Sherwood Forest Hospitals NHS
NHS Foundation Trust

Plan Name	Improvement Plan
Executive Sponsor	Susan Bowler
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Trust Board	Jul-15

Key:

High level Actions - to be published
CQC Specific recommendation or Keogh outstanding action
Granular actions required to deliver

Overall Timescales at Risk

Colour	Meaning
Blue	Action fully implemented
Red	No progress made or progress is not expected to be made due to barriers
Amber	Progress being made towards completion of the action or overdue on completion date
Green	Action on track to complete in line with the completion date
Lilac	Action not due to commence
White	Action / BRAG to be determined

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
DOMAIN – WELL LED													
Well Led	Hospital Inspection & Keogh	Leadership	Trust wide	1	Recruitment and retention of a credible and competent Board of Directors equipped with the skills to deliver the strategic priorities of the Trust	Chairman & Chief Executive	Chairman & Chief Executive	01/09/2014	31/03/2015	A credible and competent board in place with the necessary skills to competently deliver the strategic priorities as outlined within the Strategic Plan	Board Review and Development Programme commissioned September 2014. Individual and team coaching commissioned for all Executive Team members September 2014. Appropriately experienced and competent interim Chief Financial Officer – post offered December 2014		A
	SMART action plan	Board Development	Trust wide	1.2	Ensure effective personal development process is in place for all board members.	Chairman & Chief Executive	Chairman & Chief Executive	01/04/2014	31/03/2015	All board members have received an appraisal and personal development review and are clear of their priorities and development needs.	Chair and NED appraisal process agreed and implemented. Chief Executive and ED appraisal process agreed and implementation is on going. **27.01.15 update:** Chair and NED appraisals completed. Chair's objectives agreed at Council of Governors. CEO drafted objectives but not yet agreed. **03.03.15 updated:** CEO objectives agreed. Training completed as planned for Executives for Gold on-call duties. MBTI completed and discussed by Executive Team. **April 2015 update:** Chairman to reflect interim CEO's objectives. Board members continue with development. **June 2015 update:** Team development sections are continuing to develop the Board.	Completed appraisal documentation. Reports to COF and Remuneration and Nominations Committee	G
	SMART action plan			1.4.2	Appointment of a substantive Chief Operating Officer:	Chief Executive	Chief Executive	Dec-14	31/03.2015	Appropriately skilled and competent substantive COO appointed	**05.02.15 update:**Interim Director of Operations has participated in the team developing sessions. Chief Operating Officer job description has been written in draft and to be agreed. **03.03.15** - The Leadship Academy have been commissioned to work with us to recruit to the COO, and have taken a briefing from the Trust and are developing a recruitment timeline. Director of HR and CEO met with Leadership Academy 2 March 2015. Interim arrangements remain in place. **April 2015 update:** Interim arrangements remain in place, and are likily to be extended. **May 2015 update:** Interim arrangements remain in place. **June 2014 update:** Interim arrangements remain in place, working with recruitment company to substantitive recruit to this post.	Job description Offer Letter	A
	SMART action plan			1.4.4	Appointment of a Recovery Director	Turnaround director	Turnaround Director	Mar-15	31/03/2015	Appropriately skilled and competent Delivery Director	**03.03.15:** Interviews for Interim Delivery Director to take place this week. **March 2015 update:** Offer made, following interviews, awaiting outcome. **April 2015 update:** Interviews taken place, awaiting outcome. **May 2015 update:** Helen Flear (Interim Recovery Director) has commenced. **June 2015 update:** Interim arrangements remain in place.	Email confirmation	A
	SMART action plan			1.4.5	Appointment of a Programme Director	Turnaround director	Turnaround Director	Mar-15	31/03/2015	Appropriately skilled and completed Programme Director	**03.03.15 -** Interview for Interim Programme Director to take place this week. **March 2015 update:** Offer made, following interviews, awaiting outcome. **April 2015 update:** Interviews taken place, awaiting outcome. **May 2015 update:** Adrian Ennis (interim) has commenced. **June 2015 update:** Interim arrangements remains in place.	Email confirmation	A

		Newark	Newark	1.7.1	Establish, develop and implement plans to increase utilisation of current capacity and increase service offer to Newark and Sherwood patients place this second to last in this section	Director for Newark Hospital	Assistant of Director of Operations	01/07/2014	30/03/2015	Ensure all services at Newark are efficient and appropriately utilised to create a vibrant and thriving local hospital.	A Transformation Programme is in place and a programme of work is in place for delivery over the next 6 months. To support this, a communication strategy has been developed including a series of planned staff forums, along with presentations to other stakeholders on the plans for Newark. A listening event led by the Chief Executive is to be held in November 2014. Recent appointment of Jacqueline Totterdill as Director of Newark **23 February 2015 update:** Internal plan in place which is being monitored by the Hospital Manager, with individuals. Work is ongoing with the preparation for communication. Transformation programme around the increase in capacity. Weekly project meetings and monthly programme board. Comms cell on the wall in the corridor for all stakeholders to see at any time. **March 2015 updates:** Weekly whole hospital comms cell in place, with workstreams in place to implement plans to increase activity and transform services across elective care, urgent care and diagnostics. Additional theatre lists have been planned for Newark to increase utilisation of empty theatre slots, along with the development of services not currently available, for example, a business case for delivery of a DEXA service. A choose Newark Hospital campaign has been establlished to increase awareness of the Newark service offer, educate patients and GPs about what services are available and to increase the market share in Newark. **April 2015 update:** Newark Hospital has a Twitter account @ChooseNewark - in order to keep up to date with all the latest news and events from Newark Hospital. **May 2015 update:** Ongoing promotion through the Choose Newark Campaign, with Newark Hospital staff actively engaged. RAG rating reassessed - GREEN **July 2015 Update:** Increase of theatre sessions by 5 per week, introduction of breast surgery, introduction of LA injection theatre list, increase in urology surgery, increase in pain theatre sessions Introduction of an OCT ophthalmology outpatient service Streamlining of medical daycase services, with the introduction of infliximab daycase service. Increase in discharges from medical inpatients, along with increased utilisation Choose Newark campaign continues with presentations to parish councils and information stands and meet the team at events such as the Nottinghamshire county show.	Theatre schedules Activity Plans and outturn. Planned staff forum. Communication plan Presentations.	G
		IT	Trust wide	1.8	IT Hardware and functions fit for sustainable purpose	Executive Medical Director	Trust IT Lead	01/03/2014	On going	Systems accommodate and responsive to clinical requests / need	PC replacement programme over 3yrs to maintain all hardware below 7yrs with adequate memory Wi-Fi upgrade completed. Systems performance monitoring, along with an ICE results reporting review has produced greater IT system stability. Phased upgrade for these clinical systems in Q.4-14/15 FY. Urgent results protocol agreed with laboratories Phase 2 Medway PAS implementation focused on nursing and medical documentation. Bid to technology fund for E Prescribing; interview in September 2014. Awaiting outcome but if successful planned implementation in Mar 2015 **26.01.15 update:** E-prescibing waits treasury outcome. David Linacre met with Steve Foley to have guidelines for Medway PAS. David Linacre attended the Medical Managers (13.01.,15) to discuss PAS phase 2; PC rollout; Floor walking technicians; and NHIS meeting the Trust's requirements. **02.02.15 update:** desktop PC replacement project is slightly off target, with completion now expected in April. It is proposed to concentrate the available budget on updating and replacing laptops to complete the Windows 7 upgrade programme. Work has been undertaken to stabilise the ORION system, further work to upgrade the servers to improve performance and realience will be completed by the end of March.	Floor walking technicians in clinical areas to deal with live issues. Activity logged. Regular Wi-Fi system testing Monitored via reporting at BI and IT ctte. Protocol ratified via Division. Monitored via ICR Board. Monitored via BI and IT ctte.	A

											Planning for phase 2 of the Medway PAS implementation of off-target due to work necessary to stabilise the core system implementation. It is expected that work on phase 2 will be largely a 2015/16 project, with the main focus being on improving and further developing the integration of PAS with other systems internally and externally and the implementation of portal technology, to safely and appropriately share electronic patient records more effectively between SFH, GP's and other organisations. **March 2015 update:** Completion of the desktop PC upgrades/ replacement project (Windows 7)) is expected in April 2015. The 'infrastructure' element of the IM&T capital programme for 2015/16 will focus on updating and replacing laptops to complete the Windows 7 upgrade programme and maintaining serviceable desktop PCs in clinical areas. Work has been undertaken to establish the ORION system, System stability and performances continues to be closely monitored. **July 2015 Update:** The Head of IT is currently working with NHIS and Finance colleagues to establish the plan and priorities and associated funding to complete the desktop PC refresh and Windows 7 upgrades commenced in 2014/15 and to implement a similar programme of work for the Trust's fleet of laptops. It is expected that most of the work will be completed by the end of the year, with clinical areas and clinical users being prioritised for early attention.		
Well led	Hospital Inspection & Keogh	Values led Culture	Trust wide	2	Our culture is focused on delivering 'Quality for All' and staff feel valued and empowered to do an excellent job and proud to work for our trust.	Executive Director of Human Resources	Executive Director of Human Resources	01/07/2014	On going	Improved staff experience and improved patient experience and care.	Listening events have led to the development of our Quality for All Values and behaviours. Staff briefings for more than 1,200 staff completed. Workshop – Leading for Values completed. Team conversation exercise completed. Ongoing progress in @quality for All' by development.		G
		Values Led Culture	Trust wide	2.1	Procure and implement arrangements for Staff Family and Friends test and quarterly pulse surveys to enable the monitoring of improvements in staff engagement	Executive Director of Human Resources	Deputy Director of Human Resources	01/04/2014	30/11/2014 **Revised** 31./03/2015	A baseline of staff engagement completed which will inform actions going forward.	Procurement exercise initiated. **November** - Procurement exercise reinitiated as OJU limits exceeded in first round of tendering. Internal mechanisms being utilised to undertake surveys in house in the short term. **Update 16.12.14** System in place for final quarter robust procurement plan in place for next year. **7 January 2015:** Internal processes in place for staff Friends & Family Test Q4 **April 2015 update:** Completed Q4 pulse test as planned. Need to link together the staff and patient FFT in the procurement exercise. **May 2015 update:** No changes to report. Awaiting the procurement exercise for a joint staff and patient FFT. **June 2015 update:** Awaiting procurement exercise for a joint FFT. **July 2015 Update:** Remain awaiting joint procurement excercise.	Staff FFT Survey outcomes.	A
		Values Led Culture	Trust wide	2.6	Work with the National Advisory Group for Cultural Alignment to gain expert guidance and support in assessing and supporting our journey of cultural shift	Executive Director of Nursing	Executive Director of Nursing, Executive Director of Human Resources	30/06/2014	01//06/15	The Trust influences national learning and sharing on cultural shift, whilst utilising expert knowledge and tools to assess our own journey	The Trust was successful in its application to work with key organisations and individuals (National Advisory Group for Cultural Alignment, Kent & Medway NHS and Social Care Partnership and the Christie NHS Foundation Trust) to assess its cultural shift. **February 2015 update:** Decision has been made to undertake a cultural assessment as part of the Kings Fund. This is being tested in other organisations, and will be applied in Q1 2015/16. **March 2015 update:** Kings Fund cultural assessment will take place in March / April 2015, and the feedback will be in June / July 2015. Director of Nursing continues to particpate in the RCN Cultural Alignment Group. **April 2015 update:** Awaiting feedback in June/July. **May 2015 update:** No changes to report, awaiting feedback in July. **June 2015 update:** No changes to report, awaiting feedback in July 2015.	National Advisory Group for Cultural Alignment Report. Application form.	G

