3. Recruitment and Retention: **Recruitment and retention of staff is a major issue which has severe consequences for:-** **- providing safe staffing levels;** **- continuity of care;** **- embedding a safety culture with personalised care, and;** **- increasing cost pressures.** **Staff groups of particular concerns are registered nursing staff, with currently more than 150 vacancies, and medical staff, specifically in Emergency Department, Geriatrics, Ortho-geriatrics and Radiology. Currently there are more than 50 medical vacancies.**																					
3.1.1	Trust wide	Recruitment and retention to be prioritised by a dedicated nursing and medical taskforce group	All medical vacancies to have a named Head of Service responsible for managing the recruitment plan	X	X	X			177 Must do's (2014)	The provider "must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity".	Director of HR - Graham Briggs	HRBPs	30/11/2015		31/03/2016		G	Personal accountability to drive medical recruitment	Named Head of Service for each vacancy	% of vacancies with names head of service	OD&W
3.1.2	Trust wide		Assign a named Head of Service responsible for managing the recruitment plan for every Medical vacancy – including challenge whether the post can be fulfilled by alternative methods such as ANP or Nurse Consultant.	X	X	X					Director of HR - Graham Briggs	HRBPs	31/12/2015		31/03/2016		G	Alternative staffing models regularly considered and early filling of vacancies driven through detailed planning	Plans for each vacant medical post	Vacant medical posts	OD&W
3.1.3	Trust wide		Weekly recruitment performance monitoring report to ET covering all categories of staff; including KPIs such as time to recruit and numbers of candidates that were lost	X	X	X					Director of HR - Graham Briggs	Hannah Parrypayne. Recruitment Manager	30/11/2015		31/03/2016		G	Recruitment prioritised at most senior level in the organisation	Weekly report to CEO	Vacancy numbers	OD&W
3.1.4	Trust wide		Medical vacancies report to be reviewed weekly with CEO and Medical Director	X	X	X					Director of HR - Graham Briggs	Hannah Parrypayne. Recruitment Manager	01/04/2016		01/10/2016		G	Recruitment prioritised at most senior level in the organisation	Weekly report to CEO	Vacancy numbers	OD&W
3.1.5	Trust wide		Develop Medical Consultant job plans to reflect revised on-call arrangements and operational expectations			X		X			Medical Director - Andy Haynes	Dr Noor Zahid	31/03/2016		31/03/2016		G	Consultant job plans reflective of operational needs	Completed job planning round		OD&W
3.2.1	Corporate	Review the end to end recruitment process to determine areas of non-value add and improve the cycle time of completion. Ensure wider clinical participation and involvement in the review process and outcomes.	Medical and Nursing taskforce along with HR, clinical and operational staff to undertake a detailed review of the recruitment process and associated policies.			X					Director of HR - Graham Briggs	Hannah Parrypayne. Recruitment Manager	31/03/2016		01/09/2016	31/01/2016 review and plan for improvement; 31/03/16 implementation of plan	G	Accelerated recruitment process	Report on process review to Director of HR	Vacant medical and nursing posts	OD&W
3.2.2	Trust wide		Agree and assign staff retention targets for Divisions, with particular emphasis on newly recruited nursing staff, monitored by ET Performance Review meetings								Director of HR - Graham Briggs	Divisional General Managers in all Clinical Divisions	31/03/2016		30/09/2016		G				OD&W
3.2.3	Trust wide		Develop interventions that support the induction and engagement of newly appointed staff	X	X	X	X	X			Director of HR - Graham Briggs	Deputy Director of HR - Kate Lorenti	31/01/2016		31/03/2016		G				OD&W
3.3.1	Trust wide	Targeted medical and nursing recruitment campaigns in UK, Europe & International commissioned	Establish and enact a programme of targeted recruitment campaigns	X	X	X					Director of HR - Graham Briggs	Hannah Parrypayne. Recruitment Manager	30/09/2016		31/03/2017	Assessment and plan 31/01/2016; Commission and procure by 31/03/2016; Implement by 30/09/2016	G	Accelerated filling of vacant posts	Campaigns completed	Vacancy numbers	OD&W
3.4.1	Trust wide	Targeted campaign for nursing staff to return to practice	Design and implement programme of targeted nurse return to practice campaigns to include training and competency assessment.	X	X	X					Director of HR - Graham Briggs	Recruitment Manager & Practice Development Matron	30/06/2016		31/12/2016		G	Accelerated filling of vacant posts	Campaigns completed	Vacancy numbers	OD&W
3.5.1	Urgent & Emergency Care - Respiratory Medicine/Emergency Department	Improved alignment of future service provision (including capacity modelling) and workforce planning.	Conduct assessment of safe nurse staffing requirements against national and specified standards. Develop and implement recruitment drive to permanently fill gaps and continually fill gaps ad hoc as necessary.	X	X	X			12 Must do's (2015) 51 Should do's (2015) Kings Mill Hospital	Ensure the provision of level two critical care on Ward 43 includes nursing staffing levels in line with the 'Core Standard for Intensive Care Units' published by Intensive Care Society and the commissioners expectations. Ensure clinical leadership the emergency department is delivered at a consistently high standard 24 hours a day seven days a week.	Director of HR - Graham Briggs	DCN Victoria Bagshaw/Kate Lorenti DDHR	31/01/2016		31/07/2016	All areas by 31/01/2016. Ward 43 by 31/12/2015	G	Staffing in line with national standards	Staffing review analysis	Staffing ratios as specified by national standards	OD&W
3.5.2	Women & Children's/Emergency Department		Conduct assessment of safe medical staffing requirements against national and specified standards. Develop and implement recruitment drive to permanently fill gaps and continually fill gaps ad hoc as necessary.	X	X	X		X	56 Should do's (2015) 51 Should do's (2015) Kings Mill Hospital	Ensure that medical consultant staffing for the children's and young people's service is in line with Royal College of Paediatrics and Child Health (RCPCH) standards Ensure clinical leadership the emergency department is delivered at a consistently high standard 24 hours a day seven days a week.	Director of HR - Graham Briggs	(Richard Hind in former Divisional role)Divisional Clinical Director Midwifery and Paediatric	31/01/2016		31/07/2016	All specialities by 31/01/2016 and children's and young people by 31/12/2015	G	Staffing in line with national standards	Staffing review analysis	Staffing ratios as specified by national standards	OD&W
3.5.3	Corporate		Scope the functionality of the current ESR workforce information management system. Ensure alignment with capacity, demand and financial planning.	X	X	X					Director of HR - Graham Briggs	Workforce Information Manager	30/09/2016		31/03/2017	Scope and identify system improvements by 31/3/16 Implement improvements by 30/9/16	G	System capable of supporting demand, capacity, workforce and financial planning	ESR system spec report	N/A	OD&W
3.5.4	Women & Children's		Conduct a nursing skills audit of non-MAST clinical practice capacity. Address gaps through further training and or recruitment of staff with appropriate skills. Deploy and monitor training capability for each shift.	X	X				17 Must do's (2015)	Ensure that at least one nurse per shift in each clinical area (ward/department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support	Director of HR - Graham Briggs	Lee Radford DD TED/ Matron for each clinical area.	31/03/2016		31/03/2017	Assessment 31/12/2015 plan 31/01/2016 deployment 31/03/2016	G	Shifts staffed with appropriate skills and training	skills audit report, staffing review	completion of training in line with needs assessment	OD&W
3.6.1	Trust wide	Enhanced learning from exit interviews used to inform retention planning	Evaluate current exit interview data and process and make improvements	X	X	X					Director of HR - Graham Briggs	Deputy Director HR - Kate Lorenti	31/01/2016		30/04/2016		G	Retention plans informed by staff feedback	Regular reports on exit interviews and evidence of responses to key themes	N/A	OD&W

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4. Personalised care:																					
We do not have an embedded approach to provide Personalised Care to our patients. This has been evidenced by findings within the Care Quality Commission report (June 2015) relating to mental health, safeguarding and end of life care.																					
4.1.1	Trust wide	Adopt a patient-centred approach that involves patients in the planning, delivery and evaluation of health care.	Create nursing assessment and care planning documentation which supports health care professionals to assess and plan care in a person centred way, including monitoring hydration and nutrition, and Mental Capacity	X	X	X	X		22 Must do's (2015)	Ensure patients in the medical care wards receive person-centred care and treatment to meet their needs and reflect their personal preferences, including patients living with dementia and those with a learning disability.	Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw supported by Practice Development Matrons Alison Davidson & Denise Clay	31/01/2016		31/05/2016	Pilot commences in November 2015.	G		new documents in place	- Audit attendance of programme; - Audit of documentation	QC
	Trust wide			X	X	X	X		42 Must do's (2015)	Ensure care plans are individual and specific to the patient to ensure staff are aware how to deliver care to patients which meets their needs.	Chief Nurse - Suzanne Banks										
	Urgent & Emergency Care						X		24 Must do's (2015)	Ensure patients in the medical wards are treated with dignity and respect at all times	Chief Nurse - Suzanne Banks										
	Trust wide			X	X	X			89 Should do's (2015)	Ensure patients are offered fluids whilst in the minor injuries unit and that this is documented in their care records.	Chief Nurse - Suzanne Banks										
	Trust wide			X	X	X			167 Must do's (2014)	The trust must ensure that accurate record keeping is maintained with regard to people's observations and hydration.	Chief Nurse - Suzanne Banks										
	Trust wide			X		X			171 Must do's (2014)	The trust must ensure that all people have an effective and current care plan that meets their individual needs and provides appropriate guidance for staff to be able to meet their needs.	Chief Nurse - Suzanne Banks										
4.1.2	Trust wide		Refine 150 care plans based on the pilot core assessment and care planning documents	X	X	X	X	X			Chief Nurse - Suzanne Banks	deputy Chief Nurse - Victoria Bagshaw supported by Practice Development Matrons Alison Davidson & Denise Clay	31/07/2016		31/12/2016		G				QC
4.1.3	Trust wide		Develop and deliver a rolling programme of "Proud To Care for You" to nursing and midwifery workforce (2,300 staff)				X	X			Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw Divisional Heads of Nursing supported by Andrea Clegg	30/04/2017		30/06/2017	Programme developed and first cohort will commence 30th Nov 2015	G		- Programme developed - Registers Evaluations presentations	- Evaluation of the day; - 6/12 self-evaluation and reflection -Audit of the attendance of the programme	QC
4.1.4	Trust wide		Review the content of all existing training programmes to ensure all have taken patient-centred care into consideration (fit for purpose)	X	X		X				Chief Nurse - Suzanne Banks	Deputy Director of Training - Lee Radford & Andrea Clegg supported by the Professional Education Team & PDM	31/12/2015		31/03/2016	- scoping and agreeing of the standard	G			-Amendment to the programme and immediate evaluation by 31/01/2016; - Completion of the amendment of the training programme by 29/02/2016; - From 1 April 2016, all training programmes will have the theme of patient-centred care approach	QC
4.1.5	Trust wide		Review Communication: Threading through the "hello my name is ……… " concept in to all aspects of care Patient personal care. Preference is clearly articulated and visible to the multi disciplinary teams.	X	X		X				Chief Nurse - Suzanne Banks	Kerry Smith Practice Development Matron	31/03/2016		30/06/2016		G	This will also address reference 22 Must do's		- Update the care and comfort boards. - Structured executive walk around process implemented.	QC
4.1.6	Trust wide		Develop and implement a ward accreditation programme	X	X	X	X	X			Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw	Pilot completed by 31/03/2016		Full roll out to all inpatient wards by 30/4/2017		G			Pilot to be delivered 31/3/2016 Roll out to all wards by 30/4/2017	QC
4.2.1	Trust wide	**Mental Health** -Staff will recognise patients will mental health status on admission; - Staff will recognise an acute deterioration in patient's mental health and understand the escalation process.	Complete staff awareness training on Mental Capacity Act and re-launch one-to-one guidance	X	X	X			44 Must do's (2015)	Ensure patients mental capacity to make decisions is assessed in line with current guidance and legislation	Chief Nurse - Suzanne Banks	Jane Freezer	31/01/2016		30/05/2016		G		Prioritise hotspot and target roll out commission mental health specialist resource to deliver training programme		QC
				X	X	X			4 Must do's (2015)	Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities											
				X	X	X			29 Must do's (2015)	Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities											
4.2.2	Trust wide		Complete staff awareness training on self harm and re-launch one-to-one guidance	X	X	X			2 Must do's (2015)	Ensure staff are appropriately trained to provide the care and support needed by patients at risk of self-harm	Chief Nurse - Suzanne Banks	Sarah Addlesee; Heads of Nursing	31/01/2016		To be confirmed per CQC	Trajectory of the % of training to be delivered to frontline staff. Whilst have a commitment to support training from specialist services further gap analysis required as to the time resource they can realistically deliver and what additional resources will be required to achieve the critical mass of training required in timeline. Commission mental health specialist resource to deliver the training programme.	G		Prioritise hotspot and target roll out commission mental health specialist resource to deliver training programme		QC
				X	X	X			31 Must do's (2015)	Ensure safe care for patients with mental health conditions at the minor injuries unit and especially those who may self-harm or have suicidal intent											
				X	X	X			Section 29a												

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
4.2.3	Urgent & Emergency Care		Review and develop assessment process and documentation to include cognitive assessment for all over-75 ED attenders	X	X	X			6 Must do's (2015)	Ensure all patients over the age of 75 have a cognitive assessment when arriving in the emergency department	Chief Nurse - Suzanne Banks	Dementia Lead - Lorraine Brooks Steve Rutter	31/12/2015		30/04/2016	The Emergency Department have implemented a cognitive screen to be completed for all patients during nurse triage. The screen is based on the AMT and includes 4 questions; age, date of birth, place and year. Research suggests that the AMT4 may be useful in the initial assessment of cognition in elderly patients, with little loss of accuracy in detecting marked cognitive impairment when compared to the AMT. When the assessment has been completed this is given to the doctor to review to ensure further assessment, appropriate plans of care are in place and referrals are made to appropriate services if required (e.g. Liaison Psychiatry)	G		- National Dementia CQUIN; - Audit A&E		QC
4.2.4	Trust wide		Develop and deliver dementia training programme to ensure appropriate staff have appropriate knowledge about dementia and care requirements.	X	X	X			99 Should do's (2015)	The dementia training programme should be developed to ensure staff are suitably knowledgeable about dementia and the care that patients require.	Chief Nurse - Suzanne Banks	Dementia Lead - Lorraine Brooks Steve Rutter	29/02/2016		31/07/2016	Dementia Awareness (Tier 1) is currently delivered to all staff joining the Trust. This is delivered on the Trust's Orientation Day which all new starters attend.	G		National dementia CQUIN	-Amendment to the programme and immediate evaluation by the end of Dec 2015 - Completion of the amendment of the training programme by the end of February 2016	QC
4.2.5	Trust wide		Review policies, procedures and practices with regards to care for patients with dementia against best practice guidelines	X	X	X			43 Must do's (2015)	Ensure the care of patients living with dementia is in line with current guidance and recognised good practice	Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Sarah Addlesee	30/11/2015		30/04/2016	Relevant evidence and guidance: • Care Quality Commission (2014), Cracks in the Pathway. • Department of Health (2013), Putting Dementia on the map and driving up standards of care. • Dementia Action Alliance (2012), Right Care: A call to action to create dementia friendly hospitals. • Sherwood Forest Hospitals(2012), Dementia Strategy. • Department of Health (2009), National Dementia Strategy. • Department of Health (2009 & 2015), Prime Minister's Challenge Current practice and developments: Environment: People living with dementia are less likely to become confused and distressed in an environment designed with their needs in mind. Dementia friendly signage has been installed in key inpatient areas at the Trust. This signage is about to be installed across all wards and departments. Clocks which enable easier orientation	G		National dementia CQUIN		QC
4.2.6	Trust wide		Review of risk assessments and escalation processes within the health and safety audit programme will be undertaken for clinical environments	X	X	X					Chief Nurse - Suzanne Banks	Health & safety mgr - Rob Dabbs	31/01/2016		31/03/2016		G			Completed risk assessments undertaken and if any enhanced risks identified	QC
4.2.7	Trust wide		Detailed risk assessment of ligature points in the Minor Injuries Unit at Newark Hospital	X		X		X	104 Section 29A letter 33 Must do's (2015)	Your systems to assess, monitor, and mitigate risks to people receiving the care as inpatients and outpatients are not operated effectively. Ensure the ligature risk posed by the use of non-collapsible curtain rails in the minor injuries unit is addressed	Chief Nurse - Suzanne Banks	Director of Strategic Planning and Commercial Development - Peter Wozencroft	30/11/2015	23/11/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Following the risk assessment process collapsible (anti-ligature) curtain rails to be installed at Newark MIU on the week commencing 23/11/15. All fixed curtain rails to be replaced. Additional to Newark MIU detailed ligature point risk assessments have been completed for the following areas: Paediatric Ward 25 (6/2/15), Emergency Assessment Unit (16/10/15), Emergency Department (6/11/15) and the Maternity Ward (11/11/15). Surveys and risk assessments are planned for Clinical Decisions Unit and Surgical Assessment Unit as similar admissions and higher risk clinical areas. Meetings with departmental leaders are planned to highlight any perceived areas of vulnerability when taking account of the other aspects of the policy.	Findings and recommendations from assessments are being collated and work to be reported to Clinical Quality and Governance Committee in January 2016.	Completed assessments and appropriate actions. Issues entered on risk registers Documentation in Patients notes	QC
4.2.8	Urgent & Emergency Care		Distribute Ligature Cutting equipment across the Trust	X		X		X	Section 29a		Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Sarah Addlesee	30/11/2015	16/11/2015	To be confirmed per CQC	Completed - subject to CQC confirmation	G	'Safety knife' style Ligature cutters were added to the resuscitation trolleys, in all areas, by 1st October 2015. Guidance on the Safe Use of Ligature Cutters to support training is available on the Health and Safety microsite of the Trusts Intranet. 319 Trust staff, in higher risk areas, have been trained on the safe use of ligature cutters as of 16/11/15.	Contents list and compliance audits regarding resuscitation trolleys. Training records on OLM (electronic training record).	Part of daily checks of resus	QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
4.2.9	Urgent & Emergency Care		Awareness training to include anti-ligature measures and the use of ligature cutters.	X		X		X	Section 29a		Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Sarah Addlesee	30/11/2015		To be confirmed per CQC	Trainers have completed anti-ligature cutting trainings; Awareness training sessions which will be delivered by Nottinghamshire Healthcare colleagues to commence 20th November Mental Health services are also devising a 3hr training package which will commence in January 2016. The use of ligature cutters will be included in a face to face session on the Trust mandatory update training programme for 2016/17. The exact session and trainers to be signed off at the mandatory training planning meeting 25.11.15. The use of ligature cutters is now included in the Trust induction for all new RN/HCA/ODP/Midwives.	G	Fully trained staff who are able to identify patients who may self-harm, identify and mitigate environmental risks (including ligature, poisoning & cutting) and use relevant equipment such as ligature cutter		Documented compliance with awareness and implementation training for all staff.	QC
4.2.10	Trust wide		Develop policy for Assessment and Management of Patients at risk of Self-Harm	X		X		X	Section 29a		Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Sarah Addlesee	29/10/2015	20/11/2015	To be confirmed per CQC	Completed - subject to CQC confirmation	R	Following recommendations received from the Trust Management Board, the policy was amended and signed off by the Acting Chief Executive 16/11/15. It will be rolled out to all wards and departments by 20/11/15 and internal communication plan is in place to raise profile with all staff.	Collaborative forum will review audit outcomes and any reported Datix incidents	Policy and complementary procedure to be in place in all clinical areas. Compliance audit for all patients presenting with identifiable, i.e. coded, psychiatric disorders on a quarterly basis.	QC
4.2.11	Trust wide		Secure support from Mental Health colleagues on multi-disciplinary working group	X				X	Section 29a		Chief Nurse - Suzanne Banks	Director of Strategic Planning and Commercial Development - Peter Wozencroft	30/11/2015		To be confirmed per CQC	Working shop has been established; Support from Nottinghamshire Healthcare NHSFT colleagues on weekly working group from 08/09/15; and Support provided from Mental Health colleagues to provide joint training.	G	Specialist mental health expertise in driving improvements.	Training compliance records;	6 month review of effectiveness of mental health liaison team arrangements.	QC
4.2.12	Trust wide		Develop and implement delirium pathway	X	X	X			11 Must do's (2015)	Ensure patients in the critical care unit are routinely and properly assessed for delirium	Medical Director - Andy Haynes	Lisa Milligan	31/10/2015	31/10/2015	31/10/2016	Completed - Subject to confirmation from CQC	G	Pathway in place and audits produced	Delirium audit undertaken in October		QC
4.3.1	Trust wide	**Safeguarding** all staff will recognise children and vulnerable adults presenting in their service and staff will have the appropriate training and level of competence for their specialist areas to care for this group of patients or escalate if specialists are required.	Ensure the training programmes for safeguarding children are in accordance with 2014 Inter-Collegiate Guidance	X	X	X	X		1 Must do's (2015)	Ensure all staff receive training in safeguarding children and vulnerable adults. The training must be at an appropriate level for the role and responsibilities of individual staff	Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Joanne Waine	31/03/2016		30/09/2016		G			-Amendment to the programme and immediate evaluation by 31/01/2016; - Completion of the amendment of the training programme by 29/2/2016; - From 1 April 2016, the updated safeguarding training programmes will be rolled out.	QC
4.3.2	Trust wide		Ensure the training programmes for safeguarding adults are in accordance with [Nottingham County guidance on safeguarding]	X		X					Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Jane Freezer	31/03/2016		30/09/2016		G			-Amendment to the programme and immediate evaluation by 31/01/2016; - Completion of the amendment of the training programme by 29/2/2016; - From 1 April 2016, the updated safeguarding training programmes will be rolled out.	QC
4.3.3	Trust wide		Review the safeguarding establishment against national guideline and best practice to establish a safeguarding team	X		X		X			Chief Nurse - Suzanne Banks	Deputy Chief Nurse - Victoria Bagshaw; Interim head of safeguarding	31/12/2015		30/06/2016	External recommendations demonstrating gap in resource	G			- Identify the resource to take on the establish review by [30 November 2015]; - Complete the establish review by [31 December 2015] to identify the resource and skills gaps; - Complete business case by 31 January 2016; - Complete recruitment by [ ];	QC
4.3.4	Trust wide		Review and implement safeguarding children and adults policies	X		X		X			Chief Nurse - Suzanne Banks	Jane Freezer & Joanne Waine	31/03/2016		30/09/2016		G			- Complete reviewing the safeguarding policies by 31 December 2015; - Update the safeguarding policies by 31 March 2016; - Roll out the updated policies in the training programme from 1 April 2016.	QC
4.4.1	Trust wide	**End of life care** Based on national guidance and best practice, provide evidence-based end of life care to dying patients and support to their families.	Based on national guidance and best practice, define model of care for specialist palliative care and end of life care			X			54 Should do's (2015)	Ensure there is a review the hours of service provided by the specialist palliative care team to consider a face to face service available seven days a week	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/04/2016		30/04/2017	End of life summit has been organised by CCG on 14 December 2015	G				QC
	Trust wide			X	X	X		X	94 Should do's (2015)	Ensure there is a service level agreement for the provision of specialist palliative care to minimise the risks associated with this service being withdrawn.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/04/2016		30/04/2017	This is a high and ongoing operational and reputational risk. Limited progress has been made, the risk was registered and is in escalation. Draft business case shared with executive leads. Although completion date is April 2016 there is a risk that current improvements and contractual requirements (e.g. CQUIN) will not be met.	G			Service level agreement is agreed following the End of Life summit.	QC