		Values Led Culture	Trust wide	2.7	Undertake an assessment of our current organisational culture to explore how the findings can be reflected within our programmes for change (e.g. Quality for All, Transformation)	Executive Director of Human Resources/ Executive Director of Nursing	Executive Director of Nursing	01/10/2014	31/01/2015 **Revised:** 30.06.15	A Trust wide cultural assessment is undertaken in which to develop individual responses	The Trust is working with the National Advisory Group for Cultural Alignment to identify a tool to undertake a trust wide cultural assessment, which triangulates with other information the Trust has acquired over the last 3 months like 'In Our Shoes', Medical Engagement Survey and Staff F&F's. Currently in conversation with a number of universities and companies who assist with cultural assessment. Also exploring QUASER work with Foresight and the possibility of being a pilot site in Naomi Fulop's research to look at the readiness for quality improvement and the impact of interventions . **Update 15.1.15** - The Trust has agreed to utilise the King's Fund Cultural Assessment Tool **26.01.15 update:** This tool will be available in Q1 2015/16 **March 2015 update:** Awaiting the King's Fund Cultural assessment in April 2015. **April 2015 update:** Awaiting feedback in June/ July. **May 2015 update:** No changes to report, awaiting feedback in July. **June 2015 update:** As above.		G
Well Led	Hospital Inspection	Leadership	Trust wide	3	Implement our leadership strategy with appropriate focus at divisional and service lines to support our leaders to deliver the strategic objectives	Executive Director of Human Resources	Executive Director of Human Resources	Jun-14	31/03/2015	Divisional and service line structures in place with clarity of roles and responsibilities. Leaders with the capability to deliver the strategic priorities.	Leadership Strategy currently being developed (final draft by 31 January 2015). Workshop completed and action plan developed to improve organizational effectiveness. Leadership development programmes evaluated and recommissioned.		G
		Leadership	Trust wide	3.1.1	Medical Engagement Programme Developed and Implemented.	Executive Medical Director	Executive Medical Director	Jun-14	On going	Medical staff effectively involved in Trust activities and live by Trust Quality for All values	MES survey completed In Your Shores event held Engagement Event completed with Juniors and Consultants Programme designed with external consultants. **Updates 09.12.14** Rolling programme for MD to attend team meetings. MD to attend divisional meetings. Programme of weekly informal suppers with Consultants commenced in November. Medical Engagement Group formed with NED's, MD and consultants to explore mentoring and buddying. All newly appointed consultants meet MD at 12 weeks. Informal suppers for new consultants to meet colleagues. All new consultants to have a mentor within their own service. Monthly meeting for HoS, MD, ND and OD starting in 2015. Quarterly clinical forum for all consultants with Exec team in 2015. All Board members to spend time with a consultant in 2015. Consultant induction course, HoS training course and leadership courses in discussion with TED. **26.01.15 update:** Medical leadership Programme commences 20.02.15. April Strategy attending Medical Manager's meeting 27.01.15 for half day time out. **February 2015 update:** Service Line management is being taken forward through annual planning process for 2015/16 supported by the Head of Strategic Planning. Leadership and management training needs analysis has been completed in January 2015. **March 2015 update:** The Medical Engagement Scale (MES) was undertaken in July 2014. It demonstrated that we had average The MES responds slowly to change and it is not recommended to repeat this at least for 12 - 18 months. However, a new tool has been developed mini-MES for this purpose which can help with regular checks. The tool is currently being run and the Trust will be one of the first to undertake this in the UK. On 4 March 2015 there will be a presentation from HM Coroner to the Grand Round on record keeping. **April 2015 update:** The mini-MES results overall demonstrated a slight improvement. We continue to make progress but we are aware that further work is required. **May 2015 update:** A provisional medical leadership programme has been agreed with Peter Lees, which is underpinned by the Faculty of Medical Leadership and Management Standards of Medical Leadership for the Royal Colleges and based on a leadership model developed by Steve Radcliffe. The programme will be delivered by faculty members of the NHS Leadership Academy, the first module is due to commence in July 2015. **June 2015 update:** First medical leadership programme to commence in July 2015. **July 2015 Update:** Held Clinical Senate on 5th June & Clinical Assembly on the 10th June with 120 medics in attendance. Positive feedback received and regular meetings scheduled for the rest of 2015/16 to discuss and communicate strategic directions.	Email confirming Medical Engagement Strategy- copy of Strategy Medical Engagement Group with NED – papers Diary evidence of MD meeting new Consultants Diary evidence of HoS, MD meeting monthly Diary evidence of all Board members spending time with consultants Dates for quarterly clinical forums First three Medical Matters Bulletins MES survey results In Your Shoes event dates Engagement event dates Registers of all events Diary evidence of MD attending team meetings and divisional meeting Consultant induction course	A

	SMART action plan	Leadership	Trustwide	3.1.2	Proactively plan a schedule of medical contributions to the Trust Board meetings	Director of Corporate Services & Director of Strategic Planning and Commercial Development	Director of Corporate Services & Director of Strategic Planning and Commercial Development			Medical staff value opportunity to tangibly influenc strategy development as evidence by % attendance at Board sessions and improvement in engagement.	**30.01.15 (from SMART action plan) -** Medical Consultants attended the private session of Trust Board 29.01.14 to support strategy workshop. The Cancer Lead and Clinical Director for EC&M were 2 of the attendees. **March 2015 update:** The 3rd wave Trust Leadership Programme commenced with 15 clinicans enrolled on a 12 month programme. The CEO and the Medical Director launched the event and will re-attend on 9 March to discuss strategic objectives. **May 2015 update:** Leadership Programme is in development facilitated by the Leadership Academy. **July 2015 Update:** First 3 sessions on the Medical Leadership Programme held on the 10th, 21st, 22nd July with the aim of developing a group of senior clinicians focussed and capable to deliver a clinically led organisation.		A
		Leadership	Trust wide	3.2	Leadership Strategy and action plan developed and implemented	Executive Director of Human Resources	Executive Director of Human Resources	01/09/2014	30/11/14 **Revised** 31/12/14 **Revised** 31/05/2015	Strategy developed and implemented and leadership and management development programmes aligned to the strategy.	Leadership Strategy in draft form. Conversation with Kings Fund on 04.11.14 (KF and AH) to discuss Collective Leadership Programme. **November** Senior HR Leaders development workshop has been completed (6/11) to map existing strategies into a Leadership Strategy and identify gaps. Draft strategy currently being developed. **Update 16.12.14** Senior HR Leaders Development Workshop was completed on 6th November 2014 to map existing strategies across to a leadership strategy and identify gaps, strategy is in draft form. Revised completion date for draft strategy is 31st December 2014. **7 January 2015:** Draft strategy written. Completed and consulted by 31 March 2015. **March 2015 updates:** Continues to be developed. **April 2015 updates:** Continues to be developed. **May 2015 update:** Presented at Executive Team Meeting 18 May 2015. **June 2015 update:** This is now to be developed and monitored through the OD & Workforce committee **July 2015 Update:** Strategy developed and presented to OD and Workforce committee. Action plan to deliver strategy being developed - monitored by OD& Workforce Committee. LR has had discussions with AH to discuss collective leadership programmes. AH to discuss with Exec team and Board to secure support.	Published Leadership Strategy Collective Leadership Programme	A
		Leadership	Trust wide	3.3	Undertake capability review of middle managers and implement required improvement actions	Executive Director of Human Resources	Deputy Director – Training and Development	01/08/2014	28/02/2015 - TNA completed Focus Group 31/03/2015	Leadership and management training needs analysis completed that assess the leadership and management training capabilities and skills of managers to then inform the required development programmes that we need to put in place.	**26.01.15 update**:Focus group to take place to understand what it feels like to be a middle manager and what issues they are faced with. **February 2015:** Middle and senior managers focus groups have been established for March and April 2015 to sense check the training needs analysis and to explore leadership development themes emerging from staff exit interviews. Feedback to the OD & Workforce Committee will be given in April / May 2015. **March 2015 update:** Focus groups are established for late March and into April 2015. Training Needs Analysis completed **April 2015 update:** Training Needs Analysis was presented to the Workforce & OD Committee in April 2015. Managers focus groups took place in March and a further one is scheduled for April. **June 2015 update:** Continues to be monitored through the OD & Workforce Committee **July 2015 Update:** TNA has been completed from focus groups. A List of Masterclasses is being developed in response.	Evidence of focus groups	G
		Medical Leadership	Trustwide	3.5.2	Develop an ongoing programme of Medical Leadership	Executive Director of Human Resources	Deputy Director - Training & Development	01/03/2015	01/06/2015	Develop a programme of Medical Leadership	**March 2015 update:** Need to develop an ongoing programme of medical leadership and management developments, including succession planning and talent spotting. **April 2015 update:** Meeting arranged with Peter Lees Head of Faulty for Leadership and Management to discuss medical leadership. **May 2015 update:** As above - RAG rating reassessed - GREEN **June 2015 update:** To commence in July 2015. **July 2015 Update:** Peter Lee senior Medical Leadership programme commenced in July '15. 2 additional sessions planned for coming months.		G

	SMART action plan	Medical Leadership	Trustwide	3.6.2.1	Medical Consultant job plans reflect revised on-call arrangements and operational expectations.	Executive Medical Director	Executive Medical Director		31/03/2015	Ensure all consultants understand and support delivery of the optimal model of inpatient care.	**30.01.15 (from SMART action plan) -** Medical Engagement Day facilitated by April Strategy 27 January 2015 attended by medical managers. Clinical Director for EC&M has had dialogue with all Heads of Service and job planned 7 Day Service. Job plans in place for Gastro, Cardiology, Diabetes and Endocrinology and Respiratory to commence April 2015. Haematology discussed dialogue in progress with PC&S. **April 2015 update:** Allocate programme is on track to deliver by June 2015. Job plans to be signed off by June and finalised in May. **May 2015 update:** Allocate programme is on track. **June 2015 update:** Temporary Spend Programme Lead now in place, Allocate Project Manager in post. **July 2015 Update:** Allocate programme off track - extra resource required to complete job planning by the end of July 2015.	Number of job plans approved by 31 March 2015	A
	SMART action plan	Medical leadership	Trustwide	3.6.2.2	Senior medical ward rounds are undertaken daily on each ward	Executive Medical Director	Clinical Directors		28/02/2015	Ensure all consultants understand and support delivery of the optimal model of inpatient care.	**30.01.15 (from SMART action plan) -** Continuing daily review at bed meeting with feedback to Medical Director where not completed and escalated. **13.02.15 (from SMART action plan) -** Toolkit progressing through LNC. 7 Day job plans continue to progress, (Allocate business plan approved) **April 2015 updates:** A Gap Analysis has been completed against the 10 Clinical Standards. **May 2015 update:** Plans to ensure daily consultant ward rounds by August 2015. **June 2015 update:** Plans remain in plan, awaiting deadline in August 2015. **July 2015 Update:**Plans remain on track. Awaiting deadline in August 2015.	Feedback from junior doctors and ward staff	A
	SMART action plan	Medical leadership	Trustwide	3.6.2.3	Board rounds are undertaken daily on each ward with senior medical presence	Executive Medical Director	Clinical Directors		28/02/2015	Ensure all consultants understand and support delivery of the optimal model of inpatient care.	**30.01.15 (from SMART action plan)** - Regular visits to wards by Medical Director to undertake spot check **March 2015 updates:** Board Rounds are undertaken daily, and this is monitored at the morning meeting in the Capacity and Flow office. All ward staff provide assurance that the Board Round has occured. Board Round audit has taken place by the Improving Excellence Team. **April 2015 update:** A review of the quality of the Board Rounds is taking place, by the Emergency Flow Programme, with a view to relaunch them. iCare2 communication was launched on 26 March 2015. **May 2015 update:** Emergency Flow team are working with individual teams to support the full implementation of Board Rounds **June 2015 update:** Board Rounds taking place daily, outputs to be monitored for effectiveness. **July 2015 Update:** Board rounds in place and metrics fed back to individual services weekly.	Board Round Audit	G
		Leadership	Trust wide	3.7	Fully implement and embed service line management in the Trust	Director of Strategic Planning and Commercial Development	Director of Strategic Planning and Commercial Development	01/10/2014	01/10/2016 **Revised:** 31.03.15	Clinical leadership strengthened through equipping the service line leadership teams with the skills and tools to determine and deliver the future for their own services.	SLM maturity assessment completed and report with key recommendations to be concluded by end October 14. Engagement within the Trust has reaffirmed commitment to principles of good SLM. **26.01.15 update:** Service line management taken forward through annual planning process for 2015/16, supported by Head of Strategic Planning. **March 2015 update:** Service line planning metings held. All service lines have produced plans for 2015/16. Feedback received on information that would support better Service Line Management. Scoping of information analysis required being taken forward by annual planning working group. clinical reference group for strategy being established to embed strategy development at a service line level. **April 2015 update:** Service line planning meetings are diarised for 2015. **May 2015 update:** Service line planning meetings are arranged **June 2015 update:** Service line planning meetings are arranged and are monthly.	SLM maturity paper – TMB Action plan	G

											July 2015 Update: An in-depth analysis of service lines across a range of metrics will be taking place over the next two months. This analysis will cover financial performance, non-financial performance (operational, quality and workforce) as well as market share and strategic positioning. The outputs of this analysis (along with the recently developed strategic narrative) will provide the basis for strategic planning / decision making with service line management teams. In addition, this work will support the development of improved regular reporting at service line level, which will support SLM to become more established.		
	SMART action plan	Medical leadership	Diagnostic & Rehabilitation	38.2.2.	Agree job plan with new Clinical Director that co-ordinates non-clinical sessions with existing Clinical Directors	Chief Executive	Director of Operations		23/02/2015	Agree job plan	**March 2015 update:** Awaiting appointment of the Clinical Director for D&R. **April 2015 update:** Awaiting the outcome of the 3.8.2.1 **May 2015 update:** Awaiting the outcome of 3.8.2.1 **June 2015 update:** Clinical Director for D&R appointed, now able to align with other clinical directors **July 2015 Update: Completed**		C
	SMART action plan	Medical leadership	Trustwide	3.9	Agree job plans with Clinical Directors for PC&S and EC&M identifying coordinated set sessions for corporate/ leadership responsibilities	Executive Medical Director	Director of Operations			To review scope and priorities of Clinical Director's role	**30.01.15 (from SMART action plan) -** Job plans for Clinical Directors are being reviewed. **13.02.15 (from SMART action plan) -** Medical Director regularly attends IC and Transformation Committees. Medcial escalates non-attendance of medics and requested attendance going forward. **May 2015 update:** Fortnightly catch ups with the Medical Director and the Chief Operating Officer are now commenced. RAG rating reassessed - GREEN **July 2015 Update: Completed**		C
	SMART action plan	Medical leadership	Trustwide	3.10	Utilise regular meetings with medical Director and Clinical Directors (both individually and collectively) to provide direction and support to drive forward clinical and behavioural changes	Executive Medical Director	Director of Operations			To re-prioritise regular joint meetings and 1:1's with Medical Director and Clinical Directors	**30.01.15 (from SMART action plan) -** Existing 1:1 meetings scheduled with Clinical Director for PC&S. 1:1 meeting with recently appointed Clinical Directors for EC&M are being timetabled. **13.02.15 (from SMART action plan) -** Medical Director meets collectively every Tuesday with CDs at Medical Manager's meeting. **April 2015 update:** Medical Director and Director of Operations have fortnightly meetings with Clinical Directors, where issues are dealt with. **June 2015 update:** Fortnightly meetings with Medical Director, Chief Operating Officer and Clinical Directors now in place to address directive and strategic direction. **July 2015 Update: Completed**		C
Well Led	Hospital Inspection and Keogh	Risk Management	Trust wide	4	Ensure Trust Risk Management processes are robust including appropriate identification of risks, incidents, mitigation and learning at all levels in the organisation	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow & Patient Safety Manager	01/07/2014	28/02/2015	Risk registers and BAF adequately reflect current risks. DatixWeb implemented to increase the opportunity for improved information and opportunities for giving feedback and sharing of trends and themes to services and individuals. Evidence of Divisions learning and improvement from incidents through Clinical Governance Committee and Quality Committee	Risk Manager appointed. Review of divisional risk registers undertaken. Corporate risk register currently being revised to ensure risks are reported and scored appropriately and reflect the BAF. BAF currently being redesigned – To be presented at November '14 Trust Board. DatixWeb implemented and new level of information being obtained – being reported to Quality Committee and Clinical Governance & Quality Committee. July Risk manager appointed and commences on 3rd August 2015:interim currently in post. Interim Risk Manageris supporting and training relevant members of staff on the Datix riskmodule.Interim Risk Manager has met with Deputy Director of Corporate Services re:principle risks and reflecting BAF.Ongoing review of risks within Divisions and tabled at Governance forums.		G

		Risk Management	Trust wide	4.8	Ensure there is a robust incident and reporting system is in place (DatixWeb) and that lessons learnt from investigations are shared with staff to improve quality and safety.	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow, Patient Safety Manager	01/07/2014	28/02/2015	Divisional and corporate risk registers reviewed to ensure they capture risks with appropriate mitigation and escalation. Evidence of Divisions learning and improvement from incidents through Clinical Governance Committee and Quality Committee.	DatixWeb rolled out across the Trust. Training completed. Staff being supported to improve quality of responses – 'other' category removed. Evidence of feedback to reporter is mandatory feedback in Datixweb. New style report being produced for Quality Committee and Clinical Governance Committee which includes themes and learning. **Update 16.12.14** Band 2 allocated from GSU to work with Datix co-ordinator to ensure cleansing of data and that lessons learnt are completed. **February 2015 update:**Regular, robust reporting of significant risks and the risk profiles fo the trust is taking place at TMB, RMC and CQ&GC on a monthly basis. **March 2015 update:** The platform for Datix is migrating on the 4 March 2015 in readiness for uploading of version 12.3 week commencing 9 March 2015. Version 12.3 allows the automatic feedback functionality to be enabled and the Datix co-ordinator is currently considering the specific section to be agreed for feedback. Uploading to NRLS is occuring monthly. **April 2015 update:** Version 12.3 unable to upload and reamins with Datix to fix. Robust incident reporting is through the Trust with an increase in incident reporting. **May 2015 update:** no changes awaiting version from Datix. **June 2015 update:** Version 14.0.2 to be installed by Datix following a technical issues. **July** Interim Risk Manager is supporting and training relevant members of staff on the Datix risk module.Identifying a clearer process and escalation to various committees currently being reviewed.	Lessons Learnt data. Learning report Clinical Quality & Governance Committee	G
Well Led	Hospital Inspection	Learning	Trust wide	5	Ensure that staff receive appropriate and timely feedback from incidents and complaints and that actions taken and lessons learnt are shared across the divisions to improve quality and safety	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow, Patient Safety Manager	01/07/2014	31/12/2014	Staff feel they are receiving appropriate and timely feedback. Improved quality and safety as a consequence of sharing and learning	DatixWeb in place across the whole Trust. This version increases the opportunity for incident reporters to receive feedback whilst also improving the depth and sensitivity of information to aid learning. Quality Summit shared best practice from Maternity, Critical Care and C&YP. Examples of 'what works well' from individual service lines discussed. Development of Medical Matters, use of iCare2 and safety bulletins. Strengthened SI process to support sharing and learning being implemented across the Trust. Learning from incidents and complaints strategy being developed.July Datix mobile workshops completed and ongoing which include advice re shared learning. Upgrade version 14.2 planned for the end of August 2015 will have automatic feedback. Advice leaflets have been circulated to all handlers to support with what informaiton to include in lessons learned section in preparation for automatic feedback.		A
		Incident Reporting	Trust wide	5.1	Implementation of Incident Module on DatixWeb. This version increases the opportunity for incident reporters to receive feedback whilst also improving the depth and sensitivity of information to aid learning. Closure of incident due dates to form part of Ward Assurance document. The quality of information within lessons learnt will be reviewed at the Ward Assurance meeting. One to one training for handlers and specialists will be initiated as required.	Executive Director of Nursing	Clinical Governance Lead	01/04/2014	31/12/2014	DatixWeb implemented across the Trust, with revised reporting and sharing of themes and trends developed. Responsive approach to reported incidents, actions taken and lessons learnt	DatixWeb in place across the whole Trust, training undertaken with staff using the new system. Lessons learned field on Datix system being completed. Further work required in respect of detail and quality of responses. New style reports being established to aid divisional and service line reporting of themes and trends. Datix Administrator (DA) quality controlling incidents supported by CGC's and GSU CGL. DA also quality controlling lessons learnt field and returning forms to ward leaders to make amendments before finally approving. This process also includes making sure feedback is given to the reporter. Roles and responsibilities to the management of incidents have been sent to all managers. Training for handlers is on request and reporter training is part of the nurse and Doctor induction. Plan to access the Trust induction days. **Update 16.12.14** Band 2 allocated from GSU to work with Datix co-ordinator to ensure cleansing of data and that lessons learnt are completed. **April 2015 update:** As per 4.8 **May 2015 update:** As per 4.8 **June 2015 update:** As per 4.8 July -upgrade to version 14.2 planned for end of August which will provide greater functionality and allow more intelligent reporting of complaint themes.Test environment is currently up and running.	Register of Datix training Evidence of defined roles and responsibilities in management of incidents. Training handlers presentation/ register.	A

		Complaints learning	Trust wide	5.2	Implementation of the Patient Experience module (Datix) to improve recording of complaints and learning opportunities.	Executive Director of Nursing	Executive Director of Nursing	01/09/2014	30/11/14 **Revised** 31/01/15	Improved recording of complaints subject and sub subject and lesson learnt to be completed.		Patient Experience Dept Structure. Screen shot of patient experience module Evidence of training.	G
		Learning through investigation	Trust wide	5.4	Deliver in house 1-2 day RCA training workshops.	Executive Director of Nursing	Head of Governance Support Unit	01/08/2014	31/01/15 and on going	To improve the quality of the investigation to enable clear identification of root cause and lesson learnt.	RCA training day for Governance Coordinators, Practice Development team and Matrons was undertaken during August. This was evaluated very positively with agreement to roll out monthly training for 2015 onwards. From January 2015 a programme of training will be rolled out across the Trust. To include RCA training report writing and being open policy. **15.01.15 -** RAG rating reassessed as GREEN on track **February 2015 update:** RCA training commenced on the 16 February 2015, and currently all available places are full. **March 2015 update:** 14 staff attended the full two day Lead Investigator Training Day on 16 & 17 February 2015. There were two attendees who were medical the reminder were nursing staff, predominantly from EC&M. The feedback was excellent with all participants scoring the days a 5 for presentation, content, relevance and an oportunity to participate. The next course is in March, and there will be minor amendments to provide even more time for practical. **April 2015 update:** Training dates available on the intranet for 2015/16. **May 2015 update:** Training dates are on the intranet, and have been continued July Training dates are on the intranet and have been continued. May 16 staff attended and June 11 staff attended	Evidence of RCA training/ register.	G
		Sharing and learning	Trust wide	5.8	Sharing and learning report for Quality Committee to be produced quarterly – this will include triangulated learning from themes and trends identified in incidents, complaints, claims and inquest. In addition to include Parliamentary and Health service Ombudsman PMHSO feedback.	Executive Director of Nursing	Head of Governance Support Unit	01/01/2015	31/01/2015 **Revised** 31/03/2015	Triangulated lessons learnt reports.	Meeting held 23/09/14 and agreed divisional pack core content. Meeting notes available upon request. Quarterly template report drafted and is work on progress. **January 2015** - A Clinical Effectiveness & NICE learning report was presented to the Quality Committee - full report to March Committee **February 2015 update:** Demonstration of learning and connections between complaints, incidents and feedback are discussed in Clinical Quality & Governance Committee. Learning templates are being utilised in Divisional Governance meetings. Learning report will be a standing agenda item on Clinical Quality & Governance Committe from March 2015. **March 2015 update:** The three divisions and Newark Hospital produced their first divisional quarterly learning report which are being presented to CQ&GC in March 2015. The content of these will be used to produce a themed learning report. These are a good platform from which to now start to triangulate the learning for future reports and I would envisage a different style of report for quarter 4. **April 2015 update:** Presented at the Quality Committee in March and at Clinical Quality & Governance Committee in April 2015. **May 2015 update:** Learning Report being written and reported.	Patient Safety Bulletin. Divisional pacts Sharing & Learning report = example Divisional learning reports - Q3	G

		Sharing and Learning	Trust wide	5.10.	Introduce an Innovation Hub to share the learning of the transformation work with patients, staff and visitors.	Executive Medical Director	Transformation Director	01/08/2014	11/11/2014 **Revised:** 31.03.15	Visibility of transformation agenda to patients, staff and visitors.	Innovation Hub established on Trust HQ Corridor. Showcase hubs planned in Comms Strategy to implement as soon as possible. **November** Improving Organisational Learning Task Group commenced - multidisciplinary membership. **Update 09.12.14** Plans agreed with PFI partners to create a hub in the main foyer by February 2015. **26.01.15 update:** Theatres and Radiology Innovation Hub in place, Innovation Hub on the Executive Corridor. **March 2015 update:** Innovation Hub in place onthe Executive Corridor, continue to await the plans from Estates. **April 2015 update:** Communications plan to be enacted. Transformation team are reviewing. **May 2015 update:** Innovation/ Transformation Hub on Executive Corridor. Programme Director to facilitate change.	Photo of door/ office. Transformation Communication Strategy. Improving Organisation Learning Task Group – minutes from meeting.	A
DOMAIN - SAFE													
Safe	Hospital Inspection & Keogh	Staffing	Trust wide	6	Build safe and effective staffing levels with escalation processes to meet unpredicted demand.	Executive Director of Nursing/ Executive Medical Director	Executive Director of Nursing, Executive Medical Director	01/01/2014	01/04/2015	Staffing levels reflect the needs of patients and are sufficiently flexible to support variability in demand.	Acuity review completed for all inpatient wards. Nurse staffing numbers and skill mix collated and reviewed daily. Staffing information is uploaded onto UNIFY and Trust Board receive monthly reports which relates staffing shortfalls to incidents. Recruitment campaign in situ, with overseas recruitment established. Successful recruitment of Consultant Posts over past 6 months. Proactive recruitment of newly qualified nurses and increased numbers of HCA's on the nurse bank.		A
		Nurse Establishment & Skill Mix	Trust wide	6.1	Implement nurse staffing investment strategy (3 year plan - commenced 01.04.14) to increase the number of nurses and change the skill mix to 70:30 (RN:HCA) in line with professional and evidence recommendations.	Executive Director of Nursing	Executive Director of Nursing	01/04/2014	31/06/16	For inpatient wards RN Nurse: Patient ratios do not exceed 1:8, ward sisters have a supervisory role and the skill mix does not fall below 65:35. Nursing care outcomes improve with the increase of RN complement.	Trust Board has agreed to £4 million investment in Nursing (January '14). Additional Registered Nurse in place on all inpatient wards since July '13. All nursing staffing information collated into one spreadsheet (includes investment, actual, planned, and vacancies.). Director of Nursing and Director of Operations have met with all ward sisters to communicate current establishments and expectations for 2014/15. **January 2015 -** Surgery now at 60:40. Mansfield Community Hospital has increased its registered nurse complement, EAU ward leadership has been strengthened. ED staffing has increased on nights. RAG rating reassessed as GREEN - on track **February 2015 update:** Staffing proposal for 2015/16 has been agreed by senior nurses and submitted to finance for costing. **March 2015 update:** Divisional Matrons continue to work towards the agreed staffing levels. **April 2015 update:** Divisional Matrons continue to work towards the agreed staffing levels. PC&S are at 60:40 skill mix, and EC&M are working towards this. Closure of medical wards will improve the skill mix. **May 2015 update:** Divisional Matrons continue to work towards the agreed staffing levels. Recruitment Strategy has been implemented on the 1 April 2015, with successful recruitment day on the 25 April 2015 and Clearing House on the 30 April 2015 for student nurses.	Safe Staffing levels Sept 14. Implementation plan for nursing investment.	G
		Medical Consultants	Trust wide	6.2	Develop a robust Workforce plan for medical consultants from the current workforce strategy.	Executive Medical Director	Executive Medical Director / Executive Director of Human Resources	31/10/2015	31/03/2015	Substantive clinical expertise available for all medical specialties.	This is within the OD & Workforce strategy. **March 2015 update:** 2015/16 workforce plan is being developed to align with the annual plan and from that we will extract the Consultant workforce plan. **May 2015 update:** as above **July 2015 Update: Completed**	Workforce & OD Strategy	C