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	Trust wide			X	X	X	X	X	883 Legacy QIP	Fast track and rapid discharges	Medical Director - Andy Haynes	Carolyn Bennett, Lead Nurse	30/04/2015		30/04/2016	Completed	G	Clinical Outcome will be to achieve: 1. Communication with GP/health care professional on discharge 2. Anticipatory medications prescribed 3. Care plan in place 4. Notification to CNCS 5. Do not resuscitate documentation in place Progress on this local CQUIN is on track : - Further progress will be made after the resource gap is filled	The evidence is collated through proactive audit and presented to commissioners on a quarterly basis.	measures are set out in the CQUIN	QC
4.4.2	Trust wide		Complete establishment review to identify the End of Life Care Team resource requirement and training needs	X	X	X	X	X			Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	31/12/2015		31/01/2016		G			- Complete the establishment review to identify the resource gaps by 31 December 2015	QC
4.4.3	Trust wide		Review the current trust policies regarding end of life care to ensure that they are in line with national guidance and best practice		X	X		X	Legacy QIP	**The priority has been implementing new guidance and documentation for Last Days of Life Care.** GSF: impossible to assess impact on patient care after discharged (no commissioner lead process with hospital and GPs). AMBER care bundles have had limited impact where implemented and there is a new emerging national alternative strategy: Treatment and Escalation Plan (led by RC UK). EPaCCS is part of an information sharing system	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	31/10/2014	31/10/2014	30/04/2016	Completed	G	National guidance will have been considered and reflected into local policy, guidance and practice through the Pall & EoL strategy group . New guidance and standards of documentation will have been embedded into clinical practice improving the quality of care in the last days of life. Longer term strategy with other systems of care will be agreed with local providers and commissioners. All clinical policies were up to date by June 2015 and they were at the time in keeping with national guidance. NICE and other national guidance is a standard item on the Palliative + EoL care Group agenda. There is an active engagement process with staff and monitoring through audit / governance systems. Last days of Life: We maintain current use of GSF and Amber care bundle until there is an agreed approach with local commissioners. We have been supporting current use AND (DNAR CPR) at local and are involved at regional level. We have been considering new TEP in line with anticipated national strategy.	Minutes of the meetings reflect that national guidance is considered and reflect into policy, guidance and practice. Policy and guidance. Organisational Internal system of review for policy and guidance e.g. NICE appraisals, medicines management Local and national audit data (for last days of life)	Planned Peer Review (tba) measures as set up in the national system of measurement and those agree with local commissioners e.g. CQUIN Policies and guidelines are in place to ensure implementation of End of Life Care key enablers, e.g.. AMBER care bundles, Gold Standard Frameworks in Acute Hospitals to enable staff to develop guidance for patients I their last days of life.	QC
4.4.4	Trust wide		All frontline clinical staff complete Basic Level 1 training on End of Life care.	X	X	X	X	X	13 Must do's (2015)	Ensure staff delivering end of life care receive suitable training and development	Medical Director - Andy Haynes	Carolyn Bennett, Lead Nurse	31/03/2016		30/04/2017		G		Training records to show that staff will be trained to provide care for patient with end of life in accordance with best practice		QC
4.4.5	Trust wide		Appropriate Specialist Nurses and End of life champions complete advanced training on End of Life Care	X	X				14 Must do's (2015)	Ensure all patients at the end of life receive care and treatment in line with current local and national guidance and evidence based best practice.	Medical Director - Andy Haynes	Carolyn Bennett, Lead Nurse	31/03/2016		30/04/2016	There is an annual Training Plan for end of life care. 2015-16 plan was updated to include a mandatory requirement in the Trust workbook. All doctors must attend mandatory training at induction. We are just meeting the plan to meet a minimum requirement. Gap: limited staffing in the end of life care team and SPC poses a risk of not meeting this plan	G	End of life care specialists are properly trained to have the appropriate competence in line with national guidance.	Training records show that End of life care specialists are properly trained to have the appropriate competence in line with national guidance. Evaluation of training, OLM / T&D team records of mandatory training.	Measures match with the evidence of attendance and evaluation of training. Other measures / correlation methods will be undertaken to look at a range of improvements in clinical outcomes through planned clinical audit and other quality based evaluations including investigations of incidents / serious incidents / complaints	QC
4.4.6	Trust wide		Based on the establishment review, identify and fill in the resource gaps to ensure the end of life care is effectively delivered.		X	X		X	95 Should do's (2015)	Ensure there are sufficient resources to support the end of life care team to deliver an end of life care programme and roll out end of life care initiatives throughout the trust.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/04/2016		30/04/2017	Completed	G	The end of Life team and SPC will meet at least minimum establishment to delivery high quality service, support and training and governance as set out in the business case	Team establishment / new contract	- Agreement and delivery of the business case for the end of life care team - An established team in place in accordance with national guidance. - Peer review	QC
4.4.7	Trust wide		Working with external partners, including CCG, set up an effective reporting system to enable risks, serious incidents, issues and incidents to be reported to the trust board	X	X			X	16 Must do's (2015)	Ensure risks for end of life care services are specifically identified, and effectively monitored and reviewed with appropriate action taken.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/06/2015		30/04/2016	Completed Designated Non-executive director for end of life care agreed November 2015 - Ruby Beech	G	A risk register was implemented in June 2015. Risks are entered on Datix and escalated. Incidents, patient experience etc. are reviewed monthly and acted upon where assurance has not been received. Gap: the strategy group does not receive all relevant information re: EoL care due to limitations of central reporting systems (Datix, Patient Experience).Risk Register will be embedded into the Quality governance of the Palliative and EoL care Group. Gaps on the receiving and acting on quality / performance information relating to end of life care will have been closed / reduced to an acceptable level	Evidence will be generated through the minutes of the strategy group, through analysis of performance systems especially Patient Experience / Bereavement Survey A comprehensive dashboard (including specialist palliative care and end of life care) will be developed.	Evaluation of Risk Management from Governance Support Team	QC
				X	X			X	38 Must do's (2015)	Ensure risks for end of life care services are specifically identified, and effectively monitored and reviewed with appropriate action taken.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/06/2015		30/04/2016	Completed Designated Non-executive director for end of life care agreed November 2015 - Ruby Beech	G				QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
4.4.8	Trust wide		Based on national audit tools and adopted trust tools, develop and implement the action plans to improve the 6 key patient experience outcome indicators: - Safe: recognising dying appropriately (Last Days); - Effectiveness: pain assessment tools / symptom control and anticipatory prescribing; - Training: mandatory work book achievement; attendance at induction training - Patient Experience (number and types of complaints / concerns per month; minimum response rate from CODE bereavement survey and demonstrate learning); - Responsiveness (fast track / rapid response process – currently part of CQUIN); - Equity / Access: SPC activity - contract pending	X	X				15 Must do's (2015)	Ensure the quality of the service provided by the specialist palliative care team is monitored to ensure the service is meeting the needs of patients throughout the trust.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/04/2016		30/04/2017	Commissioners have contractual obligation in current contract to monitor the activity and quality of this service provided to this Trust. SPC have provided limited information to SFH FT only at inspection, have not routinely done this before or after . Gap: there is lack of contractual lever to ensure SPC report accurate and timely clinical quality and performance data	G	There will be a contract (change to existing or new contract and or new provider) with a more detailed service specification and performance system in place to support the delivery of a high quality service	contract, service specification and performance system, audit of service provided	as set out in the requirements of the contract	QC
				X	X				37 Must do's (2015)	Ensure the quality of the service provided by the specialist palliative care team is effectively monitored and reviewed to ensure the service is meeting the needs of patients throughout the trust.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	30/04/2016		30/09/2016	Commissioners have contractual obligation in current CHP contract to monitor the activity and quality of the service provided to SFH FT. SPC have provided limited information to SFH FT at inspection. The Trust will review this after 6 months of the new expected contract / service in 2016	G	There will be a contract, service specification and performance system in place to support the delivery of a high quality service	contract, service specification and performance system	as set out in the required contract	QC
					X				55 Should do's (2015) Kings Mill Hospital	Ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	31/01/2016		30/04/2016	Terms of reference of Palliative Care and EoL Group require the monthly monitoring of performance and risks. Annual audit plan with local internal, independent (360 Assurance) and national audit participation. Gap: limited staffing in the end of life care team and SPC poses a risk of not meeting this plan. Updated KPIs are to reflected in ongoing review of Terms of Reference. Ensuring Executive support (for agreed attendance); Nomination of Non Executive Director (to champion EoL care at Board and guide Board assurance requirements) Further discussions with CCG and other providers to provide a more systematic review of deaths that this trust might have contributed to care but were not the provider at the time of death. This will include those discharge through fast track / rapid discharge and in the care of the hospice	G	Palliative Care and EoL Strategy Group will provide enhanced level of assurance information. Attendance of executive director at required meetings. Presence of Non Executive Director on Board to champion EoL care	New terms of reference to support the evidence from minutes, dashboard and assurance reports from the Palliative Care and EoL Strategy Group,.	Key Performance and Quality measures are to be reviewed and new reporting system updated as part of the planned update to trust governance systems. Safe : recognising dying appropriately (Last Days) ; Effectiveness: pain assessment tools / symptom control and anticipatory prescribing; Training: mandatory work book achievement; Patient Experience (number and types of complaints / concerns per month; minimum response rate from CODE bereavement survey and demonstrate learning); Responsiveness (fast track / rapid discharge process – currently part of CQUIN); Equity / Access: timely access to SPC (on need rather than diagnosis) measured through contract performance	QC
					X			X	96 Should do's (2015) Newark	Ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients.	Medical Director - Andy Haynes	Ben Lobo, Clinical Lead for EoLC Carolyn Bennett, Lead Nurse	31/01/2016		30/04/2016		G				QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
5. Safety culture:																					
We do not have an embedded safety culture throughout our hospitals. This has been evidenced by finding within the Care Quality Commission report (June 2015) relating to sepsis, mortality, infection prevention and control, equipment and medicines management.																					
5.1.1	Trust wide	A systematic approach to create an open culture where all staff understand the connection between what they do and how that impacts patient safety, in which staff feel empowered to learn and initiate improvements from incidents and near misses. This will follow the 7 steps outlined by the National Patient Safety Agency: 1. Build a safety culture. 2. Lead and support your staff. 3. Integrate your risk management activity.	Establish a Patient Safety Lead and supporting team to drive the programme of work (January 2016);	X				X			Medical Director - Andy Haynes	Medical Director - Andy Haynes	31/01/2016		31/01/2017		G				QC
5.1.2	Trust wide		Establish resource requirements (patient safety champions, clinician lead, full time project manager), programme structure, objectives and timelines.	X				X			Medical Director - Andy Haynes	Patient Safety Lead (to be appointed)	31/01/2016		31/03/2016	reference 1.3.1 - Check the dates	G				QC
5.1.3	Trust wide		Link with Patient Safety Collaborative (PSC) established with Board development day and intervention in ED and Maternity services.	X				X	Section 31		Medical Director - Andy Haynes	Patient Safety Lead (to be appointed)	29/02/2016		30/09/2016		G				QC
5.1.4	Trust wide		Link into leadership development programme to ensure all senior leaders have necessary knowledge and tools to support the programme.	X				X			Medical Director - Andy Haynes	Patient Safety Lead (to be appointed)	31/03/2016		30/06/2016		G				QC
5.2.1	Trust wide	**Mortality and morbidity** – bringing HSMR and other measures down to expected NHS levels;	All divisions will have a senior Clinical Governance lead with responsibility to ensure issues of concern are highlighted, escalated and acted on.	X		X		X	169 Must do's (2014) Sherwood Forest	The trust must ensure that all staffs have the competence to recognise when a person is deteriorating so appropriate care is provided.	Chief Operating Officer - Jon Scott	Lee Radford	31/01/2016		28/02/2016	Reference 1.2.2	G				QC
5.2.2	Trust wide		Key risks and performance reporting will be used in standardised monthly performance meetings between divisions and executives, where reporting on assessment of unexpected and avoidable deaths is reviewed	X				X	169 Must do's (2014) Sherwood Forest	The trust must ensure that all staffs have the competence to recognise when a person is deteriorating so appropriate care is provided.	Medical Director - Andy Haynes	K Badrinath	31/12/2016		30/06/2017	Reference 1.3.1	G				QC
5.2.3	Trust wide		Establish standardised monthly multi-professional mortality review meetings within specialties	X	X	X					Medical Director - Andy Haynes	K Badrinath	31/12/2015		31/03/2016	Meetings set up and operating - more work needed to ensure these are using standard agendas and interrogating data appropriately Badri to get confirmation from service leads that all are holding/attending mortality review meetings	G				QC
5.2.4	Trust wide		Develop electronic proforma in to which mortality review data is directly input by the reviewing clinicians	X	X	X					Medical Director - Andy Haynes	Jo Richardson	30/11/2015		31/03/2016	Proforma developed and trials underway	G				QC
5.2.5	Trust wide		Develop database (from data captured in electronic proforma referred to above) with reporting functionality to allow specialties and divisions to interrogate data independently	X	X	X					Medical Director - Andy Haynes	Jo Richardson	31/01/2016		31/03/2016		G	Regular reporting can be produced on expected vs. unexpected deaths and allow drill-down in to individual cases within specialty teams	Outputs to be filed once complete		QC
5.2.6	Trust wide		Monthly meetings will be held between service leads and coding teams to ensure data quality		X			X			Medical Director - Andy Haynes	Tony Kinsella	31/12/2015		31/03/2016		G				QC
5.2.7	Trust wide		Training and support will be provided to Service and Clinical Governance Leads to allow proactive interrogation of data.	X				X			Medical Director - Andy Haynes	Tony Kinsella	31/03/2016		31/03/2016	Programme of training between information team and clinical governance leads to be established	G				QC
5.2.8	Trust wide		"Front door" paperwork updated to ensure better capture of comorbidities	X	X						Medical Director - Andy Haynes	Jo Richardson	31/03/2015	31/03/2015	31/03/2016	Completed	G	Better capture of comorbidities allows more accurate coding which contributes to better measurement of mortality rates. Compliance with paperwork being audited weekly	Acute medicine compliance report Charleston index trajectory chart		QC
5.2.9	Trust wide		Coding team relocated to work together in the same space, closer to clinical services to allow better interaction with clinicians	X	X						Director of Strategic Planning and Commercial Development - Peter Wozencroft	Tony Kinsella	31/12/2015		31/12/2016		G				QC
5.2.10	Trust wide		Coding team being strengthened with appointment to vacant clinical coding manager post and creation of new clinical coding auditor/trainer post.	X	X						Director of Strategic Planning and Commercial Development - Peter Wozencroft	Tony Kinsella	31/12/2015		31/12/2016		G				QC
5.2.11	Urgent & Emergency Care		Establish a Task & Finish group to address immediate concerns regarding diagnosis of fractures and processes moving forward	X	X	X			49 Should do's (2015)	Ensure the process for diagnosis of fractures and how learning is analysed and shared within the emergency department reduces the impact of missed diagnosis on patients.	Chief Operating Officer - Jon Scott	Head of Service - Emergency Care	31/01/2016		30/06/2016		G		Conclusions and minutes from task & finish group		QC
5.3.1	Trust wide	**Sepsis** – reducing and maintaining death rates from sepsis to within the national expected range	Establish weekly audit for Sepsis Screening in admission areas (ED, MIU, EAU, SAU, GAU, Maternity, Paediatrics Ward 25)	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital	Ensure the sepsis care pathway is followed so that patients with sepsis are identified and treatment is delivered.	Medical Director - Andy Haynes	Paula Evans/J Garrod	31/07/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure all patients with a NEWS score of 3 or more and at least 2 SIRS criteria are screened for sepsis to enable rapid access to Sepsis 6 bundle	report on compliance %	>90% compliance by the end of September	QC
5.3.2	Trust wide		Establish weekly audit for Sepsis 6 Bundle compliance in admission areas	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Paula Evans/J Garrod	31/07/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure patients with severe sepsis are identified, Sepsis 6 bundle is deployed and appropriate escalation performed	report on compliance %	>90% compliance with IV antibiotic time <1hr the end of August >90% compliance with full bundle by the end of September	QC
5.3.3	Trust wide		Establish monthly audit for Sepsis Screening in all ward areas on all three hospital sites	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Paula Evans/J Garrod	31/01/2016		To be confirmed per CQC		G	Ensure all patients with a NEWS score of 3 or more and at least 2 SIRS criteria are screened for sepsis to enable rapid access to Sepsis 6 bundle	[report on compliance % last month?]	>90% compliance by the end of November	QC
5.3.4	Trust wide		Establish monthly audit for Sepsis 6 Bundle compliance in all ward areas on all three sites	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Paula Evans/J Garrod	31/01/2016		To be confirmed per CQC		G	Ensure patients with severe sepsis are identified, Sepsis 6 bundle is deployed and appropriate escalation performed	[report on compliance % last month?]	>90% compliance by the end of November	QC
5.3.5	Trust wide		Retrospective audit of Sepsis Screening in all admission areas for national CQUIN	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Paula Evans	31/03/2016		To be confirmed per CQC		G	Ensure sepsis screening is embedded in all admission areas. Triangulates the weekly prospective data	report on compliance %	>90% compliance by Q4 2015-1	QC
5.3.6	Trust wide		Retrospective audit of antibiotic administration in severe sepsis in all admission areas for national CQUIN	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Laura Hardy	31/03/2016		To be confirmed per CQC		G	Ensure administration of antibiotics within 1hr of recognition of sepsis to reduce mortality	report on compliance %	>90% compliance by Q4 2015-16	QC
5.3.7	Trust wide		Monthly retrospective case note review of Sepsis HSMR deaths	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Paula Evans	31/01/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Identify suboptimal care and avoidable deaths. Review Sepsis Screening and Bundle compliance. Identify ceiling of care and coding issues	HSMR measure at last complete month and average over last 3-6 months	Reduce Sepsis HSMR to 100 by Q4	QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
5.3.8	Trust wide		Monthly review of Datix reported incidents related to sepsis.	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Martin Bullock	30/09/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Review of failures of screening, Sepsis 6 Bundle compliance and themes contributing to poor sepsis care	Monthly report		QC
5.3.9	Trust wide		Monthly review of RCA reviews of cardiac arrests in septic patients	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Chris Miles	31/12/2015		To be confirmed per CQC		R	Identify issues with suboptimal care or failure to record ceilings of care	[Last monthly report?]		QC
5.3.10	Urgent & Emergency Care - Critical Care		Weekly review of ITU admissions for Sepsis Screening and Bundle compliance	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	J Garrod	30/09/2015		To be confirmed per CQC		R	Feedback to clinical teams recognising good and highlighting suboptimal performance		Zero unplanned ITU admissions with sepsis	QC
5.3.11	Trust wide		A presentation of key facts on Sepsis, screening and Sepsis 6 Bundle given to all senior clinical staff to cascade to all front line clinical staff with signed registers to acknowledge staff have received the presentation via handovers and board rounds	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest	Ensure staff receive effective and appropriate guidance and training about assessment and treatment of sepsis. The trust must ensure that all staffs have the competence to recognise when a person is deteriorating so appropriate care is provided.	Medical Director - Andy Haynes	Dr B Owens Mr R Hind Phil Bolton Liz Williamson (Divisional Teams) Michele Platt Dr J Garrod	30/09/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Reinforce importance and clinical ownership at all levels	report on compliance %	Full compliance from registers except for those on long term sick leave, maternity leave or sabbatical	QC
5.3.12	Trust wide		Sepsis presentation slides communicated to all clinical areas via Learning Boards	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	Dr J Richardson	24/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Visual reinforcement to be used for communications at ward level			QC
5.3.13	Trust wide		Teaching at induction for all new junior doctors	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	Dr J Garrod Lee Radford	05/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Raise awareness			QC
5.3.14	Trust wide		Teaching session to all doctors in F1 and F2 grades on Sepsis, Fluid Management and Acute Kidney Injury	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	J Garrod J Richardson	30/09/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Raise awareness	Survey monkey questionnaire results	Survey monkey questionnaire to test awareness	QC
5.3.15	Trust wide		Presentations to Medical Grand Round Patient Safety Briefing Joint Medical and Surgical Grand Round	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	J Garrod J Richardson	30/11/2015		To be confirmed per CQC		G	Reinforce fundamental messages and learning			QC
5.3.16	Trust wide		Sepsis presentation included in locum induction	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	Dr B Owens Mr R Hind Dr J Garrod Lee Radford	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure temporary staff are aware of sepsis protocols	Signed acceptance of induction package (held by HR)		QC
5.3.17	Trust wide		Sepsis and Fluid Management included in induction for all nurses	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	Michele Platt Paula Evans	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Raise awareness			QC
5.3.18	Trust wide		Sepsis and Fluid Management included in Student Nurse Orientation Day	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	Michele Platt	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Raise awareness			QC
5.3.19	Trust wide		Assess the number of registered nurses competent for IV cannulation and fluid bolus administration	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	M Coggan (Nurse Educator ICU) Andrea Clegg (Practice Development Lead)	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Complete gap analysis and implement a programme to increase the number of nurses able to perform these tasks which will speed access to sepsis bundle compliance	Register [maintained by HR]		QC
5.3.20	Trust wide		Sepsis update added to "Green Card" check list for Agency Nurse induction	X	X	X			s31 Sepsis Action Plan; 3 Must do's (2015) Kings Mill Hospital; 169 Must do's (2014) Sherwood Forest		Medical Director - Andy Haynes	Michele Platt	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure temporary staff are aware of sepsis protocols			QC
5.3.21	Trust wide		Appoint Project Manager for Sepsis Task Group	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital	Ensure the sepsis care pathway is followed so that patients with sepsis are identified and treatment is delivered.	Medical Director - Andy Haynes	Karen Fisher	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Oversee the work of the Task Group. Michele Platt, ITU Nurse Consultant and CCOT Lead seconded to role			QC
5.3.22	Trust wide		Establish Sepsis Champions on every ward and create	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Paula Evans	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Maintain awareness at ward level and provide educational support using the Sepsis portal on the trust intranet - support transfer of initiatives to "business as usual"			QC
5.3.23	Trust wide		Refresh Sepsis portal on trust intranet	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	J Richardson	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Include teaching video for nurses linked to a workbook, sepsis documentation and policy			QC
5.3.24	Trust wide		Create full time post for Sepsis Nurse Lead	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	S Bowler Lee Radford	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure adequate resource to develop and drive the cultural and process changes medium and long term			QC
5.3.25	Trust wide		Free Sepsis Lead Clinician for an extra 1 day a week	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Embedding - As sepsis task group completes actions across the K42:K47	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure adequate resource to establish short and medium term roll out of screening and compliance audits			QC

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5.3.26	Trust wide		Extend Critical Care Outreach (CCOT) support to give access until 02:00 on a daily basis and the development of real time VitalPac monitoring which will proactively trigger experience to deteriorating patients	X	X	X			s31 Sepsis Action Plan; 45 Must do's (2015) Mansfield Community Hospital		Medical Director - Andy Haynes	Michele Platt Liz Williamson	31/10/2015		To be confirmed per CQC		R	CCOT currently has 4.68wte providing band 7 support 07:45 to 20:45 x 7 days with additional band 6 10:00 to 18:00 x 7 days. This will be extended by 3.36wte to give additional cover and extend to 02:00. Provide maximum support to ward areas for recognition and support of deteriorating patient including severe sepsis.	Monthly report to Sepsis Task Group and bimonthly flash report from CCOT to Patient Safety Group	Reduced unplanned admission to ITU Increase CCOT calls after 20:45 50% decrease in missed Acute Response Team (ART) calls	QC
5.4.1	Trust wide	**Infection control** - meet national targets for infection control and become a leading performer within East Midlands peer trusts;	To develop outcome measures based on the 8 domains of the IPC annual plan	X	X	X	X	X		Ensuring the systems and processes are in line with current guidance and national strategy	Medical Director - Andy Haynes	Rosie Dixon/ Dr A. Kumar	31/12/2015		31/03/2016	The infection Control plan of work is underway; however there are potential risks associated with inadequate infection prevention staffing that may jeopardise timely completion	G	For the IPC programme to be successfully completed	IPC plan	Audit, surveillance, educational data. Reporting processes	QC
5.4.2	trust wide		Continue the "deep clean" programme of wards at Kings Mill	X	X	X			28 Must do's (2015) Newark Hospital	Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance	Medical Director - Andy Haynes	Rosie Dixon/ Liz Nicholas	31/08/2015		31/03/2016	Completed - Subject to confirmation from CQC	G	All wards to have deep clean annually, to a high standard. Annual programme to be in place from 31/3/16. Wards 31,24 and 36 have completed their deep clean.	Deep clean SOP and deep clean programme of ward moves.	Environmental Infection Control Audit results to be consistently above 95%	QC
5.4.3	Trust wide		Implement an infection control accreditation scheme across all wards and clinical areas to reinforce clinical ownership and earn autonomy (pilot and whole hospital roll out plan by February 2016);	X					83 Should do's (2015) Kings Mill Hospital	Ensure that staff practices on all wards including the medical care wards are in line with trust policy and current legislation regarding the prevention and control of infection	Medical Director - Andy Haynes	Rosie Dixon	31/03/2016		31/03/2019	the accreditation programme content has been devised and the use of TS+ audit tool has been implemented. to progress this further additional IPC staffing resources are required to ensure staff engagement and help fill the theory to practice gap.	G	All wards/clinical departments to be fully engaged in the infection prevention process; to have access and understanding of the evidence supporting infection prevention.	Accreditations awarded Schedule of accredited wards	To be determined by accreditation criteria	QC
5.4.4	Trust wide		Recruit additional Infection Control Nurses for effective infection control nurse:bed ratio to 1:156, to support the delivery infection prevention and control programme.	X		X					Medical Director - Andy Haynes	Rosie Dixon	31/03/2016		30/06/2016	A paper has been written and presented to the executives for approval	G	For trained IPCN's to be in post to provide support, information and education to all staff, patients and visitors within the organisation.	A paper supporting need for staff to deliver infection prevention and control programme.	closer working with staff, and patient groups, improved surveillance and audit results	QC
5.4.5	Trust wide		Introduce "Start Smart and Focus" programme to antimicrobial stewardship. Maintaining twice weekly microbiology ward rounds to all wards and multidisciplinary review of all C diff cases.	X		X					Medical Director - Andy Haynes	Monica Marriott antimicrobial pharmacist	31/03/2016		30/09/2016	The TS+ medical audits is to be evaluated as to its ease of use to help monitor and control antimicrobial prescribing engaging medical staff during the process.	G	To alter the antimicrobial audit process to fall in line with the DH antimicrobial 5 year strategy. To reduce the risks of increasing antimicrobial resistance for antimicrobial prescribing to be in line with national and international recommendations and when needed	audit results for prescribing practice	Audit results and infection rates [Is this C-diff and MRSA]	QC
5.4.6	Trust wide		Establishing a county-wide c-diff task and finish group to implement a strengthened approach to infection, prevention and control.	X					Legacy QIP		Medical Director - Andy Haynes	Rosie Dixon, Nurse Consultant IP&C	31/03/2015		31/03/2016	Completed	G	The county wide cdiff group has been meeting for 10 months and several actions have been taken. closer working between community and acute services; educational programmes to promote antimicrobial prescribing stewardship	meeting minutes, PLT event programme	more effective open dialogue	QC
5.4.7	Trust wide		All patients with a hospital acquired infection (starting with c-diff and MRSA) will have a RCA undertaken within 72 hours of diagnosis. A cause and action report submitted immediately to the Executive Team	X					Legacy QIP		Medical Director - Andy Haynes	Rosie Dixon, Nurse Consultant IP&C	31/03/2015		31/03/2016	Completed	G	The RCA's are undertaken within 72hours, initial actions identified and further reported. The executives are part of the distribution group informing people of the situation			QC
5.4.8	Trust wide		Achieve 90% compliance with hand hygiene throughout organisation through use of audits and responsive education	X	X		X		61 Should do's (2015) Kings Mill Hospital	Ensure that staff in the maternity service follow the trust hand hygiene policy	Medical Director - Andy Haynes	Rosie Dixon	31/01/2016		30/04/2016	Overall hand hygiene compliance 87%Medical staff 78%	G	For 90% of staff to be trained in good hand hygiene	training data/ audit results	audit results will identify whether theory is applied in clinical environment	QC
5.4.9	Urgent & Emergency Care - Emergency Department		Identify where new hand gel dispensers are needed in ED and arrange fitting.	X					25 Must do's (2015) Kings Mill Hospital	Ensure sufficient provision of hand gel dispensers within the emergency department	Medical Director - Andy Haynes	Richard Clarkson	30/11/2015		31/01/2016		G		Email exchange with Bbraun (supplier) - email Toni Buxton		QC
5.4.10	Trust wide		HCAI and IPPC discussion are cascaded effectively across divisions to inform practice as evidenced by changes in practice as a result of information flow	X		X			Legacy QIP		Medical Director - Andy Haynes	Rosie Dixon, Nurse Consultant IP&C	31/03/2016		30/09/2016	Attendance at divisional governance and monthly reports	G	improved processes for learning through actions	divisional governance reports and meeting minutes		QC
5.4.11	Trust wide		Establishing and implementing clear escalation procedures to the Medical Director and Nurse Director when breaches to IPC policy are repeatedly observed	X				X	Legacy QIP		Medical Director - Andy Haynes	Rosie Dixon, Nurse Consultant IP&C	30/09/2015		31/03/2016	Completed	G	reduce repeated compliance breaches of IPC processes are managed proactively with authority. All breaches of IPC, where repeated, are escalated to executive lead	email trails alerting executives to certain issues.		QC
5.4.12	Trust wide		Develop a systematic method of taking timely and appropriate specimens introduced.	X		X			Legacy QIP		Medical Director - Andy Haynes	Rosie Dixon, Nurse Consultant IP&C	31/03/2016		30/09/2016	sampling proforma introduced in April 2015, compliance varies between 70-100%	G	for all specimens to be obtained following appropriate assessment in line with policy	audit results	audit results	QC
5.5.1	Trust wide	**Medicines management** – improve compliance with procedures and policies and develop awareness of risks among front-line staff; and	Specific issue of medicines being kept outside of pharmacy-controlled areas, leading to some medicines falling out of date - identified and resolved with medicines brought back in to controlled storage areas.	X		X			19 Must do's (2015) Kings Mill Hospital	Ensure that medication is monitored, in date and fit for purpose in all clinical areas of the children's and young people's service.	Medical Director - Andy Haynes	Steve May	30/10/2015		31/01/2016	Completed	G		Pharmacy review		QC
5.5.2	Trust wide		Introduce monthly trolley checks by pharmacy team								Medical Director - Andy Haynes	Steve May	31/12/2015		31/03/2016		G				QC
5.5.3	Trust wide		Patient Group Direction policies have been updated and implemented in Newark	X					27 Must do's (2015) Newark Hospital	Ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance	Medical Director - Andy Haynes	Steve May	30/06/2015		31/01/2016	Completed - Subject to confirmation from CQC	G				QC
5.5.4	Trust wide		Medicine's management committee and medicines action group to determine procedural guidance and feed in to ward accreditation programme.	X					41 Must do's (2015) Mansfield Community Hospital	Ensure medicines are safely administered to patients in line with local policies and procedures and current legislation.	Medical Director - Andy Haynes	Steve May	01/02/2016		31/03/2019		G		See ward accreditation programme - 5.4.3		QC
5.5.5	Trust wide		Develop ward accreditation programme across all wards and clinical areas to reinforce clinical ownership and earn autonomy - medicines forms part of this and involved in development of it.	X		X		X			Medical Director - Andy Haynes	Victoria Bagshaw	01/02/2016		31/03/2019		G		See ward accreditation programme - 5.4.3		QC
5.5.6	Trust wide		Develop approach to monitoring room temperatures in medicine storage areas in Mansfield	X	X				98 Should do's (2015) Mansfield Community Hospital	The room temperature should be monitored where medications are stored.	Medical Director - Andy Haynes	Sally Marsh / Steve May	31/12/2015		31/03/2016	Thermometers have been ordered and delivered. Clarity needed around who is responsible for checking temperatures and protocol where temperatures go outside required range - then roll out approach across whole trust	G				QC
5.5.7	Trust wide		Complete monthly audit of missed/delayed doses	X	X				168 Must do's (2014) Sherwood Forest	The trust must ensure that accurate record keeping is maintained on drug administration charts so people receive the appropriate care and treatment for their needs	Medical Director - Andy Haynes	Phil Bolton, Liz Williamson - Divisional Nurses EC&M and PC&S, respectively	31/12/2015		31/03/2016		G				QC