		Medical and Nursing Staffing	Trust wide	6.3	Ensure there are sufficient numbers of qualified, skilled staff at all times in our wards and departments.	Executive Director of Nursing/ Executive Medical Director	Executive Director of Nursing, Executive Medical Director	01/01/2014	01/04/2015	Staffing levels reflect the needs of patients and are sufficiently flexible to support variability in demand.	Acuity review completed for all inpatient wards. Nurse staffing numbers and skill mix collated and reviewed daily. Staffing information is uploaded onto UNIFY and Trust Board receive monthly reports which relates staffing shortfalls to incidents. Overall the Trust nurse and medical staffing levels reflect demand apart from ED, EAU and some medical wards. Recruitment campaign in situ, with overseas recruitment established and a number of overseas nurses working at SFH. Successful appointment of Medical Cardiology Consultants , ED Middle Grades and newly qualified nurses for EAU. **Update 09.12.14** Additional Acute Physician appointed November 2014 with 3 more starting in Jan/Feb 2015. Review of junior doctor distribution across wards by DME underway. **26.01.15 update:** Urgent meeting last week re: H@N. Additional junior doctor on at night to support H@N. Surgical juniors are part of the H@N team and do tasks as allocated. Further work to be undertaken to review the Night Team Leader role and further recrutiment. **February 2015 update:** All wards exceeded the UNIFY standard of 85% average fill rate. 4 out of the 31 wards at SFH did not meet the internal standard, and it was acknowledged that all 4 wards were undergoing a staffing reconfiguration. Additional junior doctor has been added to the Hospital @ Night team with immediate effect. Additional resources has been added to the Falls team and End of Life team. **March 2015 update:** Unify return demonstrates good compliance compliance of actual versus staffing numbers. Staffing numbers in all areas are monitored daily at all the bed meetings. **April 2015 update:** Unifty return demonstrates good compliance. Hospital at Night group has enhanced the team with an additional doctor on nights, ED has been enhanced with an additional middle grade. **May 2015 update:** Unify return continues to demonstrate good compliance. Staffing for medicine, ED and EAU for nursing and medicine is discussed at the bed meetings 4 x a day.	Acuity audits Daily staffing reports TB monthly reports Evidence of international recruitment Evidence of medical appointments Review of junior doctors distribution	A
		Staffing	ED	6.4	Ensure there are sufficiently available Medical and Nursing staff to provide safe, timely care in the Emergency Department.	EC & M Divisional Clinical Director	ED Head of Service, ED, Matron	01/04/2014	31/03/2015	Staff levels and skill mix reflect the activity, and acuity needs of the patients. Patents are assessed and treated within a timely model of care.	ED nursing has been benchmarked with other similar sized Trusts and changes are required to increase midnight to 6am cover. The divisional team are developing a paper if this requires additional investment. **February 2015 update:** SFH has responded to the ED NICE staffing guidance, undertaken a gap analysis against the reocmmendations. This has informed the budget setting process. ED medical and nursing staffing / skill mix are discussed at all bed meetings (3 x daily and 7 days a week). **March 2015 update:** Interviews for 8th Consultant in ED w/c 2 March 2015. Divisional team reviewing costing of the ED NICE staffing guidance. **April 2015 update:** Nursing off duty ensures there are the correct numbers per shift with the appropriate skill mix. Escalation processes in place to provide additional staffing if patient demand increases. Medical and nursing staffing for ED are reviewed at the bed meeting 3 times a day, 7 days a week. **May 2015 update:** Nursing and Medical staffing are reviewed 4 x aday at the bed meeting. **July 2015 update:** BEST audit completed for nursing staffing tool and submitted in June. Daily reviewing of staffing continues as described. Extra middle grade now on nights to support senior decision making and junior Drs when higher volumes of patients. Staffing numbers increased on nights within current establishment.	Benchmarking on ED staffing	A

		Staffing	ED	6.4.1	Review ED workforce model to match demand profiles.	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/04/2014	30/11/2014 Stage 2 - 30.04.15	Clinician capacity reflects demand and attendance modelling, with the 4 hour access target consistently achieved .	The agreed medical workforce strategy for ED has been refreshed to reflect the current market. Consultation has taken place with relevant staff to make rota changes to increase senior decision maker presence in the evening and at weekends. The department has been successful in international recruitment and middle grade posts are in the process of being filled (awaiting commencement). **Update 09.12.14** 2 additional ED middle grades in post and 2 more scheduled for Jan/Feb **February 2015 update:** as per 6.4 **March 2015 update:** Review of ED workforce model was completed in November, and is now being reviewed again. **April 2015 update:** BEST tool is being undertaken this month. Medical profile altered to meet activity peaks. Increase in senior presence in ED. **May 2015 update:** 8 the Consultant recruited, and 6 Acute Physician in post **July 2015 Update:** Middle Grade recruitment: Consideration to recruitment /retention packages that encompass training programmes (rotational through Paeds, Medicine, Anaesthetics)	Medical Workforce Strategy for ED	G
			Emergency Care & Medicine	6.4.4	The Trust has had difficulty with recruiting and sustaining high calibre front door clinical decision making and therefore alternative models for recruitment are required.	Director of Operations	ED Head of Service	01.07.14	29/09/2014. first phase although this work is continuing	To recruit high calibre medical staff to deliver high quality safe care. Reduce admissions from improved decision making from substantive staff.	The Trust has had significant success from international recruitment, acute physician posts and ED middle grade posts are in the process of being filled with candidates starting to commence. **January 2015 -** 6 Acute Physicians in place by March 2015. **February 2015 update:** Final 2 Acute Physicians to be in post by March 2015, this is the most successful recruitment of Acute Physicians the Trust has experienced. **March 2015 update:** Six Acute Physicians now in post, 8th ED Consultant interviews w/c 2 March 2015. **April 2015 update:** Six Acute Physicians in post, and an 8th ED Consultant to commence in June 2015. **May 2015 update:** 8th ED Consultant to commence in June 2015. Incentives in place to retain and recruit staff **July 2015 Update:** 8th ED consultant in post. Consultant retention in place. Currently no Drs in training (Registrar) identified for KMH in August/September 2015. 2 out of programme Registrars identified to support from September.	Report – Exec Team Middle Grad Doctors V3. Evidence of posts filled.	G
		Nurse Staffing	EAU	6.5	Ensure there are sufficient qualified nurses to provide safe care in the Emergency Admissions Unit.	EC & M Divisional Matron	ED Matron	01/06/2014	31/12/2014 Revised 31/05/15	All shifts are safely staffed, but where staffing levels do not meet demand, bed numbers are reduced to provide safe care.	All vacant RN posts recruited to. Agreed staffing ratio of 1:6 RN to patient maintained in the day and 1:8 at night. Agency/bank and temporary staff used to maintain agreed levels **January 2015 -** recruitment of 7 x Band 5 and 3 x Band 3 planned **February 2015 update:** Recruitment of the Band 5 is planned for the last week in February 2015. **March 2015 update:** Recruitment is going, with a high turnover of Band 5 nurses, seeing 7 vacancies at the start of March 2015. On-going monthly recruitment programme. Band 6 x 3 posts being advertised. Development of Band 6 role continues. Bank and agency usage to maintain additional beds being opened at 56. **April 2015 update:** There are vacancies in the number of qualified nurses in EAU, currently there are 10.6 wte. A rolling programme of recruitment is in place. Regular use of Bank staff, regular agency staff and overtime, ensures the off-duty is covered. **May 2015 update:** Recruitment continues to be undertaken. Regular use of Bank Staff, regular agency staff who are familiar with the ward and overtime are utilised to enusre the offduty is covered.	Daily staffing tool used to review and evidence staffing Levels. Daily bed state identifies bed occupancy. Safer staffing care tool.	G

		Nurse Staffing		6.6	Ensure there are sufficient numbers of qualified, skilled and experienced nursing staff at all times within the Medical Wards.	Executive Director of Nursing	EC & M Divisional Matron	01/06/2014	31/03/2015	All the medical wards are staffed with substantive staff to meet the acuity and dependency needs of the patients.	Utilisation of bank/agency temporary staffing to maintain agreed levels of nursing. Recruitment manager in post. Lead PDN for recruitment / retention employed. Additional Preceptorship Nurse in post. Rolling RGN recruitment in place. International recruitment programme underway. Executive Team currently discussing a bed reduction plan which would enable teams to be merged to reduce the use of bank/agency nursing staff. **November** x3 daily staffing template indicates that shift numbers for medicine are being met. UNIFY return for October indicates no areas in Medicine are below 100% fill rates, with many wards exceeding 110% fill rates for HCA. A large use of 1-1 support and no adverse variance on the ward assurance matrix indicates safe environments. Successful recruitment of overseas nurses with the majority now within the establishment numbers. 2 months of preceptorship (6 month programme) for newly qualified nurses completed with increased preceptor support. Further information in relation to nurse staffing has been included within the Trust Board 6 Month Nurse Staffing paper. This milestone has been reassessed as Amber. **February 2015 update:** All medical wards met the UNIFY standard of 85% average fill rate, and the Trust's internal target. There remains a large need for 1:1 enhanced support across the Trust. Additional winter capaccity remains open. 50 international nurses has been recurited to the Trust, and we are looking to develop a long term recruitment plan for further international recruitment. EC&M are developing a marketing strategy for recruitment of registered nurses with open days and external journal adverts.	Utilisation of bank/agency temporary staffing to maintain agreed levels of nursing. Recruitment manager in post. Lead PDN for recruitment / retention. Additional preceptorship Nurse in post. Rolling RGN recruitment in place. International recruitment programme. UNIFY staffing information.	A
											March 2015 update: Unifty return demonstrates good compliance of actual versus staffing numbers. Separate nursing recruitment campaign is planned, and the Executive Team has been asked to support further international recruitment. Nurse recruitment strategy and campaign being agreed with personalised branding. Additional winter ward capacity remains open. **April 2015 update:** Unify return continue to demonstrate good compliance of actual versus staffing numbers. Recruitment strategy has been implemented from April, with an additional 2 cohorts of international recruitment. Winter Ward has been reduced and staff utilised to support plans. **May 2015 update:** Unify return continues to demonstrate good compliance with actual versus staffing numbers. Winter ward has closed on the 10 April 2015 with staff returning to their base wards. Recruitment strategy was implemented on the 1 April 2015 with a Recruitment Day on the 25 April 2015, and a student nurse Clearing House on the 30 April 2015.		
		Nurse Staffing	Medicine	6.6.3	To reduce bed capacity as part of QUIPP and the cost improvement programme explore the possibility of merging two poorly established medical wards to improve the skill mix and numbers on other Trust Wards (redeployment of staff).	Director of Operations/ Executive Director of Nursing	Divisional Matrons	01/10/2014	29/11/14 **Revised:** 24/12/14 **Revised:** 28.02.15 **Revised: 30.06.15**	Bed reduction programme supports the staffing pressures within the remaining Trust wards through the redeployment of permanent staff into other vacancies.	This proposal is being discussed as part of the Trust plan to meet the current priorities. **Update 1.12.14** Ward 21 will be empty 24.12.14. Wards 14 and 21 will be amalgamated in Surgical Admissions ward. **Update 16.12.14** Ward 21 to be merged with Ward 14 by 24th Dec 2014. Staff have been given placement choices across the Trust. **January 2015 -** Ward 21 was opened to facilitate an increase in Medical admissions during late December and January 2015. RAG rating reassessed as AMBER **30.01.15 updates:** DTOCs 'pull' team requested as part of the 'perfect week' roll out, to commence week commencing 9 February 2015. 14 days LoS stay and over distributed to all wards to unblock and make visible long waiting patients. Increased use of the discharge lounge. **February 2015 updates:** Winter bed capacity remains open . Disccharge Lounge utilisation was 218 patients in January - 12.45% of the Trust's discharges used the Discharge Lounge. **March 2015 update:** Emergency Flow Matron has been established and are reviewing the 14 days and over LoS. Winter Ward remains open, but the capacity is decreasing. **April 2015 update:** Reduction in the 14 day LoS patients in the Trust has begun to see the impact, as the Winter Ward will close - w/e 12 April 2015. Implementation plans are in place to reduce bed capacity over the summer period.	CIP Paper Staffing plans for Ward 21 staff. Communications information on ward closure.	A

											May 2015 update: Winter ward closed on the 10 April 2015, and there are now plans in place to reduce bed capacity by a further ward over the next month. The Emergency Flow team are working with the division to reduce the number of patients who are in hospital 14 days or over. **July 2015 Update:** Ward 33 currently empty with full formal closure and decomissioning on the 26th August (24 beds). Emergency Flow matron post now funded through to January 2016. 10 beds closed on Sconce Ward at Newark Hospital in June 2015.		
		Medical Staffing	Medicine	6.7	Ensure there are sufficient numbers of Medical Staff to safely care for patients in the medical wards.	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/05/2014	30/11/2014	To provide timely, responsive and high quality medical care, 7 days per week.	All areas have been reviewed and the medical model of rehabilitation and delayed transfer of care areas amended to ensure medical resources are deployed according to needs. This will reduce number of locums required. **March 2015 update:** Risk assessment completed to establish that all locum posts were required, and this has been reported back as all post are required. **April 2015 update:** Continue to monitor. Risk assessment suggests that there is a need for more geriatricians, and closure of wards will assist this process. **May 2015 update:** Continue to monitor. Reduction in bed capacity will improve medical staff ratio to patients.	Medical teams and current vacancies.	A
			Trust wide	6.7.1	To implement alternative, attractive strategies to recruit into 'hard to fill Medical posts.	Director of Operations	Director of Operations	1.7.14.	29.9.14. continuing	To ensure the Trust is providing attractive packages to recruit and retain staff.	The Trust recognised that in the current climate, alternative recruitment strategies are required. A recruitment and retention package for middle grade doctors in hard to fill specialties has been implemented to improve recruitment and retention. To date there has been improved success particularly in ED and Acute medicine. **Update 1.12.14** A Plan has been developed for each specialty as appropriate. **March 2015 update:** 8th ED consultant (Locum) appointed. 6th Acute Physician now in post. Geriatrics - recruitment and retention premium payments agreed to attract consultants. **April 2015 update:** Ongoing with Recruitment & Retention premium for hard to fill vacancies. **May 2015 update:** Ongoing recruitment and retention premium for hard to fill vacanices. **July 2015 Update:** Reviewed recruitentn and retention premium for Geriatrics and Middle grade posts to reflect scarcity. Targetted recruitment campaign	Recruitment and retention packages for middle grades.	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8	Ensure there are sufficient numbers of Radiologists to meet clinical demands with escalation processes if reporting times are breached.	Director of Operations	D & R, Divisional General Manager	01/04/2014	30/03/2015	Staffing levels meet clinical need. Diagnostic waiting times and reporting targets are met.	The Trust has developed a detailed Consultant Radiologist strategy which is currently being implemented. First year of the strategy is currently on track. **Update 09.12.14** Phase 2 of the external consultancy work starts 08.12.14 and will produce a clear operating and management framework, with a service improvement portfolio, quick wins and continued leadership development. On going partnership in EMRAD Board to develop common technology platform and new models of working across Nottinghamshire including joint consultant appointments. **February 2015 updates:** Interviews for Interventional Radiologist schedule to create a service hosted from NUH project board for the EMRAD created to implement a common digital imaging system across seven trustl This will facilitate reporting across the region. **March 2015 update:** From April 2015 the division will be searching for a Radiologist locum with on-call arrangement. The division has now written a paper on 'Recruitment & Retention' premiums, this will lead to a further recruitment campaign. **April 2015 update:** Locum Radiologist currently being sought, which will cover gaps in the on-call rota. **May 2015 update:** Appointed 0.6 wte Radiologist from 25 May 2015 who will cover the on-call rota. No issues with reporting or breaching.	Radiology Strategy Evidence of Consultancy work and plan Recruitment plan for Radiologist Evidence of joint appointment	G
											July 2015 Update: Interviews for breast radiology (28/07/15) - 2 candidates with 3rd potential. Advertising for 3 consultant radiologists interviews begining of Sept'15.		

		Radiology Staffing	Diagnostics & Rehabilitation	6.8.1	To provide a safe radiology service which meets current demands whilst transforming to meet the 24/7 requirements.	Director of Operations	D & R , Divisional General Manager	01/04/2014	30/03/2015	To have a sustainable radiology workforce that meets the needs of current demands, but is also able to respond to the 24/7.	The Trust has an excellent track record of recruiting and retaining radiographers however this is becoming more challenging and with the national shortage of Consultant Radiologists, has commissioned an external consultancy with expert radiology expertise to work with the Radiology team to develop and implement transformational changes to ensure a sustainable service. .The Phase 1 review will conclude in October and an action plan implemented in Q3 and Q4 in Phase 2. **March 2015 update:** Francis Group completed. Wards and departments now have access to CRIS. Working with the 7 Day Service lead to progress. Gap analysis for 7 Day Service standards has been completed. Reporting turnaround KPIs weekly. **April 2015 update:** Radiology continue to work towards the 7 Day Service clinical standards. **May 2015 update:** We continue to meet a safe service. **July 2015 Update:** Extended days now in job plans. Consultant job plans to be reviewed to cover Sat/Sun. 24/7 service needs further review to establish.	Initial report from external consultancy will report at the beginning of November as planned.	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.2	Review radiology staffing levels to identify any potential gaps in service provision.	Director of Operations	D & R , Divisional General Manager	01/07/2014	31/10/2014	Clinical capacity sufficient to meet demands and diagnostic waiting times.	Francis team working with the clinical team to review radiology provision to identify efficiencies and transformational change. Locum Radiologist secured to cover vacancies. **Update 01.12.14** Stage 2 Frances due to commence. Adverts placed for recruitment of substantive Radiologists. **March 2015 update:** Developing strategies to recruit into vacancies. Vacant posts are being coverd by locums. **April 2015 update:** We are advertising for 3 Radiologist and 1 Breast Radiologist in April 2015. **May 2015 update:** No candidates for the substantive Radiologist. Breast Radiologist to be advertised this week, interviews will be in June 2015 and this a very hopeful that we will recruit.	Frances team outcomes Radiology rota. Job bulletin 10 April 2015 Advert for post and HR paperwork.	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.3	Ensure radiology reporting KPI's are met.	Director of Operations	D & R , Divisional General Manager	01/07/2013	31/07/2013	Reporting times met KPI's.	Outsourcing utilised to support reporting times. Radiographer reporting extended. Robust reporting issues escalation process implemented. **March 2015 update:** Continues to be monitored weekly. **April 2015 update:** Radiology reporting KPIs continue to be met. **May 2015 update:** Radiology reporting KPIs continue to be met. **July 2015 Update:** No backlog for over 2 years - advise more to complete.	Radiology reporting reports. Escalation process. Radiographer extended reporting roles KPIs	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.4	Recruitment of Radiologists.	Director of Operations	D & R , Divisional General Manager	01/07/2014	31/03/2015	Clinical capacity reflects demands.	Joint appointment with Nottingham for Interventional Radiologists out to recruitment. Work being undertaken with Nottingham to improve Paediatric Radiology. International recruitment tried but not successful. Plan to reattempt recruitment with revitalised advert. **November** Radiology has progressed with phase one. Meetings with other Trusts are on going. This milestone has moved from red to amber. **Update 09.12.14 (AH)** Nottingham have recruited Interventional Radiologists and the provision of an interventional service to SFH is under discussion. **February 2015 updates:** Interviews for interventional Radiologist are scheduled. **March 2015 update:** as 6.8.2. **April 2015 update:** as per 6.8.2 **May 2015 updat:** NUH were unsucessful at recruitment of Radiologist, but they continue to provide the Trust with sessional interventional Radiology. We have agreed with NUH to jointly recruit to a Neurology Radiologist.	Recruitment of Radiologists. Evidence of 5 day interventional Radiologist.	A

		Staffing	Trust wide	6.9.1	Establish an effective temporary staffing function (in house bank) and ensure effective rostering/deployment of clinical staff.	Executive Director of Human Resources	Deputy Director of Human Resources	01/04/2014	31/10/2014 **Revised:** ongoing	Temporary staffing requirements are met by appropriate competent individuals at a cost effective price. Increased numbers of staff registered on the trust bank, improved process for booking and monitoring bank staff, reduction in variable pay spend.	Options appraisal currently being developed. Standard Operating Procedure currently development for all bank processes. Review of current rostering systems completed. **Update 01.12.14** New Rostering systems approved by TMB 24.11.14. SOP's completed and rolled out. **26.01.15 update:** Workforce efficiency tool has an established project plan to support roll out. In house bank arrangements being developed to support Registered Nurse and Admin & Clerical termporary requirements **February 2015 updates:** The Allocate rostering system is on track, and are currently on site offering training to the Bank Office team. **March 2015 update:** Allocate on site providing training. **April 2015 update:** Allocate project is on track. **May 2015 update:** Allocate project is on track. **July 2015 Update:** Allocate project currently reviewing work undertaken to ensure project remains on track. This will move to allocate roll-out workstream which is part of turn-around.	Options appraisals SOP Bank Report Rostering system tender and procurement	G
Safe	Hospital Inspection	Equipment Management	Trust wide	7	Ensuring equipment maintenance programmes are fully compliant and operate systems to identify, assess and manage risks relating to the health, welfare and safety of service users and others.	Director of Operations	Medical Physics Manager	02/06/2014	01/12/2014	Staff are aware and following the Trust equipment maintenance programme, The medical device management policy has been strengthened, staff are using standardised reporting systems and a system of escalation for missing items is established.	Policy been approved. Comms team and MEMD will re-launch the policy to highlight key areas of change.		G
		Equipment Management	Trust wide	7.3	Introduce a new escalation process for missing maintenance items. Part of the escalation process will be to agree corrective action plans with the Matrons for missing maintenance items.	Director of Operations	Medical Physics Manager	01/10/2014	30/11/2014 **REVISED: 30.06.15**	Escalation process introduced with clearly defined actions plans for missing maintenance items to ensure all equipment is appropriately maintained. Evidence of staff using medical device management policy.	Datasets currently being analysed following introduction of upgraded medical device information system and will be distributed to Heads of Nursing for comment by end October. Update 01.12.14 The analysis will be complete by end of Dec 14 and distributed to Heads of Nursing for comment. Service lines will be informed of missed maintenance items. **January 2015 update:** 12.01.15 - Learning Boards to be utilised to display the posters for choosing the right equipment - 'Choosing right; Using right' Keeping right'. 19.01.15 - Trustwide amnesty to take place in January 2015 to identify outstanding equipment for maintenance. **February 2015 update:** posters on the learning boards 'choosing right: using right' keeping right'. **March 2015 update:** MEMD are completing the data valdiation of where they are with the missed maintenace and we are proactively visiting areas to correct this, this demonstrated that 100% defibrillators, 100% neonatal incubators and resuscitaires, 92% of infusion devices, 92% of pressure relieving air matresses have been serviced. There is now a campaign to service all the hospital beds, which stands at 68%. **April 2015 update:** Medical equipment maintenance has improved as 97% of infusion devices and 72% of hospital beds have now been serviced. The total for SFH is 77%, with a breakdown by site as: Kings Mill 77% Newark Hospital 81% Mansfield Community Hospital 67%. Planned maintenance to be prioritised at Mansfield Community Hospital in April. **May 2015 update:** Prioritised work is maintained. Equipment Day is planned for the 1 July 2015. **July 2015 Update:** Monthly 'personalised' reports sent to wards to identify their specific equipment that is requiring maintenence. Detailed monthly reports to ward Sisters/Dept leaders to be ongoing.	Copy of the Medical Device information system analysis Evidence from Risk Registers.	G
Safe	Hospital Inspection	Medicines Management	Trust wide	8	Improve the systems and processes for the storage and administration of all medicines. Reduce the incidence of medicine omissions.	Executive Medical Director	Chief Pharmacist	01/07/2014	30/03/2015	Drugs are managed in line with Trust policy and legislative and omitted medications are appropriately managed. Patients receive all prescribed medications.	Task group chaired by DoN meeting weekly. Ward Medicine Champions identified. Ward 51 trialling a new swipe card access for bedside lockers, to improve security. Drug trolleys ordered for outstanding medical wards.	Agenda minutes and action log for Medicines Task and Finish Group. Medicines Optimisation Strategy. Medicines Policy Communication. Champions list of names	A