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5.5.8	Trust wide		Establish use of electronic drug cabinets and complete quarterly ward drug-security audits to ensure drug cabinets are secure and locked.	X	X				170 Must do's (2014) Sherwood Forest	The trust must ensure that there are secure systems for storing medicines and that people are given medicines according to their prescription.	Medical Director - Andy Haynes	Steve May	31/12/2015		31/03/2016		G				QC
5.5.9	Trust wide		Put in place temperature checking sheets with both maximum and minimum recordings. Ward managers to ensure this is completed and daily review by matrons.	X	X	X			97 Should do's (2015) Mansfield Community Hospital	The temperature of the fridge check should include the daily maximum and minimum temperature.	Medical Director - Andy Haynes	Sally Marsh	31/10/2015		31/01/2016	Completed - Subject to confirmation from CQC	G		check template, review notes, and audit		QC
5.6.1	Urgent & Emergency Care - Emergency Department	**Equipment** – change behaviours to ensure medical equipment management systems are used and triggered appropriately in the hospitals.	Install Call bells in all majors cubicles in ED	X		X			5 Must do's (2015) Kings Mill Hospital, 104 Section 29A letter	Ensure all patients in the emergency department are able to summon help if they need it	Medical Director - Andy Haynes	Richard Clarkson	30/11/2015	13/11/2015	To be confirmed per CQC		G	Installation in the additional areas was completed 13/11/15.		System tested and verified as fully operational by ED clinical teams and leadership team	QC
5.6.2	Trust wide		Review the operation of the equipment library, what it is possible to deliver in current configuration and what the service requirements for the organisation are (across all sites). Business case for change to be developed.	X	X	X					Medical Director - Andy Haynes	Richard Scott	31/12/2015		30/04/2016		G	Will centralise control over equipment and consumables to ensure they are appropriately checked and serviced and available when needed.			QC
5.6.3	Women's & Children's		Include paediatric & neonatal services in monthly nursing metrics which includes monthly audit of resus equipment checks.	X	X	X			18 Must do's (2015) Kings Mill Hospital	Ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in all clinical areas in the children's and young people's service	Medical Director - Andy Haynes	Christine Miles (Resus training manager)	30/11/2015		30/11/2016		G				QC
5.6.4	Women's & Children's		Performance management system to be exercised where instances of non-compliance with equipment checks identified	X	X	X					Medical Director - Andy Haynes	Medical Director - Andy Haynes	31/12/2015		31/03/2016		G				QC
5.6.5	Urgent & Emergency Care - MIU		Process for regular checking of resus equipment and trollies in MIU to be reviewed to ensure it corresponds with trust standards	X	X	X			30 Must do's (2015) Newark Hospital	Ensure all equipment, including emergency lifesaving equipment is sufficient and safe for use in the minor injuries unit	Medical Director - Andy Haynes	Vince Hannington. Acute Care Practitioner / Deputy Department Leader MIU & UCC Newark	31/12/2015		30/06/2016	MIU has a red cardiac arrest trolley. These are in use throughout the trust and are sealed by MEMD who are responsible for stacking them. MIU staff check daily that the tamper proof seal is in place ands sign to that. Other trolleys (advanced airways and PREM) are now sealed by MEMD and subject to the same checking controls.	G				QC
5.6.6	Trust wide		Roll-out of equipped resus trolleys to ward areas checked daily by nurse in charge	X	X	X			175 Must do's (2014) Sherwood Forest	Emergency resuscitation equipment boxes must be checked and audited regularly.	Medical Director - Andy Haynes	Richard Scott	29/02/2016		31/08/2016	All new resus trollies and checklists rolled out across the whole trust. Check put in place amongst senior nurses. Resus boxes have been removed & replaced with trollies. Checked and reviewed by nurse in charge. Roll-out to Theatres due in February.	G				QC
5.6.7	Trust wide		Anywhere not utilising resus trollies to have quality assurance solution similar to that implemented with trollies	X	X	X					Medical Director - Andy Haynes	Richard Scott	29/02/2016		31/08/2016		G				QC
5.6.8	Trust wide		Refreshed trust policy on medical device management and training programme in place.	X				X	175 Must do's (2014) Sherwood Forest	Emergency resuscitation equipment boxes must be checked and audited regularly.	Medical Director - Andy Haynes	Richard Scott	30/11/2015	27/08/2015	30/11/2016	Further work to be done on defining what user responsibilities are - campaign to be developed?	G				QC
5.6.9	Trust wide		Update equipment check logs, ensure that these are reviewed by nurse in charge of shift and all approved by ward leaders on leadership rounds every 24 hours.	X	X			X	175 Must do's (2014) Sherwood Forest	Emergency resuscitation equipment boxes must be checked and audited regularly.	Medical Director - Andy Haynes	Victoria Bagshaw	30/11/2015	27/08/2015	31/12/2015		G				QC
	Women's & Children's			X	X	X			20 Must do's (2015) Kings Mill Hospital	Ensure emergency lifesaving equipment in the maternity service is checked regularly and consistently to ensure it is safe to use and properly maintained.	Medical Director - Andy Haynes	Victoria Bagshaw	30/11/2015		31/12/2015		G				QC
5.6.10	Urgent & Emergency Care - Emergency Department		All 4 defibrillators moved in to resus AED in place in minors, majors & children's & young peoples Extra 10 blood pressure & cardiac monitors in place (7 wall mounted in observable bay) Removing need to use defibrillators for cardiac monitoring Train all staff in equipment use.	X	X	X			26 Must do's (2015) Kings Mill Hospital	Ensure adequate provision of defibrillators and cardiac monitoring equipment within the emergency department	Medical Director - Andy Haynes	Richard Clarkson	30/11/2015		31/01/2016		G		Receipt/invoice can be provided (Peter Lee)		QC
5.6.11	Diagnostics & Rehabilitation		Review process for disposal of pacemaker devices removed from deceased patients	X					39 Must do's (2015) Newark Hospital	Ensure the pacemaker devices removed from deceased patients are safely and promptly disposed of.	Medical Director - Andy Haynes	Shafiq Gill	31/12/2015		31/03/2016	Pacemakers are not currently removed from deceased patients within the trust.	G				QC
5.6.12	Urgent & Emergency Care - Emergency Department / Ambulatory Care		Needs assessment of IT requirements in ED to be undertaken - where further computers needed work to be undertaken with IT to source and provide computers.		X	X			47 Should do's (2015) Kings Mill Hospital	Ensure there are sufficient computers available for staff use in the ambulatory care area of the emergency department	Medical Director - Andy Haynes	Richard Clarkson	31/12/2015		31/03/2016	4 new computers have been put in place in Majors area - under trial phase with restricted access for AMPs and consultants - may be rolled out to open up access to wider staff group. Placing computers in ambulatory area is impractical due to information governance issues, so wider computer access across the department needs to be dealt with, rather than placing computers in that specific area.	G				QC
5.6.13	Trust wide		Ensure wards have appropriate access to working kitchen facilities	X	X	X			100 Should do's (2015) Mansfield Community Hospital	The dishwasher on Oakham ward should be replaced.	Medical Director - Andy Haynes	Sally Marsh	130/1/2015	12/11/2015	31/12/2015	Completed	G	Oakham ward shares a dishwasher in a fully fitted regeneration kitchen. This has been checked and is in good working order.			QC

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6. Timely Access: **The Trust has a long history of poor performance in providing timely and effective access to its services across most service areas, including urgent, elective and cancer care.** **Emergency Care:** **- Incorrectly allocated resources and lack of compliance pathways to achieve timely access to emergency care;** **- Insufficient volumes through ambulatory pathways;** **- Undertaking assessments inside the hospital that could occur elsewhere causing delays in discharge.**																					
6.1.1	Urgent & Emergency Care - MIU	**Emergency care** - Allocation of resources in emergency pathways to match patient demand along side right-sizing resource levels.	Re-allocate emergency department resources based on seasonal demand and optimise for efficiency.	X	X	X			32 Must do's (2015) Newark Hospital	Ensure the inter-facility transfer protocol with East Midlands Ambulance Service is updated and is effective in providing safe and timely care for patients at the minor injuries unit	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/12/2015		31/03/2016		G				FC
6.1.2	Urgent & Emergency Care - Emergency Department		Implement new 'Delayed Transfer of Care' guidance so as to reduce all delays for patients			X			50 Should do's (2015) Kings Mill Hospital	Ensure the time taken for the transfer of patient care from ambulance staff to emergency department staff is improved	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/01/2016		30/06/2016		G				FC
6.1.3	Urgent & Emergency Care - Emergency Department		Implement protocols to achieve national standards regarding ambulance hand-over time			X					Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/03/2016		30/06/2016		G				FC
6.1.4	Urgent & Emergency Care - Emergency Department		Clear signage and information available and accessible in the Emergency Department			X			48 Should do's (2015) Kings Mill Hospital	Ensure there is appropriate signage and information in the emergency department and that this is available and accessible to all people using the service	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/01/2016		31/03/2016		G				FC
6.1.5	Trust wide		Fully utilise the substantive discharge lounge to increase morning discharge			X					Chief Operating Officer - Jon Scott	Divisional General Manager - Urgent and Emergency Care	30/11/2015		31/03/2016	Achieved 24% morning discharge so far	G	Discharge lounge moved and increased number of patients for discharge by 10am		Increase number of morning discharges to 35% (National High Impact Interventions)	FC
6.1.6	Surgery - Theatres		Introduce new transfer protocol to transfer patients back to the wards from theatre	X	X	X			80 Should do's (2015) Kings Mill Hospital	Ensure systems are operated effectively to reduce delays in transfer from theatre recover to the surgical wards	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/12/2015		29/02/2016		G		Transfer protocol established	Review the transfer time	FC
6.1.7	Surgery - Theatres		Establish theatre improvement plan to reduce the down time	X	X	X			81 Should do's (2015) Kings Mill Hospital	Review the use of theatres to improve flow and reduce delays between surgical cases	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	29/02/2016		30/09/2016		G	Target 15% reduction in theatre downtime			FC
6.2.1	Urgent & Emergency Care - Emergency Department	**Emergency care -** Increase numbers going through ambulatory care pathways and improvement of the efficiency of the pathways.	Initiate 'No Place like Home' on a regular cycle of focused and embed 5 changes			X					Chief Operating Officer - Jon Scott	Divisional General Manager - Urgent and Emergency Care	31/12/2015		31/03/2016		G				FC
6.2.2	Urgent & Emergency Care - Emergency Department		Join the ambulatory care network as part of wave 6.			X					Chief Operating Officer - Jon Scott	Divisional General Manager - Urgent and Emergency Care	30/09/2015		30/06/2016	Completed	G				FC
6.2.3	Urgent & Emergency Care - Emergency Department		Using the ambulatory network's toolkits for 'breaking the cycle' methodology every 8 weeks			X					Chief Operating Officer - Jon Scott	Divisional General Manager - Urgent and Emergency Care	30/09/2015		30/04/2016	Completed	G				FC
6.3.1	Urgent & Emergency Care	**Emergency care** - Move the location of the following assessments; Decision Support Tools and Health Needs Assessments, to a location outside of the hospital.	Work with commissioners as well as social care and community care providers as part of the system resilience group to re-locate the assessments to community based locations.		X	X					Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	30/09/2015		31/03/2016	Completed	G	Resource needed subject to confirmation of recurrent funding.			FC
6.4.1	Trust wide	**Planned care and Cancer care** - Development of an automated real-time patient treatment list for outpatients and use of the list to plan clinics.	Establish daily monitoring of all outpatient waits across all pathways including unreconciled, missing outcome, Appointment Slot Issues, Inter- Consultant Referrals, clinic admin rebook, and capacity on hold, Appointment slot issues, Inter Consultant Referrals, capacity on hold	X	X	X		X	103 Section 29A letter Sherwood Forest 9 Must do's (2015) Kings Mill Hospital 35 Must do's (2015) Newark Hospital 36 Must do's (2015) Newark Hospital	Ensure systems and processes are effective in identifying where quality and safety are being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to outpatient appointment issues. Ensure robust and effective governance links and oversight are established and maintained between outpatient services at Newark and Kings Mill Hospitals	Chief Operating Officer - Jon Scott	Divisional General Manager Diagnostics and Rehabilitation (DGM D&R) - Elaine Torr	31/07/2015		To be confirmed per CQC	Completed - subject to confirmation from CQC	G	KPIs established to monitor unreconciled appointments / missing outcomes, ASI list, inter-consultant referrals awaiting an appointment, overdue reviews, clinic admin re-bookings, cancelled appointment re-bookings and capacity on hold. Meetings / governance structure implemented Daly monitoring established. Demonstrable significant improvement was reviewed daily, but now formally reviewed twice weekly through the Outpatient Capacity Meeting, weekly through the RTT Steering Group and fortnightly through the Outpatient Improvement Board with upward reporting to the Trust Management Board and Quality Committee. Unreconciled appointments are being outcomes' within 15 days as planned, which is to be reduced to 10 days by end Dec 15. Overdue review list cut from 8,000 in March 15 to 2,200 patients in November 15 with none without a date waiting over 12 weeks. Ophthalmology make up half of those overdue and additional private sector capacity is now scheduled to make further improvement. ASI cut from 1,600 in September to 440 in November 15. Inter-consultant referrals reduced to 280.		100% Compliance against standards defined in Access Booking and Choice Policy	QC
6.4.2	Trust wide		Improvement in the information used to plan outpatient clinics	X	X						Chief Operating Officer - Jon Scott		31/07/2015		31/01/2016	Completed	G				QC
6.5.1	Trust wide	**Planned care and Cancer care -** Introduction of a refreshed access policy for planned care. Right-sized resource levels of administration staff, improved education of administration staff and introduction of a regular audit of compliance to the new access policy. Improvement of data quality in planned care.	Daily review of, unreconciled missing outcomes, review List, appointment slot issues, inter consultant referrals, filling the capacity on hold						Section 29a		Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/07/2015		To be confirmed per CQC	Completed - subject to confirmation from CQC	G	All Outpatient appointments to have an outcome within 15 working days by the end of September 2015 All Outpatient appointments to have an outcome within 10 working days by the end of December 2015 All Outpatient appointments to have an outcome within 5 working days by the			QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
6.5.2	Trust wide		Complete Overdue Review Patients Incident investigation			X		X	Section 29a		Chief Operating Officer - Jon Scott	D&R Divisional General Manager - Elaine Torr	30/09/2015	11/11/2015	To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure all patients have undergone review of harm in relation to the delay. Overdue Review List investigation complete and incident closure report completed. Presented to Serious Incident Group for sign-off on 13th October 15. Presented and shared with other Divisions at Clinical Quality and Governance Committee 11th November 15. Overdue review appointments monitored daily and formally reviewed now twice weekly at the Outpatients Capacity meeting		100% of patients seen by the end of September 2015. (with exceptions of patient choice)	QC
6.5.3	Trust wide		Review of OPD RTT and booking processes by Intensive Support Team					X	Section 29a		Chief Operating Officer - Jon Scott	Patient Services Manager - Rob Walker	31/07/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure notes available for patients OPD appointments escalate any missing notes. Review carried out by Peter Hyland from the IST. Recommendations incorporated in to Access Policy. Follow-on visit took place on 26th October 15 to review the Trust plans to develop a more robust PTL to support the management of RTT. Recommendations have been received and will be incorporated in to Trust plans. The implementation of this new PTL is a major change process that will likely illuminate a number of new issues. SFHFT together with Mansfield & Ashfield and Newark & Sherwood CCGs have requested a further root and branch review by the IST of Outpatient waiting list management process, procedures and compliance.		>99% Notes available for OPD appointment	QC
6.5.4	Diagnostics & Rehabilitation		Transfer Booking Team into the D&R Division and implement new structure		X			X	Section 29a		Chief Operating Officer - Jon Scott	Interim Access Booking and Choice Manager	31/03/2016		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Structure consulted on and implemented. • Interim patient administration and booking team structure developed to ensure continuity and sustainability of service provision. • New structure implemented from September 2015. • Quality impact assessment completed. • Initial plans developed to integrate KMH and Newark Hospital governance arrangements. • Booking Team funding and establishment reviewed. Case of need to be developed to further expand the team.		Establishment and budget transfer	OD&W
6.5.5	Diagnostics & Rehabilitation		Develop business case for Reception and Administration team		X			X	Section 29a		Chief Operating Officer - Jon Scott	D&R General Manager - Elaine Torr	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Ensure fit for purpose Reception and Admin Team. 27 October 2015 update: Business case developed and agreed by Finance Committee.		Business case approved	OD&W
6.5.6	Trust wide		Recruitment and training of reception and clinic prep staff		X			X	Section 29a		Chief Operating Officer - Jon Scott	Patient Services Manager - Rob Walker	31/10/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Full Recruitment to agreed Establishment. 27 • Business case developed and agreed by Finance committee. • Recruitment in progress – all posts appointed, but some HR checks still pending to confirm all start dates. . • Remodelling of reception service in progress – draft rota developed. • Induction programme and training / competency pack developed for reception		Full recruitment achieved by end November	OD&W
6.5.7	Trust wide		Implement new Saviance self check-in system including electronic reconciliation					X	Section 29a		Chief Operating Officer - Jon Scott	Patient Services Manager - Rob Walker	30/06/2016		To be confirmed per CQC	27 October 2015 update: Saviance pilot within Clinic 6 commenced October 2015.	G	• Pilot has taken place as planned in Clinic 6, but a number of technical issues are compromising its use and preventing realisation of the benefits. • High level review taken place with Saviance Managing Director, technical issues fixed and pilot to be re-launched week commencing 16th November 15. • Still expect to be in a position to evaluate benefits and develop a business case by end December 15 if the expected benefits are realised.		System in use 100% on day reconciliation for Saviance assisted clinics	QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
6.5.8	Trust wide		Develop business case for additional data quality resource advertise and recruit to the post.			X		X	Section 29a		Chief Operating Officer - Jon Scott	Interim Chief Information Officer	31/12/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Approved business case Fit for purpose Data Quality team identifying areas of concern for rectification across the organisation. • Business case developed and approved at Finance Committee. o Job description submitted for evaluation on 22nd October 15. Meeting held with HR on 26th October 15 to start recruitment. o Visit to Derby in November 15 to learn from their Data quality and RTT education experience. • Funding secured from NHS England to purchase Cymbio. When configured, this will highlight data quality concerns requiring investigation / validation in dashboard form. o Procurement underway. o Visit to Derby in November 15 to learn from their experience of implementing Cymbio.		Recruitment of additional resource by end of December 2015	OD&W
6.5.9	Trust wide		Develop and test SOP's for administrative staff including reception staff and PPC's Develop and test SOP's for Access and Booking administrative staff					X	Section 29a		Chief Operating Officer - Jon Scott	Patient Services Manager - Rob Walker	30/11/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Reinforce importance of ownership at all levels. • SOPs developed for reception staff and booking team. Developing specific 'Cue cards' o Clinic admin new appointments SOP o Patient demographics SOP o Outpatient reception and clinic prep SOP o Waiting list SOP • Developed guidance notes on some common specialty / pathway themes		Audit results of compliance against SOP's	QC
6.5.10	Trust wide		Teaching and development of an induction programme for all new administrative staff					X	Section 29a		Chief Operating Officer - Jon Scott	IT Training Co-ordinator	31/10/2015		To be confirmed per CQC	• Local induction programme and competency / training matrix developed and to be implemented for reception staff, but needs to be rolled-out across all administrative staff groups.	R	Robust Competency based Training Programme.		Training records	QC
6.5.11	Trust wide		Teaching session to all clinical staff on RTT and reconciliation					X	Section 29a		Chief Operating Officer - Jon Scott	IT Training Co-ordinator	31/10/2015		To be confirmed per CQC	• DQ training co-ordinator has run multiple training sessions for administrative and clinical staff. Sessions initially incorporated both RTT and Data Quality, but since May these have been split into separate sessions. o All appointment call centre and booking team staff have completed RTT training session. o Visiting Derby to review their experience of rolling out a RTT education programme and discuss the potential to provide additional RTT training capacity whilst capacity is increased in-house.	A	Raise awareness.		Signed training register	QC
6.5.12	Surgery		Implementation of revised Access, Choice and Booking Policy					X	Section 29a		Chief Operating Officer - Jon Scott	PC&S Divisional General Manager – Dale Travis	39/2/16		To be confirmed per CQC	• Consultation on the new Elective Access, Booking and Choice Policy has been completed, including with commissioners. o Final amendments are being made and the policy will be launched together with training for relevant staff. • An audit specification has been devised to assess compliance with the policy. o Retrospective patient notes audit will be used to highlight where non-compliance with the Access, Booking and Choice policy has occurred Note: Section 29a refers to timeline of 30 October 2015 - this referred to comissioner signoff which has been met. No implementation timeline was included - this has been set as February 2016.	G	Compliant Policy with National Standards.		Audit of compliance against Policy	QC
6.5.13	Trust wide		Ensure senior Chief Information Officer is in place to develop suite of information to support delivery and sustainability of RTT	X	X	X					Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	30/11/2016		31/01/2016	27 October 2015 update: Interim CIO appointed 26 May 2015. Substantive recruitment has commenced	G	Interim Chief Information Officer appointed		Data quality and RTT compliance audits improved	QC
6.5.14	Trust wide		Establish effective governance and performance managements arrangements for RTT targets	X	X	X					Chief Operating Officer - Jon Scott	Dale Travis Divisional General Manager PC&S	31/05/2015	31/05/2015	31/12/2015	Completed - Subject to confirmation from CQC	G	Review of structure to provide an effective operational management team. 27 October 2015 update: Weekly 18 week delivery group established incorporating representatives for all 3 clinical divisions and central support function, plus information services. ToR have been developed and agreed. The functions included: Monitoring delivery against all 3 targets and the agreed trajectory taking actions as relevant to ensure delivery and sustainability. Review of Diagnostic PTL and issues affecting 18 week RTT delivery.		An effective management of RTT	QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsive	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
6.6.1	Women's and Children's Paediatric allergy clinic	**Planned care and Cancer care -** Introduction of continuing capacity and demand planning to inform resource planning decisions.	Establish a retrospective clinical patient pathway review audit. Review of ten sets of notes per month within three separate specialities commencing with highest risk specialties	X	X	X			Section 29a		Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/01/2016		To be confirmed per CQC	Retrospective audit specification produced for RTT Non-Admitted, Admitted and Incompletes Notes audit on 10 sets each of Cardiology, Gastroenterology and Ophthalmology completed in October 15. Urology, Neurology and Respiratory to be audited in November 15.	G				FC
6.6.2	Women's & Children's		Understand the capacity requirements of Paediatric allergy clinic						58 Should do's (2015) Kings Mill Hospital. Section 29A	Ensure that the paediatric allergy clinic meets the 18 week referral to treatment target	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/10/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	1 consultant pa and 3 nursing sessions per week			FC
6.6.3	Trust wide		Using best practice from external expertise to up-skill the Trust teams on how to plan the capacity and demand planning on a continuous basis. The Trust teams will take the capacity and demand modelling forward	X	X	X					Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/12/2015		29/02/2016		G				QC
6.6.4	Trust wide		Establish a Bi- monthly Outpatient Improvement Board with review of summary level outpatient information (dashboard)			X		X	10 Must do's (2015) Kings Mill Hospital	Ensure any remedial actions taken to address outpatient appointment issues are regularly audited to give assurance improvement has taken place	Chief Operating Officer - Jon Scott	D&R Divisional General Manager - Elaine Torr	30/11/2015	16/11/2015	31/03/2016	Completed - Subject to confirmation from CQC	G	Outpatient Improvement Board established. Reviews outpatient data and patient experience fortnightly		Outpatient improvements against plan	QC
6.6.5	Trust wide		Establish data quality audit process covering outpatient (RTT & non RTT reporting, Waiting list, Inpatient and ED), Establish data quality audit process against the local access policy standards and CCG and trust defined patient pathways	X				X	Section 29a		Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/10/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Data quality points are being examined through case note audits, which started in October 15. Audits have initially focussed on RTT administration, but will expand to include compliance with the Elective Patient Access Policy. Audit reports escalated to Divisional Governance Committees with key actions overseen by the Outpatient Improvement Board. Existing information reports provide scrutiny of some specific measures, but a more comprehensive audit process is needed. The procurement of Cymbio will provide a comprehensive foundation for this. Elective Patient Access Policy consultation process completed. Pending final amendments and Committee approval prior to formal launch. The policy narrative it augmented with 'cue / flash cards' to provide staff with quick reference guides. A draft audit specification has been developed. The monthly audit programme will not include compliance with the Access Policy standards as well as RTT.	Audit report	85% accuracy rate by March 2016 rising to 95% accuracy by September 16	QC
6.6.6	Trust wide		Monthly audit of compliance against role specific SOPs for administrative staff	X		X		X	Section 29a, 53 Should do's (2015) Kings Mill Hospital	Ensure systems and processes are operated effectively to minimise delays for patients in outpatient clinics.	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/01/2016		To be confirmed per CQC	A number of SOPs have been developed for reception staff and the booking team, but these are lengthy and specific 'Cue cards' are also being developed. Clinic admin new appointments SOP Patient demographics SOP Outpatient reception and clinic prep SOP Waiting list SOP Guidance notes on a number of common, high volume administrative specialty / pathway specific themes. The audit specification is work in progress, but audit work is expected to start in January 16 as planned.	G				QC
6.6.7	Trust wide		Establish daily capacity and flow meeting Develop Dashboard of all OPD KPI's	X	X	X		X	Section 29a		Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/08/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	The daily Outpatient Capacity and Flow meeting was established and has been running for some months. It has recently been stepped down to twice weekly in response to improving performance, but nevertheless remains high profile with senior representatives in attendances. Dashboard of KPIs established and is reviewed twice weekly. Progress is shared with the RTT Steering Group, Outpatient Improvement Board, Division Management Board and other Trust Committees.			QC
6.6.8	Trust wide		Note availability tracked 24 hours in advance of clinic		X			X	52 Should do's (2015) Kings Mill Hospital 92 Should do's (2015) Newark Hospital	Ensure patient records are available when patients attend outpatient and diagnostic imaging clinic appointments	Chief Operating Officer - Jon Scott	D&R Divisional General Manager - Elaine Torr Chief Operating Officer - Jon Scott	31/10/2015		31/03/2016	Completed - Subject to confirmation from CQC	G	27 October 2015 update: Missing notes monitored daily and action plans developed for high risk areas. Daily agenda items at capacity meeting. Speciality level data to be shared with divisions.			QC
					X	X			92 Should do's (2015) Newark Hospital	Ensure patient records are available when patients attend outpatient clinic appointments.		Deputy Chief Operating Officer - Peter Watson	30/11/2015		To be confirmed per CQC						
					X	X		X	Section 29a												