		Medicines Storage	Trust wide	8.3	Treatment room doors and all medicines cupboards including patient's own drug lockers to be kept locked when not being accessed.	Executive Medical Director	Chief Pharmacist	Re-focus 01/10/12	31/12/2014 Review Ongoing	All medicines stored securely at all times not allowing unauthorised access.	Issue has been highlighted previously, but has remained an on going concern. Audits taking place on wards and departments to assess medicines security. Nursing metrics audited monthly re medicines storage. Outcome guardian visits being undertaken. **Update 01.12.14** Outcome of Medicine Safety audit will be published in 2 weeks. **Update 09.12.14** 2 spot checks in ED by Pharmacy and both times the drugs were secure. **02.02.15 update:** Audit completed in January - awaiting results **February 2015 update:** Trailling new pharmacy medicine secure box, with a plan to implement across the Trust by the end of March 2015. **March 2015 update:** Audit completed 3 weeks ago, this did not demonstrate good compliance. To be discussed through the governance process. **April 2015 update:** Audit demonstrates further improvements required in locking of medicine cupboards. EAU and ED particularly require action. **May 2015 update:** Drug security audits being completed daily, to increase staff awareness **July 2015 Update:** These audits have move to a quarterly programme with the next taking place in Autumn 2015.	IPR September Quality and Safety V2 Nursing metrics – medicines storage Medicine safety audit Spot check audits January audit	A
		Medicines Storage & Missed & delayed doses	ED & EAU	8.4	Optimise administration process and minimize security risks by use of technological solutions.	Executive Medical Director	Chief Pharmacist	01/02/2014	31/03/2015	High turnover/high risk areas to utilise electronic medication cabinets.	ED and EAU to have electronic secure storage and dispensing cabinets installed by the end of 2014/15. **02.02.15 update:** On track to implement. **March 2015 update:** Enabling work currently underway on ED and EAU. **April 2015 update:** Work underway with contractors in EAU and ED to install the security cupboards. **May 2015 update:** IT and suppliers working towards June completion. **July Update:** The company providing the equipment are unable to deliver this until late August (delivery of training). Alming for September/October 'go live'.	Business case, meeting notes. Photos Procurement details email from SM	G
		Medicines storage	Trust wide	8.5	All areas to have secure bedside lockers in working order.	Director of Strategy and Commercial Development	Chief Pharmacist	06/08/2014	On going constant maintenance	All patients medication will be stored securely at their bedside.	A list of the areas being formulated re issues with bedside lockers. Ward 51 trialling a new swipe card access bedside lockers, awaiting feedback. Additional keys to be organized forward areas that have insufficient for each nursing team. **15.01.15 -** RAG rating reassessed as GREEN - on track **02.02.15 update:** Still some outstanding bedsie lockers, plan in place. **March 2015 update:** Improved poisition, areas to contact Ben Widdowson. New replacement key systems being trialled on Ward 51, key fob proxmity. **April 2015 update:** reviewing different locks and lockers, reviewing funding streams **May 2015 update:** Audit undertaken, SOP circulated to Matrons and Ward Leaders. **July Update:** The checks on lockers will be undertaken as part of the quarterly audits (as per section 8.3)	Audit Outcome guardian and metrics	G

		Missed & delayed doses	Trust wide	8.9	To reduce the amount of missed and delayed doses.	Executive Medical Director	Chief Pharmacist	01/02/2014	On going	For incidents around missed and delayed doses to be reduced across the Trust.	Pharmacy carrying out monthly audits, consideration being given of whether audits should be undertaken on a weekly basis. RAG rating reassessed as GREEN on track Medicine rounds to be given high profile within the organization comparable to 'mealtimes matter'. Trust standards to be agreed for drug administration to include the wearing of red tabards. Order code to be circulated. New Drug administration trollies ordered to prevent interruptions to drug rounds. New medicines chart has been agreed at Drugs &therapeutics to include missed doses section. To be sent to print, drug chart to be implemented. 10/11/2014. Implementation of the accountability handover project, this will highlight delayed and missed doses. Practice development matrons and medicine champions in all area to promote good practice. Introduce use of Medicines Safety thermometer to measure and highlight areas of good practice or concern. Introduction of red cards in ED and EAU to highlight STAT doses of medication to prevent missed doses. **January 2015 update:** 12.01.15 - PDMs had a focus week in December on medicine safety including missed and delayed medications. Divisional Matrons to produce an action plan to inform the QI meeting on how they are going to close the gap on missed doses. Medicine Safety thermometer will be on the wards by the end of January 2015. Missed dose audit will continue fortnightly. **02.02.15 update**: ED to review 'red card' system or alternative. Missed and delayed audits did demonstrate an improvement, Divisional Matrons to develop action plan and report back to Quality improvement meeting end of February **March 2015 update:** Medicine Safety Thermometer completed and data subitted for February 2015, awaiting official results but the provisional information demonstrates positve outcomes. The latest Missed and Delayed drug audit demonstrated that only 2.5% of drugs were missed or delayed in February 2015. **April 2015 update:** Improvements made with further improvements to be made. Medicine Safety Thermometer we were better than the mean. **May 2015 update:** Audits maintained. Third set of data entered to Medicine Safety Thermometer. **July 2015 Update:** This audit is ongoing - clinical areas with low compliance are continuing fortnightly audit. Those who demonstrate consistently good practice will move to Monthly Medicines Safety Thermometer audit for monitoring. Additionally, pharmacy will be undertaking quarterly unannounced audits on missed doses.	iCare 2 notice – New Trust general drug chart. IPR September 2014 Quality & Safety. Evidence of missed dose audits. Evidence of red tabloids. Evidence of trollies on wards are ordered. Audit of accountability handover. PDM's in all areas – medicine focus report Medicine Safety thermometer. Red cards in ED & EAU for stat doses.	G
		Missed & delayed doses	Trust wide	8.10.	Ward leaders to check prescription charts on their leadership rounds – check for missed doses, documentation, legibility of prescriptions.	Executive Director of Nursing	Divisional Matron	22/10/2014	3/11/14 **Update 15.12.14** ONGOING	Reduce missed and delayed doses, improve prescription legibility.	Nurses to pick up discrepancies and issues. Highlight legibility issues with prescribers. **Update 01.12.14** Included in nursing metrics. Agenda item for ward leaders development day 09.12.14. **Update 15.12.14** Completion date revised to on-going. RAG rating reassess as AMBER. **March 2015 update:** Audit of missed doses has reduced from 3% to 1.5%, all missed and delay doses have reduced from 4% to 2 - 2.5%. The Acccountability Handover results from February 2015 may have contributed to the improvement. **April 2015 update:** Accountability Handover is picking up on missed doses, and this is felt to be the cause of the reduction. **May 2015 update:** Monitored through the Accountability Handover audit. **July 2015 Update:** SOP for medicines omissions audit being written by Practice Development Matron to continue delivery of robust audit programme and incentivise continuous improvement in clinical areas.	IPR Sept 2014 Quality & Safety. Nursing metrics. Audit of missed doses. Agenda from Ward Leader development day.	A

		Missed & delayed doses	Trust wide	8.13	Develop and communicate list of responsibilities for staff groups in relation to missed and delayed doses.	Executive Medical Director	Chief Pharmacist	06/08/2014	31/12/2014 **Revised: 30/06/15**	All staff understand their role within ensuring medicines are given. Reduced missed doses.	To be initiated. To be included at staff induction and within Medicines Policy. Includes Nursing and Medical staff. **Update 01.12.14** Not yet included in staff induction. Policy will be revised in 6 months. **March 2015 update:** policy to be review in June 2015. Director of Nursing covers missed and delayed drugs at the fortnightly nurse induction programme, and at the Proud to Care study days. **April 2015 update:** Medicine policy will be discussed at the Medicine Management meeting in May 2015., **May 2015 update:** Audits continued. **July 20015 update:** Advise move this action to completed.	Medicines policy Induction programme	G
		Missed & delayed doses	Trust wide	8.18	Implement e-prescribing	Executive Medical Director	Chief Pharmacist	2010	2017	Provide electronic tool for highlighting missed doses and hence reduce frequency.	E-prescribing on ward 14 since Feb 2012. Ongoing work related to procurement of system in progress. **26.01.15 update:** Eprescribing awaits treasury outcome. **March 2015 update:** Did not get funding from the Technology Fund. Further meeting next week to discuss how this is progressed. **April 2015 update:** e-Prescribing to be discussed at CQ&GC to look at alternative ways in which e-Prescribing can be achieved by 2017. **May 2015 update:** No changes to re;port **July 2015 Update:** Discussed at CQGC meeting (July) escalated to Exec team for further direction regarding the future of e-prescribing.	E- Prescribing system Meeting notes Roll out plan	A
Safe	Hospital inspection	Documentation and Records	Trust wide	9	Ensure patient records are appropriately maintained in line with Trust policy and legislative requirements	Executive Director of Nursing/ Executive Medical Director	Divisional Teams.	01/07/2014	31/12/2014	Confidential patient documentation available to all relevant professionals to support consistency of treatment and interventions to maximise health outcomes	Trust policy for Standards for nursing record keeping has been reviewed setting out the expectations of the organisation. Developed a 'how to' guide for record keeping and frameworks which will help individuals to improve their record keeping. These will be printed and launched by 31/10/14. Developing a new documentation audit tool which is sensitive to the qualitative aspects of record keeping. Currently developing a proposal for a consistent approach to nursing document storage. Care & Comfort champions for each ward identified and focus group dates set. Use of accountability handover process to be audited as part of documentation audit. Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director commenced. Compliance in WHO checklist improved.	iCare2 Clinical Record Keeping – Policy updated	A
		Medical Admissions Documentation	Trust wide	9.1	Rationalise admission documentation (to improve data quality and standardise)	Executive Medical Director	ECM Divisional Director and ED Head of Service	01/09/2014	30/11/2014	Ensure admissions booklet is completed by ED and Acute Medicine in a consistent manner.	Review of structure and content of exiting booklet to create areas for ED and Acute Medicine by EC&M. Revision of co-morbidities page. Plan for completion end of November. **05.12.14 update:** Progress monitored is Medical Managers Forum Implementation monitored via documentation audits. **26.01.15 update:** Emergency Care documentation completed and will be audited. **March 2015 update:** ED documentation completed, Dr Wright is writing the new documentation which will improve coding. **April 2015 update:** New documentation currently being trialling, and will be auditing in May 2015. **May 2015 update:** New documentation is being audited monthly on the HealthCare Records audit to ensure standards of documentation estahlished by the GMC are met. An audit is planned in June on pre & post implementation. Ongoing audits on the utilisation of the co-morbidity section fror compliance and to improve coding. **July 2015 Update:** New medical clerking documentation now embedded.. Documentation audit reported externally to HEEM conference-and is going through speciality governance meeting. improvements in all domains measured apparent: overall improved from 27.37% to 71.7%	Progress monitored via Medical Managers Forum notes. Implementation monitored via Documentation audits	A

		WHO Checklist	Theatres	9.3	Embed WHO checklist - especially the briefing before and after surgery. Team briefings before and after surgery mandatory from 1 July 2014.	Executive Medical Director	PC & S Divisional Clinical Director &/ Sharon Baxter	01/05/2014	01/01/2015 **Review: 31/03/2015**	100% compliance by Dec 2014. Eliminate surgical never events.	Compliance dramatically improved in latest August audit to 70%. Compliance in who checklist improved. **Update 09.12.14** Marked improvement in step 1 (brief) and step 5 (debrief) in Safer Surgery; step 1 compliance 1% Apr14, 54% Sep 14 and 89% Oct 14, step 5 1% Apr 14, 31% Sep 14 and 75% Oct 14. **Update 15.12.14.** RAG rating reassessed as GREEN - as the Trust is currently achieving good standards of compliance, being monitored through the Quality Improvement Meeting. **February 2015 updates:** continues to be monitored monthly. **March 2015 update:** Audit results for February 2015 are Stage 1 (briefing) 88% and Stage 5 (de-brief) 67%. Stages 2, 3 & 4 scored 99% (sign in, time out and sign out). **April 2015 update:** Continues to improve, Stage 1 (briefing) 97% and stage 5 (de-briefing) 88%. **May 2015 update:** Stage 1 (briefing) 90% and stage 5 (de-briefing) 80%. **July 2015 Update:** Daily Audits now taking place with individuals non-compliant being reported to head of service and medical director for action. Daily audits underway: results discussed at theatres managemnt meeting monthly. Good practice highlighted and rewarded.	Ongoing audit Need evidence of monthly audit - WHO checklist	G
	HEEM visit	Consent and WHO checklist	T&O	9.3	Consent practices within T& O include appropriate markings and completion of WHO checklist.	Executive Medical Director	Divisional Clinical Director PC&S	01/11/2014	31/12/2014	Consent procedures are compliant.	Divisional meeting with Consultants. Meeting with CEO /MD and Consultants scheduled. **November** WHO audit progressing well. Good engagement with process and need to improve. This milestone has moved from red to amber. **Update 09.12.14** Weekly report to MD and monthly meeting between Division, team and Exec. **Update 15.01.15:** RAG rating reassessed as GREEN - as the Trust is currently achieving good standards of compliance, being monitored through the Quality Improvement Meeting. T&O Consultant is champion for WHO Surgical Checklist **February 2015 update:** Monthly consent audits in T&O are taking place. **April 2015 update:** No audit undertaken for March 2015. **May 2015 update:** Consent audit demonstrates improvements and junior doctors comments were positive.	Ongoing audit – T&O specific Evidence of Divisional meetings with consultants. Diary evidence of MD & CEO meeting T&O Consultants.	G
		Consent Mental capacity assessment	Trust wide	9.5	Consent protocol updated, communicated and performance monitored. Appropriate completion of capacity assessment.	Executive Medical Director	Richard Hind, Chair Consent Ctte	30/07/2014	Ongoing	Remove variation in practice, adequately performance manage and investigate breaches	Consent policy updated and circulated to Service Directors. Datix reporting system updated. Consent training completion reviewed. Consent audit results circulated. Breach reporting system defined. Mental capacity assessment audited within documentation review. **March 2015 updates:** Consent audit for February 2015 demonstrated that 54.3% of all sections were completed. 95.1% the writing was legible and confirmation of consent fully completed was 79%. **May 2015 update:** as per 9.3. Work is identified around 2 stage capacity assessment which has been raised to Head of Service for Geriatrics.	Consent Ctte Ongoing Audit Consent policy Consent training plan/ timetable MCA audit	A