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
6.6.9	Trust wide		Ensure there is a Interim Access Booking and Choice Manager in place		X			X	Section 29A		Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	30/09/2015		To be confirmed per CQC	Completed - Subject to confirmation from CQC	G	Interim manager in post – Early September 2015. • Interim Access Booking and Choice manager secured however resigned from interim post 19th October 15. • A replacement Interim Access, Booking and Choice Manager is now in post. An Interim Co-ordinator is also in post. • The Manager and Co-ordinator are both members of the Outpatient Capacity meeting. • Case of need to be developed to establish the posts permanently		Establishment	OD&W
6.6.10	Trust wide		Ensure the delivery of RTT targets is a core part of management/ performance structure	X	X	X					Chief Operating Officer - Jon Scott	Dale Travis Divisional General Manager PC&S	31/08/2015		31/12/2016	Completed	G	twice weekly actions agreed and reported to the following meeting with redial action plan if required. review all patients waiting over 12 weeks and to advise business units on actions required to facilitate timely decisions for patients. Resources need to complete support RTT back log: 10 staff for 2 months at Band 3. 1 contract coder for 3 months Band 4. 90 days for a Trainer Band 5 for waiting times management Progress to be monitored on a weekly basis towards delivery of trajectories with actions being taken to address all issues as required. Specialty action plans to be developed to underpin trajectories. Updates on performance to be reported monthly to Divisional Board and TMB. 27 October 2015 update: PTL developed at specialty and consultant level and this is being circulated to individual consultants with request to		twice weekly review meeting.	FC
6.6.11	Surgery		Endoscopy capacity and demand modelled. Review diagnostic pathways and resources to support achievement and sustainability of RTT. Implement improvements	X	X	X					Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	30/09/2015		31/12/2016	Completed	G	All diagnostic tests to be delivered with 6 weeks by month end.		99% compliance	QC
6.6.12	Trust wide		Ensure the Trust has access to and utilises Demand and Capacity Planning Tools to ensure deliverability and sustainability of RTT Targets, Contractual Activity and Annual Plan								Chief Operating Officer - Jon Scott	Divisional General Managers in all Clinical Divisions	31/05/2015		31/12/2015	Completed	G				FC
6.6.13	Trust wide		Review risks and functionality of Medway PAS (as part of review of migration)	X	X	X					Chief Operating Officer - Jon Scott	Interim Chief Information Officer	31/08/2015		29/02/2016	Completed	G				FC
6.6.14	Surgery - Trauma & Orthopaedics		Recruit new consultant Orthopaedic Surgeon	X	X	X			82 Should do's (2015) Kings Mill Hospital	Ensure the delays in orthopaedic surgery caused by limited access to a skilled periposthetic consultant are monitored and reviewed and appropriate measures put in place to mitigate risk	Chief Operating Officer - Jon Scott	Deputy Chief Operating Officer - Peter Watson	31/10/2015		30/12/2016	Completed - Subject to confirmation from CQC	G				OD&W

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
7. Mandatory training: **The Trust is unable to gain assurance that all existing staff are compliant with their mandatory training.** **The required target of 93% of all staff compliant with mandatory training is not being achieved and there is a lack of consequences for non-compliance.**																					
7.1.1	Trust wide	Define accountability for Line Managers and Deputy Directors for non-compliance and hold them to account	Every manager produces a core and role specific mandatory training compliance plan for all accountable staff and is held accountable for doing so. (4500 staff in four months) Managers oversee the implementation of the plan to ensure 100% of eligible staff are MAST compliant.					X	87 Should do's (2015) Newark Hospital 176 Must do's (2014) Sherwood Forest	Ensure all staff complete mandatory and statutory training in line with trust targets. Staff mandatory training and appraisals must be completed to meet trust targets.	Director of HR - Graham Briggs	Deputy Director for Training Education and Development - Lee Radford	31/03/2017		30/04/2018	Compliance plan is completed by 31/03/2016. 100% of eligible staff are MAST compliant by 31/03/2017	G	All staff maintain a personalised MAST compliance plan whish is reviewed and signed off at appraisal	Plans presented at Exec:Divisional Performance Management	Existence of plans	OD&W
7.1.2	Trust wide		Divisional performance management meeting monitor non-compliance against plan and seek assurance of recovery actions for any missed targets.					X			Director of HR - Graham Briggs	Executive & divisional triumvirate	30/09/2016		31/03/2017		G				OD&W
7.2.1	Trust wide	Align all remuneration increments to mandatory training compliance	Review, amend and consult as necessary the incremental pay progression policy so that it is aligned to mandatory training and appraisals compliance and make explicit range and implementation of sanctions for non compliance. Align to Appraisal and revalidation policies as necessary					X	173 Must do's (2014) Sherwood Forest	The provider must ensure mandatory training and appraisals take place to ensure all staff are appropriately trained and have up-to-date knowledge	Director of HR - Graham Briggs	Deputy Director of HR - Kate Lorenti	31/12/2015		01/04/2016		G	Policy modified	Policy record		OD&W
7.2.2	Trust wide		Agree the revised incremental pay progression policy changes with Trade Unions					X			Director of HR - Graham Briggs	Deputy Director of HR - Kate Lorenti	31/03/2016		31/03/2016		G	Agreed policy	minutes of JSPF	published policy	OD&W
7.3.1	Trust wide	Reframe and publicise the alignment of MAST to patient safety objectives and practice	Develop proposals and consult with Divisions to enhance compliance	X							Director of HR - Graham Briggs	Deputy Director for Training Education and Development - Lee Radford	30/04/2015		30/04/2016	Proposals developed and consulted upon by31/02/2016. implement new arrangements from 01/04/2015	G	increased staff awareness and commitment to compliance	revised content or emphasis of MAST training	higher rates of compliance	OD&W
7.4.1	Trust wide	Develop multi dimensional analysis reporting of MAST compliance by person/staff group/Division/site	Assess system capabilities. Modify as system permits and provide reports to performance review meetings.					X			Director of HR - Graham Briggs	Deputy Director for Training Education and Development - Lee Radford	30/04/2016		30/04/2016	System review by 31/01/2016. new reports from 01/04/2016	G	Assurance on compliance and remedial actions	Minutes of reports presented to committee	A monthly report	OD&W