		Nursing Records	Trust wide	9.9	To help teams organise their workload and support improvement, ensure Care & Comfort rounding is consistently in place across the Trust.	Executive Director of Nursing	EC & M and PC & S Divisional Matrons supported by Kerry Smith, PDM	01/11/2013	30/11/2014	Care and Comfort embedded within the organisation	All ward areas have new C& C boards except 11&12 (due for delivery w/c 13/10/14. C& C champions for each ward identified and focus group dates sets. Website updated. **November** All ward areas have boards. Nil orally magnets delivered to all wards by K Smith. Explanation given to staff member/Nurse in charge to cascade to other staff. Notification sent out to all Ward Leaders to nominate champions. Focus groups taken place. Explanation poster to be developed for display alongside C&C board (aimed at patients &/or relatives.) Presentation to be prepared for Ward Leader meeting 20/1/15. **Update 15.12.14** No further updates **January 2015 -** Education programme commenced. Audit to be undertaken in February. **February 2015 updates:** Care & Comfort audits to take place. **March 2015 updates:** Care & Comfort audit to be undertaken. **April 2015 update:** Care & Comfort audit planned this month. **May 2015 update:** No plans currently to audit, however there is work with the Ward Leaders to ensure C&C is established and monitored through the Leadership Round. **July 2015 Update:** Care and Comfort rounding monitored through leadership rounding. This is recorded through template and monitored by Matrons.	Observed practice List of Care & Comfort Champions Evidence of website updated Evidence/audit of C&C boards on all wards Evidence of C&C rounds Focus group notes Posters aimed at patients / families Presentation from Ward Leaderships meeting 20 January 2015	G
		Nursing Records	Trust wide	9.1	Strengthen accountability handover to promote individual accountability for the care of patients by the peer review and challenge of Registered Nurses looking after those patients	Executive Director of Nursing	EC & M and PC & S Divisional Matrons supported by Ultan Allen, PDM	30/03/2014	30/11/2014	Accountability sheets at the point of handover is signed to confirm all documentation and charts have been fully completed	Teaching aids and resources produced. Champions identified and supporting implementation into their area. PDM's supporting wards at handover times to identify best practice and support individuals. Challenges due to ward size & shift times at MCH & Newark being discussed at divisions. Adapting tool to work at other handover of care time's e.g. EAU to Ward, ED to EAU, theatre to ward. Use of accountability handover process to be audited as part of documentation audit. develop a consistent approach to printed handover sheets. **November** Teaching aids and resources produced. Champions identified within their individual areas who support implementation into their area. PDM's supporting wards at to identify best practice and support individuals, but continued challenge required by ward area leaders. Ward areas to embed best practice and focus on accountability process as opposed to the 'traditional handover'. Workforce change in progress at MCH & Newark occurring at divisional level. Challenges exist with regard to on-going consultation with ED to produce a usable, effective tool that will ensure optimal patient safety without impacting on patient flow. Close working with Theatres to ensure accountability component within every aspect of patient journey.' **Update 15.12.14** No further updates **January 2015** - Audit undertaken 23 January to be fedback to Quality Improvement Meeting on 2 February 2015. Traffic light standard developed to help ownership. Intense discussions with ED to establish handover sheet. **February 2015 update**: Accountability audit has been undertaken, 96.8% patients had a current accountability handover sheet, and 54.4% accountability handover sheets had two signatures in place. This will be re-audited regularly. **March 2015 update:** Further Accountability Handover audit takes place in March 2015. **April 2015 update:** Accountability Handover audit undertaken, with an improvement noted. 98% had handover documentation in the notes, and 76% were fully completed. **May 2015 update:** Readited in May - awaiting results	Accountability handover process and Escalation Care tool. Audit of Accountability handover.	G
DOMAIN - EFFECTIVE													

Effective	Hospital Inspection & Keogh	Recognition of the deteriorating patient	Trust wide	10	Ensure the processes for the recognition of deteriorating patients are robust and appropriately acted upon	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	Jun-13	31/01/2015	Staff are confident in the identification and management of patients whose condition is deteriorating. Patients are recognized and treated in a timely appropriate and safe manner.	Vital Pac rolled out across 23 inpatient wards. 1,500 staff have received training and are using the system. Serious Incidents in relation to failure to rescue reduced. Number of calls to Critical Care Outreach Team have increased since Vital Pac implementation, demonstrating earlier identification of deteriorating patients. July CCOT annual report available from Critical Care Consultant Nurse	Flash Report	A
		Recognition of the deteriorating patient	Trust wide	10.1	Implement fluid management and nutritional screening modules to support recognition of the deteriorating patient and hydration needs (phase 2)	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/2014	31/01/2015	Patient records are consistently and accurately recorded ensuring hydration needs are met, communicated clearly and widely. Deteriorating patients proactively highlighted	Testing the modules in January 2015. **January 2015 update:** 12.01.15 - Testing the modules this month. Fluid balance will be available in to test in Q1 (2015/16). By March 2015 there will be an upgrade to the system, which will include Nutritional Screening. PDMs will have a focus week in February 2015 on the 'deteriorating patient'. Fluid balance focus week took place in December 2014. **February 2015 update:** New Fluid Balance audit being undertaken in February 2015. **March 2015 update:** The Fluid Balance module is not available until April 2015. Internal audit demonstreated further improvments required, albeit 80% compliance. **April 2015 update:** Fluid management module still under development with the Learning Clinic. **May 2015 update:** The learning Clinica are continuing to work towa4rds the next big release which includes fluid balance in June 2015. July -The Learning Clinic have delivered first test version of fluid management and nutrition modules.Testing completed and now awaiting on test of version 2.Pilot expected to commence in September.	Vital Pac Board minutes	A
		Recognition of the deteriorating patient	Trust wide	10.2	Consolidation and optimisation of the early benefits of Vital PAC (phase 1) through learning clinics, working with Critical Care Outreach Team, Practice development and clinical leads	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/2014	31/01/2015	Staff use all current "live" aspects of the Vital PAC system to a consistently high standard ensuring accurate record keeping and monitoring of acutely ill patients	**Update 09.12.14** Vital Pac Learning Clinic held 2.12.14. We consistently benchmark one of the highest performers in the completion of observations and accuracy of NEWS scores. A Vital Pac report format for ward level information will be implemented in Jan 15. Roll out of phase 1 to all sites scheduled for early 2015. **January 2015 update:** 12.01.15 - MCH and Newark Hospitals to have roll-out in January and February 2015. **February 2015 update:** Preparation of an updated version of VitalPac to educate Kings Mill users to take place in February. VitalPac project team produce weekly ward performance reports. **March 2015 update:** VitalPAC Project Team continue to provide weekly performance reports for the ward teams. The Trust is currently awaiting the next upgrade for VitalPAC. **May 2015 update:** VitalPac project team continue to work with Newark and Mansfield Community Hospitals to prepare nursing and medical staff for the roll out of VitalPac following realease in June. July -Newark and Mansfield Community Hospitals now have VitalPAC embedded.SFHFT continues to be one of most compliant nationally. Compliance measures shared through weekly reports and on monthly ward assurance dashboard.	Notes from the leaning clinic event – 2 December 2014 Implementation plan for reports – January 2015. Implementation plan for 2015 rollout.	A
		Escalation of the deteriorating patient	Trust wide	10.3	Implement Vital PAC for Doctors (phase 2) including personal portable devices for staff and automatic escalation of deteriorating patients. Clinical charts and investigation results available in responders' hands to help instigation of treatment.	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/2014	31/01/2015	Doctors and critical care outreach will be aware of deteriorating patients immediately based on clinical observations. More timely intervention leading to reduced mortality and morbidity.	Planned for December launch but currently delayed by Learning Clinic national issues. **Update 09.12.14** Expected to start implementation of alerting in early 2015. **March 2015 update:** Awaiting the next upgrade from the Learning Clinic. April 2015 update: New software needed to upgrade, current system remains in place. New software onsite, to be signed off w/c 13 April. IOS 8.0 can then be upgraded to allow new functionality . Obstetrics VitalPAC to join the project later this year when released from the compnay. **May 2015 update:** awaiting release in June, see 10.1 & 10.2 July -Testing Doctor module and working with supplier to help them optimise functionality.	Implementation plan	A

		Weekend mortality	Trust wide	10.4.1	Eliminate variation in weekday and weekend mortality	Executive Medical Director	Divisional Clinical Directors	30.10.13	Ongoing	Eliminate and sustain the difference in HSMR between weekdays and weekends	Currently weekend and weekday mortality are within the same range statistically **March 2015 update:** HSMR mortality variation for November 2014 (most current) demonstrates that the weekday and weekend mortality is similar. Morality numbers remain high. **April 2015 update:** HSMR mortality demonstrates a slight improvement in November 2014's figures. **May 2015 update:** HSMR mortality demonstrates a fall on figures reported for November 2014. RAG rating reassessed - AMBER **July 2015 Update:** weekday/weekend mortality gap is significantly reduced but overall HSMR running higher. Action plan agreed with CCG to focus on relevant areas relating to pathways including pneumonia, sepsis, end of life care, documentation and accurate coding.	Monitored via Trust Mortality Group, Divisional bed to Board report will incorporate this. Reported to Board Quarterly.	A
		Sepsis	Trustwide	10.4.3	Reduction in the number of Sepsis deaths	Executive Medical Director	Executive Medical Director	01/03/2015		Reduction in the number of Sepsis deaths	**March 2015 update -** The Medical director has asked for all sepsis deaths to be reviewed in Q2 and Q3. **April 2015 update:** Reviewed sepsis deaths for Q2 and Q3. Now reviewed monthly at the Mortality Group. **May 2015 update:** Sepsis 6 is monitored and audited monthly by the Sepsis Lead, and reported to the Dvisional Clinical Governance. **July 2015 Update:** quarter 4 full compliance with sepsis 6 bundle at 65%. Quarter 1 2015/16 ED compliance with severe sepsis at 82%. Stretch targets agreed and sepsis action plan to deliver greater than 90% compliance in admission areas by the end of August and across the trust by the end of November.	Review of Sepsis deaths	A
Effective	Hospital Inspection	Access Targets	Urgent & Elective Care	11	Ensure safe, appropriate and timely flow of patients from admission to discharge, with the support of good bed management and discharge processes .Achieving and sustaining all 3 18 ww pathways	Director of Operations	Emergency flow Project lead	Dates	31.3.15.	95% sustained Reduced LoS Achieving & sustaining all 3 18 ww pathways.	Review of infection control leads within job planning process and evidence at appraisal of attendance at relevant meetings		A
		Patient Flow	Trust Wide	11.1	Improve the flow of emergency pathway with timely access to relevant services and discharge.	Director Of Operations	Emergency flow Project lead	01/04/2014	01/03/2015	95% sustained Reduced LoS Increased Pre-noon Discharge Rate	Perfect week held. Discharge team and social services co-located. Transfer to assess project in place. Board round training in plan to complete November 2014. Discharge lounge in place. **Update 16.12.14** ED Recovery plan in place with a 6 week trajectory to improve performance. Reassessed as RED because we are unable to achieve 95% performance. **July 2015 Update:** Acheived Q1 ED standard (4hr wait). Reduced no of patients with 14 day length of stay from 245 (March 2015) to 213 (6th July 2015) as a consequence occupied bed days has reduced from 9323 to 7163 meaning average length of stay has reduced from 38 days to 33.6 days. Our current pre-noon discharge rate is 17% against a target of 35%	Perfect Week report Transfer to Assess criteria Evidence/ audit Board Rounds Discharge Lounge utilisation Discharge Lounge policy ED recovery plan	A
		Patient flow	Trust wide	11.1.1	Improve discharge education and training of ward teams, ward leadership improvements	Director of Operations	Emergency flow Project lead	01/05/2014	30/12/2014	To reduce LOS (excluding 0-1 days) to 6 days	Work commenced in July with board round principles now in place on 20 wards across the Trust. Board round process written to ensure consistency & programme to embed this within ward culture. PID and status report for first stage engagement process with IDAT complete. **July 2015 Update:** Named transfer of care coordinator from IDAT team has been placed on every ward (April 2015). Monthly trailing sessions for these staff. Implemented refresh of board rounds n May with service improvement Team. Boar rounds happen on all wards - further work is needed on their efficacy. Board rounds is a key element of improvement which makes up the length of stay work stream for Turnaround.	PID and status report for first stage. Engagement process with IDAT. Implementation of a new Jaundice pathway. Board Round process.	A