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
8. Staff engagement: **The 2014 NHS Staff Survey showed that the staff engagement score for the Trust was 3.66% and below the national average of 3.74%, this had deteriorated by 0.09% since 2013.** **Of particular concern were communications between senior managers and staff, staff job satisfaction and support staff received from immediate line managers.**																					
8.1.1	Trust wide	To understand what genuine good staff engagement means to our staff	Establish a Staff Engagement working group					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	30/11/2015		31/03/2017		G	Staff engagement groups implemented. Feedback received from staff groups that is discussed at board	Agenda items from board demonstrating feedback from staff engagement groups	Improved results of staff survey for staff engagement	OD&W
8.1.2	Trust wide		Undertake a baseline survey across staff groups and across the sites via focus groups, surveys, drop in sessions, briefings, staff suggestion schemes and trade union engagement					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	31/01/2016		31/03/2017		G	Recommendations from baseline survey implemented in Staff Engagement processes	Links that demonstrate staff feedback has changed engagement in the future	Improved results of staff survey for staff engagement	OD&W
8.2.1	Trust wide	Access the effectiveness of existing staff engagement approaches	Analyse the utilisation of current communication channels, staff bulletin and intranet hits, and participation within staff groups					X			Chief Executive - Peter Herring	Interim Head of Communications - Catherine Armshaw	31/12/2015		31/03/2017	reviewing existing communication channels. Utilising IT infrastructure to evaluate consumption to shape future communication practices	G	Use intelligence from IT review to create communication infrastructure that is fit for purpose. That demonstrates two way communication and information is disseminated through management structures.	feedback from staff they have received staff bulletin.	Improved results of staff survey for staff engagement	OD&W
8.2.2	Trust wide		Undertake staff conversations across all sites to understand how engagement would improve working lives					X			Chief Executive - Peter Herring	Interim Head of Communications - Catherine Armshaw	31/12/2015		31/03/2017		G		Improved results of staff survey for staff engagement		OD&W
8.3.1	Trust wide	Utilise staff feedback to inform revision of our Staff Engagement Strategy that clearly defines responsibilities and expectations	Revise, consult and agree a Staff Engagement Strategy					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	31/03/2016		31/03/2017		G	Staff Engagement Strategy	Published Staff Engagement Strategy	development and publication of Staff Engagement Strategy	OD&W
8.4.1	Trust wide	Develop high impact staff engagement programmes and initiatives to be rolled out across the Trust to ensure a consistent approach to staff engagement and allows for evaluation	Identify high impact staff engagement interventions					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	31/03/2016		31/03/2017		G	Introduction of staff engagement programme	identification of high impact staff engagement		OD&W
8.4.2	Trust wide		Implement staff engagement interventions identified					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	31/10/2016		31/03/2017		G		new engagement interventions in action		OD&W
8.4.3	Trust wide		Improve the effectiveness of team brief across the trust					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	31/03/2016		31/03/2017		G		feedback from staff regarding Team Brief		OD&W
8.4.4	Trust wide		Develop an innovative approach to staff suggestion on how they are actioned and celebrated.					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	31/03/2016		31/03/2017		G				OD&W
8.4.5	Trust wide		Procure and implement for Staff Family & Friends test and quarterly pulse survey to enable the monitoring of improvements in staff engagement					X	894 Legacy QIP Sherwood Forest		Chief Executive - Peter Herring	Director of HR - Graham Briggs	28/02/2016		31/03/2017		G		reporting of improvement in staff engagement. Staff Family and Friends test survey in place.	Roll out of Staff Family and Friends survey & increased response rates (baseline and target to be determined)	OD&W
8.4.6	Trust wide		Evaluate long term approach to staff engagement e.g. Listening in to Action					X			Chief Executive - Peter Herring	Director of HR - Graham Briggs	30/06/2016		31/03/2017		G		reporting on staff engagement approaches.	positive feedback from staff about staff engagement models.	OD&W
8.5.1	Trust wide	Develop effective communication and engagement skills within our leadership teams.	Develop a toolkit to support managers in communicating and engaging staff					X			Chief Executive - Peter Herring	Interim Head of Communications - Catherine Armshaw	31/12/2015		31/03/2017		G	Tool kit rolled out to all managers.	attendance at awareness sessions	100% of managers are aware of the Tool Kit	OD&W

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
9 Maternity:																					
The Care Quality Commission identified a range of issues in relation to the Maternity Department and the Trust is currently unable to assure itself that it has the right staffing, escalation, handover and risk management and learning processes within the department.																					
9.1.1	Women's and Children's Maternity	Ensure that the model of care follows the best practice and is fit for purpose for the local population	Review model of care to ensure optimum multidisciplinary working within the division, across divisions and externally	X	X	X		X	75 Should do's (2015) Kings Mill Hospital	Review the protocols for how long women remain in hospital after giving birth and consider changes to improve access to the maternity service	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/11/2015		30/04/2016	Started reviewing the protocol, monitor the discharge rate on monthly,	G		- Production of the model of care review report, - Maternity improvement board meeting minutes on the model of care review; - Recommendations implemented	- patient care is improved; - Efficiency and effectiveness is improved; - Decision will be made on whether and how to deliver "a home from home environment" for giving birth;	QC
				X		X		X	72 Should do's (2015) Kings Mill Hospital	Ensure women attending the termination of pregnancy clinic are seen by a diploma level qualified counsellor.	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/12/2015		31/03/2016				Letter to the AQP to ensure that the counsellor is offer and review the hospital protocol to ensure the women have a choice of being offered to be seen by a diploma level qualified counsellor	Women will be offered to be seen diploma	QC
				X		X			71 Should do's (2015) Kings Mill Hospital	Provide a home from home environment for giving birth for women at low risk complications	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/03/2016		30/09/2016	Workshop has been planned for January 2016 with external facilitation to review and implement a Cumberlege report			Prepare a plan/proposal to provide options of home to home environment with implementation timeline	Women will be offered at the booking	QC
						X		X	79 Should do's (2015) Kings Mill Hospital	Consider the development of a maternity services liaison committee	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/11/2015		31/01/2016	There is a partnership in maternity with the focus on obtaining service users; Prepare a summary paper by 17 December 2015			Terms of reference; Meeting minutes;	Attendance of the committee;	QC
								X	69 Should do's (2015) Kings Mill Hospital	Consider appointing a designated bereavement midwife and a diabetic specialist midwife	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016		30/05/2016				Business case completed; Job vacancy advertised	Recruitment complete	QC
					X	X	X		65 Should do's (2015) Kings Mill Hospital	Ensure appropriate care and treatment pathways are developed for women using the pregnancy day care unit.	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016		30/04/2016					Review the progress policy by 31/1/2016	QC
				X	X	X		X	73 Should do's (2015) Kings Mill Hospital	Ensure there is a designated consultant to take the lead for foetal medicine and the pregnancy day care unit	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016		31/03/2016				Annual consultant job plan.		QC
				X		X			62 Should do's (2015) Kings Mill Hospital	Ensure that workforce requirements are analysed in terms of what women using the service need, rather than what midwives do	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/03/2016		30/09/2016					Review the service against the expected public report due to be published by 31 Dec 2015	QC
9.1.2	Women's and Children's - Maternity		Review the handover process to ensure a clear understanding and agreement on respective roles and responsibilities	X	X	X		X			Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/06/2015		31/01/2016	Completed	G	- Implement daily 'UNIT' handover – Obs, Gynae and neonatal teams – at 8am every day	- Detailed review of the handover process; - Documentation of the handover process	- Implement daily 'UNIT' handover – Obs, Gynae and neonatal teams – at 8am every day; -Process for daily review of staffing levels in place - Workforce plan developed and in place, including age profile, impact of new roles, demand/activity prediction; - Analysis of potential impact of MiAPP project (Perinatal Institute led)	QC
9.1.3	Women's and Children's - Maternity		Escalation processes to identify deteriorating patients in place and used as required	X		X			21 Must do's (2015) Kings Mill Hospital	Ensure staff have the appropriate competence and skills to provide the required care and treatment to women using the maternity and gynaecology service. Specifically, women who are acutely ill or who are recovering from a general or local anaesthetic.	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/07/2015		31/03/2016	Completed	G	- Audit of escalation against MEWS criteria, including communications with on-call consultants has been completed and prepared a paper for assurance - Developed a regular monthly audit of escalation processes; - Audited recent Closure in line with Current Guideline- compliant. - Produce draft Q&P dashboard using Bath template as model - Revised Observation Policy in line with Trust - Completed audit the six unit closure SIs against policy; - Escalation Policy has been updated to be in line with trust policy; including NICE red flags.	- Audit of management of maternal and foetal sepsis and update guidance as a result; - Audit of escalation against MEWs; - Updated Escalation Policy; - Revised Observation Policy; - Daily flow meeting minutes reflect that maternity activity and staffing has been incorporated into the meetings; - Audit staff knowledge and compliance with policy	- Identify 'Pregnancy Liaison' leads from key medical specialties - diabetes, respiratory, haematology - Analysis of 'near misses', rescued patients and (pattern of) CCOT calls to provide further insight within 'Trigger Review' meeting - Staff is aware of the escalation policy and know how to comply with the policy - Incorporate maternity activity and staffing into daily flow meetings - staff are aware and understand process, including need to gain Gold authorisation for re-opening at conclusion	QC
9.1.4	Women's and Children's - Maternity		Review the trust policies and guidelines to benchmark against national guidance and best practice			X	X	X	66 Should do's (2015) Kings Mill Hospital	Ensure that midwife visits to mothers with new-born babies are in line with current National Institute for Health and Care Excellence (NICE) guidance	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/12/2015		31/03/2016		G		Review the policies regarding post-natal policies	- Stillbirth rate <4.7/1000 births, - >90% midwives received emergency skills training, - 100% maternal MEWS scores escalated appropriately, - Friends and Family scores >4.5) - All Open NICE guidance are implemented	QC
9.1.5	Women's and Children's - Maternity		Work with a partner in maternity to support the development of a patient experience programme	X		X		X	67 Should do's (2015) Kings Mill Hospital	Actively seek and record women's views and preferences regarding one to one care and postnatal visits by midwives	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016		30/06/2016	- FFT feedback and feedback from complaints/concerns are included in governance meetings - Terms of reference of the patient experience programme	G		- Governance Minutes -Examples available for staff and patients to see where patient feedback has been utilised in practice - Feedback from patient	- Responsive system with changes in practice as a result of patient experience - Patient advocacy – consultants to develop as a theme for improvement	QC
9.1.6	Women's and Children's - Maternity		Develop an action plan in response to 2015 Women's' Experience of Maternity Care Survey	X		X					Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/12/2015		30/06/2016		G				QC

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
9.2.1	Women's and Children's - Maternity	Ensure that the management structure is appropriately set up to enable multidisciplinary working and swift actions to be taken to identify and mitigate risks	Create a new Family Health Division to incorporate Obstetrics, Gynaecology and Paediatrics with a new Clinical Director (Dr H Clements, Paeds) and Clinical Governance Lead (Dr C Dunkley, Paeds) to focus on the development of robust staffing, training, escalation and governance processes.		X			X			Medical Director - Andy Haynes	Interim Chief Operating Officer - Jon Scott	31/12/2015		31/03/2016	Link to 1.2.1	G		- Establishment of family health division	- Improvement on staff training, escalation and governance process	QC
9.2.2	Women's and Children's - Maternity		A development programme for the divisional leadership team will include coaching and mentoring. Buddying support has already been received from Bath and Nottingham are offering further support to establish the governance processes (November 2015);						21 Must do's (2015) Kings Mill Hospital	Ensure staff have the appropriate competence and skills to provide the required care and treatment to women using the maternity and gynaecology service. Specifically, women who are acutely ill or who are recovering from a general or local anaesthetic.	Medical Director - Andy Haynes	Lee Radford Deputy Director of HR - Graham Briggs L&D	31/03/2016		31/03/2017	- Facilitated discussion with junior doctors and midwives regarding their views of MDT working ; - Suggestions boxes installed for staff to feedback ideas, thoughts "You said; we did" approach	G		- Training records; - Build the multidisciplinary working into annual appraisal objectives - Feedback from staff	- Multi-divisions working together as one team to deliver high patient care. - individual's annual appraisal objective which include multidisciplinary working;	QC
9.2.3	Women's and Children's - Maternity		A robust HR intervention to establish clear workforce management processes for rota co-ordination and sign off, workforce planning and leadership development.	X	X			X			Medical Director - Andy Haynes	Helena Clement - CD for Women's & Children's	31/10/2015		31/03/2016	Completed	G	This action has started in October 2015	- Birth Ratio to be calculated monthly for establishment and in post position.	- Identify 'Pregnancy Liaison' leads from key medical specialties - diabetes, respiratory, haematology; '- Analysis of consultant job plans and hours – actual against plan; including Labour ward cover, use of locums; Junior medical rota analysed; - Workforce plan developed and in place, including age profile, impact of new roles, demand/activity prediction; - Process for daily review of staffing levels in place - Analysis of potential impact of MiAPP project (Perinatal Institute led)	QC
9.2.5	Women's and Children's - Maternity		Escalation processes (operation) in place and used as required	X	X				21 Must do's (2015) Kings Mill Hospital	Ensure staff have the appropriate competence and skills to provide the required care and treatment to women using the maternity and gynaecology service. Specifically, women who are acutely ill or who are recovering from a general or local anaesthetic.	Medical Director - Andy Haynes	Interim Chief Operating Officer - Jon Scott	31/07/2015	31/07/2015	31/01/2016	Completed	G	Escalation process in place from July 2015. Maternity bed stay reviewed 4 time a day. Maternity staffing level is assessed twice a day. Maternity escalation policy including escalation to hospital management.			QC
9.2.6	Women's & Children's		Work with Trust Communication team to provide maternity information leaflets in languages other than English.				X		78 Should do's (2015) Kings Mill Hospital	Ensure maternity information leaflets are easily available in languages other than English	Medical Director - Andy Haynes	Interim Head of Communications - Catherine Armshaw	31/12/2015		30/04/2016	New electronic system is being implemented to allow patient to choose whichever language they want to use	G		Trust policies on translation and interpretation are reviewed.		QC
						X	X	X	76 Should do's (2015) Kings Mill Hospital	Ensure staff in the maternity and gynaecology service understand and comply with the trust's policy regarding interpreter and translation services	Medical Director - Andy Haynes										QC
9.2.7	Women's and Children's - Maternity		Develop a business case for elective caesarean theatre list	X		X			74 Should do's (2015) Kings Mill Hospital	Ensure there are sufficient operating theatre facilities and time dedicated for planned caesarean section operations	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/03/2016		30/09/2016		G				QC
9.2.8	Women's and Children's - Maternity		See actions 5.5.1, 5.5.4 & 5.5.9	X				X	60 Should do's (2015) Kings Mill Hospital	Ensure controlled drugs are checked twice a day on the maternity ward, in line with the trust's policy	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/03/2016		31/03/2019		G				QC
9.2.9	Women's and Children's - Maternity		Information regarding pregnant women using steroid medication has been accurately recorded and reported as part of the CQUIN	X	X	X			63 Should do's (2015) Kings Mill Hospital	Ensure accurate data is collected regarding the use of steroid medication for pregnant women at risk of early labour	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/09/2015		30/04/2016	Completed - Subject to confirmation from CQC	G	This has been monitored as part of CQINS since April 2015			QC
9.3.1	Women's and Children's - Maternity	Establish clear governance processes which are part of the overall trust system and escalations	Create a Maternity Improvement Group with membership to include families, community groups and CCG with support and advice from Fiona Wise (Improvement Director) to oversee the Maternity Improvement Plan (October 2015);			X		X			Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/10/2015		31/03/2016	Completed	G	- Maternity Improvement Group has been established; - bi-weekly meeting has been scheduled to oversee the progress of the quality of maternity ward - Produced a monthly maternity services dashboard. Include rational/decision for goal/target - Shared performance reports and outputs of Bath maternity team for	-Establishment of Maternity Improvement Group; - Meeting minutes of the group meeting; - Patient complaints; -	- Strong Assurance framework	QC
9.3.2	Women's and Children's - Maternity		Incidents are shared in the Labour Ward forum to learn from the mistakes and used to better the procedures and process.			X		X			Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/04/2015		30/04/2016	Completed	G	- Newsletters to all staff has included learning; - Midwives and medical staff have attended CTG related training - Implemented a more detailed analysis of Serious Incident investigations from past 12 months – day, time, staffing, acuity	- Outcomes and feedback from patient complaints is evident in practice areas; - Annual report from Labour Ward Forum	- Review and expand opportunities for, and approaches to, shared learning for all staff; - Include "what went well/wrong" presentations in all audit and governance meetings - Use recent CTG related SI to develop a training tool for midwives and medical staff - Complete a more detailed analysis of Serious Incident investigations from past 12 months – day, time, staffing, acuity; - more active and earlier involvement of Obstetricians in all SIsWiden (early) involvement of medical specialists, especially anaesthetists, paediatricians, neonatologist; - recommendations from TF (external report from May 2015 into SIs -process and outputs) have been enacted/implemented	QC
9.3.3	Women's and Children's - Maternity		All serious incidents are appropriately reviewed and acted upon.								Medical Director - Andy Haynes	Medical Director - Andy Haynes - Andrew Haynes	31/07/2015		31/03/2016	Completed	G				QC

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9.3.4	Women's & Children's		Address the issues raised by Walker Report (to be issued)								Medical Director - Andy Haynes	Helena Clement - CD for Women's & Children's	Date to be set on release of Walker Report		Date to be set on release of Walker Report		G				QC
9.3.5	Women's and Children's - Maternity		See action 2.2.2	X		X		X	77 Should do's (2015) Kings Mill Hospital	Ensure that all identified risks in the maternity service are regularly reviewed and added to the trust risk register where appropriate	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/11/2015		29/02/2016	Completed - Subject to confirmation from CQC	G				QC
9.3.6	Women's and Children's - Maternity		Audit via incident investigation and cardiotocograph meetings	X	X	X		X	68 Should do's (2015) Kings Mill Hospital	Ensure cardiotocograph documentation follows current local and national guidance	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/12/2015		31/03/2016	Completed - Subject to confirmation from CQC	G				QC
9.3.7	Women's and Children's - Maternity		Review current information and guidance regarding patient complaint			X		X	64 Should do's (2015) Kings Mill Hospital	Ensure information and guidance about how to complain is available and accessible to patients and visitors in the maternity service	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/11/2015		31/03/2016	Completed - Subject to confirmation from CQC	G				QC
9.4.1	Women's and Children's - Maternity	Ensure that high professional standards are maintained against best practice and national guidance	Externally supported intervention with the medical consultant team to improve team functioning;								Medical Director - Andy Haynes	Helena Clement - CD for Women's & Children's	31/01/2016		30/09/2016	Patient safety collaperative will be working with a team to assess and develop patient safety.	G			This will provide assessment on an ongoing basis for the next 4 years.	QC
9.4.2	Women's and Children's - Maternity		Provide training to staff to ensure that they have the appropriate competence, skills and knowledge	X	X	X			70 Should do's (2015) Kings Mill Hospital	Ensure all staff in the maternity and gynaecology service understand their role and responsibilities regarding the Deprivation of Liberty Safeguards	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/04/2016		31/03/2017	Develop AIMS training plan for all key staff. Increase availability of AIMS training for wider group of staff Formal request to T&D for support with AIMS course training Design and deliver an updated Emergency skills training course for all grades and professions, in response to 'hot spots' Review effectiveness of CTG interpretation training and competency – all band 7s completed national training (St Georges). Adapt in-house training in line with findings	G		Training records Mitigation lead for safeguard will assist with the DOL cases in the meantime while all midwives receive DOL training	Staff have the required level of skill and competence Assurance that this is evident in practice	QC
									21 Must do's (2015) Kings Mill Hospital	Ensure staff have the appropriate competence and skills to provide the required care and treatment to women using the maternity and gynaecology service. Specifically, women who are acutely ill or who are recovering from a general or local anaesthetic.											

10. Newark:

The Care Quality Commission identified a range of issues in relation to Newark Hospital. 'Vision and strategic direction for Newark Hospital' published in July 2013 is being implemented too slowly. This is causing frustration amongst staff at Newark and the communities that Newark Hospital serves.

There is a need for Sherwood Forest Hospitals and its partners to re-focus on the different elements of service provision and re-establish a roadmap to optimising the utilisation of the facility. The offer has three components:

1. MIU/ Urgent Care Centre;
2. Ambulatory care (outpatients/diagnostics/day case surgery);
3. Beds
- one acute ward, with limited number of direct admissions but generally used as a step down facility from KMH;
- Fernwood Unit offering rehabilitation for frail older people using SFH nurses and AHPs and with medical oversight from Newark GPs.

Issues:

- 24/7 MIU/UCC with continuing ambiguity about capability to treat emergencies and critical illness, coupled with economic challenge of low utilisation overnight;
- Constrained ability for SFH to provide broad range of ambulatory care and diagnostics at both Newark and King's Mill Hospitals due to workforce limitations, imbalance of demand and choice;
- Reducing demand for 'acute' beds as the Better Together programme builds community resources.

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsive	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
10.1.1	Trust wide	To clarify and enrich the offer for local communities in the Newark area.	To establish the Newark Healthy Communities Partnership Group					X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Interim arrangements Peter Wozencroft	31/10/2015		31/12/2015	Completed	G				TB
10.1.2	Trust wide		The Newark Healthy Communities Partnership Group to focus on the development of the strategy with components of the offer from Newark Hospital, together with other elements of health and social care, in the Newark and Sherwood area and clarify and develop proposals for future provision					X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Peter Wozencroft	30/06/2016		31/03/2017	SFH representation established at Newark Healthy Communities Partnership to engage with local partners about the future service delivery at Newark A paper to board to present the options with the support of the CCG. Complete an interim report to present the progress on the Objective for March 2016	G	Newark offer discussed, challenged and agreed by local partners	Agenda items within partnership meetings	joint communications from SFH and Newark partners around future delivery of Newark services	TB
10.1.3	Urgent & Emergency Care		Greater engagement of community and primary care providers in integrated care provision, so that MIU/UCC is clearly part of enhanced primary care offer.					X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Amanda Robson	30/06/2016		31/03/2017	At the meeting in November 2015 with the Newark Healthy Communities Partnership, the group agreed that January 2016 will be the deadline for the clinical discussions regarding service delivery model	G	To develop a strategic plan to integrate MIU/UCC and beds are part of the primary care offer	Strategic plan developed. Presented to local stakeholders		TB
10.1.4	Urgent & Emergency Care		Greater engagement of community and primary care providers in integrated care provision, so that Newark bed capacity is clearly part of enhanced primary/community offer.		X	X					Director of Strategic Planning and Commercial Development - Peter Wozencroft	Amanda Robson as an interim until DGM for the Medical Division	30/06/2016		31/03/2017		G	Formal re-designation of beds as part of the intermediate care offer.			TB
10.1.5	Trust wide		Focus from SFH on optimising the ambulatory care offer and balancing this between Newark and KMH, together with a joint CCG/SFH focus on enabling local people to access local services;					X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Rob Walker	30/06/2016		31/03/2017	Linking into the Newark Healthy Communities Partnership Group to develop a Baseline assessment and describe what ambulatory care services we currently provide in Newark. Collate any plans / actions that already exist that benefit services in Newark	G	Full integration of KMH and Newark governance and booking arrangements to improve access for people of Newark. Better session and in-session utilisation and growth in outpatient, day case and diagnostic volumes.	Quality Impact Assessment for Outpatient Action plan		TB
10.1.6	Trust wide		In the event that excess capacity is identified, that cannot be utilised by SFH, engagement will take place with other providers to enrich the offer from Newark Hospital, either via existing partnerships or procurement.					X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Peter Wozencroft	30/06/2016		31/03/2017	utilising existing link with the Newark Healthier Communities Partnership Group to own a standard agenda item to facilitate conversations about the delivery and procurement of services to be delivered from Newark	G	Engagement with Commissioning colleagues to deliver the future procurement of services to be delivered from Newark	Minutes evidencing discussions around procurement of services to be delivered from Newark	a DoS demonstrating the range of services delivered from Newark	TB
10.2.1	Trust wide	Given the challenge in activities faced in Newark, sufficient leadership is required to support these developments within Newark Hospital	Strengthened local site management at Newark Hospital linking with enhanced divisional/service line leadership teams to execute strategy more effectively					X	84 Should do's (2015) Newark Hospital	The trust should ensure effective communication between senior management and staff at Newark Hospital, engaging them in discussions regarding the future of Newark Hospital.	Director of Strategic Planning and Commercial Development - Peter Wozencroft	Chief Operating Officer - Jon Scott	29/02/2016		29/02/2016	Senior Cover two days a week	G	Greater engagement of staff in delivery of embedded services at Newark	Staff Survey		TB
10.3.1	Trust wide	A refreshed strategy, supported and developed by the Trust, its commissioners, staff, patients and the local community.	Publication and staff engagement of the key themes, of the revised strategy					X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Chief Operating Officer - Jon Scott	30/06/2016		31/09/2016	To utilise different communication models, Newsletters, staff engagement sessions, with evaluation points to ensure communication is effective and links to staff engagement strategy	G	Linking to Staff Engagement, clear lines of communication from board to ward and ward to board, communicating the decision making frameworks used and the stakeholder engagement process about the delivery of services from Newark site	utilisation of different communication models, to engage staff in the development of Newark services. Follow up evaluation of communication models to ensure effective communication		TB
10.3.2	Trust wide		Following publication of the Strategy the Trust will develop a plan of implementation, with clear milestones with accountability	X	X	X		X			Director of Strategic Planning and Commercial Development - Peter Wozencroft	Chief Operating Officer - Jon Scott	31/07/2016		31/09/2016		G				TB
10.4.1	Surgery - Theatres	Improved Theatre Utilisation across SFH estates	As part of the capacity planning process ensure appropriate usage of Newark theatres.		X			X	93 Should do's (2015) Newark Hospital	Increased use of the theatres at Newark Hospital should be considered to improve service provision and patient outcomes.	Chief Operating Officer - Jon Scott	Rob Walker	31/01/2016		30/09/2016	Following contracting arrangements, Fully embedded following Q2 information about utilisation	G	Increasing activity levels and utilisation of sessions	Increasing activity levels and utilisation of sessions	1. Review at contract closure. 2. Review at end of Q1.	TB
10.X	Urgent & Emergency Care - MIU	CQC recommendations link from Newark to other Objectives in the QIP (Referenced in Actions)	link to: Safety (5.1)	X	X	X			34 Must do's (2015) Newark Hospital	Ensure there are effectively operated systems to assess, monitor and improve the quality and safety of the services provided in the minor injuries unit	Medical Director - Andy Haynes	Patient Safety Lead (to be appointed)	31/03/2016		30/06/2016		G				QC
	Urgent & Emergency Care - MIU		link to: Mandatory Training (7.1.1)	X	X	X			88 Should do's (2015) Newark Hospital	Ensure staff within the minor injuries unit are able to attend relevant training sessions, including when training is delivered at King's Mill Hospital	Director of HR - Graham Briggs	Deputy Director for Training Education and Development - Lee Radford	31/03/2017		30/04/2018	Compliance plan is completed by 31/03/2016. 100% of eligible staff are MAST compliant by 31/03/2017	G	All staff maintain a personalised MAST compliance plan whish is reviewed and signed off at appraisal	Plans presented at Exec:Divisional Performance Management	Existence of plans	OD&W

Reference	Department/ Service	Objective	Action	Safe	Effective	Responsiv	Care	Well-Led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of planned action	Date Action Completed	Date Action Embedded	Progress (including identified resource gaps)	BRAG Rating	Outcome	Evidence	Measure	Governance and Reporting
	Urgent & Emergency Care - MIU		link to: Governance (2.1.10)	X	X	X			90 Should do's (2015) Newark Hospital	Ensure the minor injuries unit meets the College of Emergency Medicine Clinical Standards for Emergency Departments guidelines and the College of Emergency Medicine minimum requirements for Unscheduled Care Facilities	Medical Director - Andy Haynes	Colin Dunkley	31/03/2016		30/09/2016	Admin support needed to kick off getting review of past-review date documents. Overlap with 2.1.10 to be monitored.	G				QC