		Patient flow	Trust wide	11.1.2	Reviewed the working arrangements of the discharge team to ensure they are fit for purpose to support new ways of working for discharge	Director of Operations	Emergency flow Project lead	01/05/2014	01/12/2014	Supporting ward teams with patient discharges to reduce LOS to 6 days. Working as an integrated workforce with community and intermediate care teams to enable as many patients as possible to be rehabilitated in their own homes.	Discussions held between organisations to expedite these arrangements prior to winter 2014. IDAT structure reviewed and interviews for new roles at the end of October. 6 Day/week working in place from beginning of October. 7 Day/week working in place from December. **05.12.14 Update** CHP Clinical Assessor roles have now commenced to work in collaboration with IDAT to expedite discharge and improve patient experience. **July 2015 Update:** Ward based (band 3) coordinators on each ward, supported by band 6 discharge nurse for each floor. There is mandated attendance to all daily ward board rounds. Discharge 'workshop' to include all internal and external partner to review current progress and plan next steps (16/17th August) Piloting Discharge Referral Assessment Tool on 3 ward areas with a view to remove current paper based (Section 2 and 5) referrals to Social Services.	PID and status report for first stage. Engagement process with IDAT. Implementation of a new Jaundice pathway. IDAT structure review and evidence of new roles appointed. Rota to demonstrate 7 day working. Evidence of Clinical assessors in place.	G
		Patient flow	Trust wide	11.1.4	Better Together implementation – supporting the prism model of working and utilising community capacity	Director of Operations	Emergency flow Project lead	01/07/2014	27/12/2014	Reduced LOS to 6 days (excluding 0-1 days) >95% 4 hour access target consistently .Reduced no's of patients over 20 days in hospital	Teams now in place in EAU & Ward 52 and will commence work in Ward 35 week commencing 20 October. **November** Attendance of CHP colleagues within areas Urgent Care Working Group Papers and SRG Plan. **Update 12.12.14** Plan New Clinical Assessors in place from Dec 8. Full capacity PRISM model being developed staffing extended temporarily using agency. **July 2015 Update:** We take part in Better Together Workshops that are currntly focussed on Single Front Door and Care Navigation. PRISM teams are up and running and are playing a key role in early discharge.	LoS Flash Report for Improvement Plan. Evidence of teams on EAU, Ward 35, Ward 52. Urgent care working group papers. Clinical assessors.	A
		Patient flow	Trust wide	11.1.5	Better Together implementation – delivery of transfer to assess	Director of Operations	Emergency flow Project lead	01/07/2014	27/12/2014	Reduced LOS to 6 days (excluding 0-1 days) >95% 4 hour access target consistently. Reduced no's of patients over 20 days in hospital.	Teams now in place in EAU & Ward 52 and will commence work in Ward 35 week commencing 20 October. Working group has now mapped out both community and bed based transfer to assess schemes to facilitate implementation prior to winter. **November** Attendance of CHP colleagues within areas Urgent Care Working Group Papers and SRG Plan. **Update12.12.14** Plan transfer to assess service commenced Dec 8. Full service implementation by 27/12 on track. **July 2015 Update:** Transfer to Assess now in place. This is a key part of the discharge process in the organisation.	LoS Flash Report for Improvement Plan. Evidence of working group, membership, agenda, notes. Criteria for Transfer to Assess.	G
		Patient flow	Trust wide	11.1.6	Using the directory of ambulatory care, Increase the number of conditions admitted to the Clinical Decisions Unit	Director of Operations	Emergency flow Project lead	01/02/2014	01/03/2015	>95% 4 hour access target consistently. Additional 5 ambulatory pathways in place. Reduced LOS Improved patient experience.	A new jaundice pathway has been introduced during Q1 and work is ongoing. Abnormal bloods, hypertension, physiotherapy and psychiatric pathways drafted and circulated for consultation **July 2015 Update:** SFH are signed up to the ambulatory care network (National) this is due to start in September 2015. Increase in the number of patients that are treated as daycase/ambulatory rather than be admitted is a key element of the lenght of stay workstream for Turnaround.	Implementation of a new Jaundice pathway. Plan for further pathways	G
		Patient flow	Trust wide	11.1.8	Review, plan and deploy a medical daycase reducing dependency on inpatient capacity for elective (and in some case non-elective) procedures	Director of Operations	Emergency flow Project lead	06/06/2014	12/12/2014	Reduced LOS >95% 4 hour access target consistently. Improved patient experience.	Medical daycase options are now completed and trial implementation is taking place during October 2014. The unit will be based within Clinic 9 to ensure it is not impacted by any pressure. Recruitment of a Clinical lead for this area is critical. **Update 12.12.14** Recruitment of staff unsuccessful, and insufficient in first round from November. New staff model being piloted in early January. Reassessed as RED. **January 2015 update:** Department Leader in place; reviewing pathways. **July 2015 Update:** Plan to complete options appraisal to discern the possibility of colocating medical daycase with discharge lounge.	Medical Daycase Model/SOP. Recruitment plan, advert, interview dates, appointments. Medical Day Case Unit policy. Medical Day Case Unit rota.	R

		Patient flow	Trust wide	11.1.9	Undertake a review of escalation processes and site management arrangement to ensure the organisation consistently responds during pressure and site management is optimal.	Director of Operations	EC & M Divisional Manager	01/07/2014	07/11/2014 **Second document 30/03/2015**	>95% 4 hour access target consistently. Improved patient experience. Reduced admissions & readmissions. Less pressure felt across clinical services.	Escalation procedures reviewed and being operationally road tested. Full operational guide for on-call and site managers written and distributed. Monthly communication cells held with on-call and site managers to discuss and resolve issues and improve services. **Update 05.12.14** Escalation processes reviewed and implemented. Further enhancements to improve processes to support ED have been agreed by the capacity group and revisions to escalation will be piloted from w.c. 8.12. **March 2015 update:** Completed and in place, 2nd document with escalation triggers to be agreed **July 2015 Update:** Escalation triggers agreed and operating framework out for consultation.	Revised escalation process and SOP. Silver on-call framework. Capacity and Flow meeting notes.	A
		Patient Flow	Trustwide	11.1.12	Review of the Medical Outlier Policy and embed the Medical Outlier Decision Tool into the clinical areas	Executive Director of Nursing	EC&M Divisional Matron		31/03/2015	To ensure patient safety	**February 2015 update:** Policy was ratified in January 2015, and audited for compliance. The audit demonstrated 19.% compliance, the Duty Nurse Managers are reinforcing this tool as a mechanism of patient safety in moving patients to outlying beds. This audit is planned to take place again at the end of February 2015. **March 2015 update:** DNM are reiterating the policy, ward staff are being provided with the Medical Outlier decision support tool. Audit being undertaken 2 - 13 March 2015. **April 2015 update:** Medical Outlier Decision Support tool - audit has been undertaken. **May 2015 update:** Audit reported to CQ&GC and to be reported weekly to the CQC comm cells	Medical Outlier policy Medical Outlier audits	A
				11.2	Achieve and sustain all 3 18 ww pathways	Director of Operations	EC & M PC&S, DNR Divisional General Managers		31.3.15.	Achieving & sustaining all 3 18 ww pathways	18 weeks programme of work in place to sustain improvements in problematic pathways, T & O, ophthalmology & urology **July 2015 Update:** Trajectories and action plans completed and submitted to CCG and Monitor. On track to deliver and sstain from September 2015.	Evidence of RTT achievement	A
	Finance & Performance Committee	Review List	Trust wide	11.2.3	Complete the review of all patients with outstanding appointments to improve patients outcomes	Director of Operations	Director of Operations	23/03/2015	01/06/2015	No outstanding review lists	**23.03.05 -** Reported to Finance & Performance Committee the number of patients on the review list, circa 10,000 patients, with a plan to contact all patients and reduce this number to none. This will be reported weekly to the DoOps **April 2015 update:** A 6 week programme of work has commenced with the Deputy General Manager for D&R leading a team to complete this work. **May 2015 update:** Review project maintained with oversight from Chief Operating Officer **July 2015 Update:** Greater than 7500 of the 8378 now booked for appointment pre-31st July. Review of outstanding appointments now forms workstream within outpatient improvemnt group which is overseen by an outpatient group board		A
		Administration & Information System	Trust wide	11.3	Ensure that the clinical administrative model is fit for purpose and meeting relevant KPIs and that information systems support this model.	Director of Operations	Divisional General Managers	01/03/2014	02/02/2014	Typing turnaround <10 days. 80% of telephone calls to be answered within 1 minute. Supporting specialty achievement of RTT by tracking patient pathways. Improved accuracy of data on inpatient consultant allocation. Improved reporting and access to business intelligence. Reduced waste/time spent on notes/administration.	Full review of all specialties, including Newark has been completed by the Service Improvement team and all clinical teams were asked to participate in the review feedback. The recommendations are being actioned – to complete by November. Medical specialties working extremely well, surgical specialties still have capacity issues with sustaining KPIs but significant success in trauma & orthopaedics. Additional supervisory support in place for surgery to sustain and improve. Additional training is taking place to support clinical teams. **July 2015 Update:** Typing turnaround continues to be consistent in less than 10 days turnaround. PPC model continues to mature. Administrative challenges and issues regarding timely management of outpatient elements of the patient pathway are incorporated into the outpatient and associated administrative services improvement programme.	PPC Future state figures. PPC review by Service Improvement Team. Evidence of recommendations being achieved. Evidence of training.	

		Administration	Trust wide	11.3.3	The Trust is keen to ensure that all contacts from the Trust are timely and professional and when attending the Trust their appointment is not delayed and all relevant information is available.	Director of Operations	D & R Divisional Manager	01/05/2014	31/10/2014	95% of cases notes to be available for short notice (2ww) clinics. 98% of cases notes to be available for planned clinics. Improved patient experience of outpatient services	All clinic booking rules have been reviewed and amended with clinician involvement to limit delays in clinic. One-stop services have been introduced in vascular to reduce delay in clinic and in RTT pathways. Additional work is on-going as part of the elective transformation programme to use alternative models of follow-up than traditional face to face to improve patient experience e.g. Further work is continuing with clinics who overbook to plan this more effectively. **Update 01.12.14** Cross Divisional Group reviews cancellations at short notice. Clinicians are contacted at the beginning of the week to ensure they are aware of and attending clinics as booked in order to reduce short notice cancellations. **July 2015 Update:** Greater than 95% case notes are available for outpatient clinics, this is monitored as a KPI through divisional performance and outpatient improvement programme. Access to outpatient services and an improvement in patient experience is a key objective of the outpatient improvement programme. Patient experience is tracked bi-weekly on 3 separate domains as part of tracking the improvement in this area.	Missing notes and clinic cancellations. Missing notes improvement meeting. Evidence of reviewed booking rules. Evidence of 1 stop clinics. Evidence of alternative follow-ups. Notes from divisional group meetings. Evidence of short notice cancellation clinics.	A
		Administration	Trust wide	11.3.4	Improve control of booking to provide sufficient time to enable notes availability, timely notification of appointments to patients with performance managed at divisional performance meetings	Director of Operations	Access, booking & choice manager	010/5/14	31/10/2014 **Revised** TBC	95% of case notes to be available for short notice (2ww) clinics. 98% of case notes to be available for planned clinics<DNA. Improved patient experience of outpatient services.	A full project team has been established and a process agreed with divisional teams for booking. The only exceptions will be 2ww where capacity has to be managed more flexibly. KPIs agreed and will form part of divisional performance from November. **Update 01.12.14** Cross Divisional meeting has developed KPI's – currently not being achieved. **Update 16.12.14** A Booking work stream has commenced led by Steve Jenkins. A project scope is in development.	Project team action plan – ToR, membership. Evidence as part of divisional performance meeting. Booking workstream. KPIs	G
Effective	Hospital Inspection	Training	Trust wide	12	Improve delivery of mandatory and targeted training for staff	Executive Director of Human Resources	Executive Director of HR	01/04/2014	31/03/2015	Staff receives relevant supervision, appraisal and development to enable them to perform effectively in their roles and support delivery of trust strategic priorities. Mandatory training targets are achieved.	OD & Workforce Committee receive reports on approaches of training into practice. Employee supervisor Self Service launched. Mandatory training e-learning workbooks launched.		C
Effective	Hospital Inspection	Individual Staff Performance	Trust wide	13	Strengthen the processes to enhance staff performance; ensuring the availability of skilled and competent staff	Executive Director of Human Resources	Executive Director of Human Resources	01/04/2014	31/03/2015	The appropriate numbers of skilled and competent staff are deployed across the Trust	NHS Medical Appraisal Policy implemented and distributed to all Medics. Eight Practice Development Matrons have commenced in post. New preceptor programme commenced Sept 2014. Work in progress on Stress management. Revised Appraisal policy agreed. Incremental progression protocol agreed.		R
	HEEM	Medical trainees	ED & T&O	13.2	Improve working relationships between ED and T & O	Executive Director of Human Resources/ Executive Medical Director	Divisional clinical director PC&S and Head of Service ED	20/10/2014	31/03/2015	Reported positive working relationships between ED staff and T&O trainees	HEEM feedback – action plan developed. Trauma Pathway review completed. **26.01.15 -** HEEM action plan agreed and submitted, regular meetings with T&O Consultants to monitor actions/delivery - next meeting planned 27.01.15. **February 2015 update:** HEEM action plan is being monitored through OD & Workforce Committee. **March 2015 update:** Monthly meeting with Trauma & Orthopaedics. Service Lead attended meeting around the development of the Trauma Assessment Unit. **April 2015 update:** EC&M Clinical Director to attend T&O junior doctors forum in April. **May 2015 update:** Medical Director meets monthly with T&O Consultants and Clinical Directors meets with the team regularly	Monitored via LETB and GMC surveys at Workforce Ctte. Reviewed at Junior Doctor Forums. HEEM feedback & action plan. Trauma pathway review.	G

	HEEM	Medical trainees	Trustwide	13.3	Address safety concerns raised by HEEM visit	Executive Director of Human Resources/ Executive Medical Director	Deputy Director of Training & Education	20/10/2014	Next monitoring HEEM visit November 2015	HEEM monitoring lifted	Review of ICE results concerns by Patient Safety Fellow and NHIS to identify issues and training required. Review by cardiology Head of Service; consultant vacancies recruited. **Update 09.12.14** Action Plan in place. **26.01.15 update:** Delivery continues to be monitored. RAG rating reassessed to GREEN. **02.02.15 update:** Action plan monitored montly by OD & Workforce Committee, reamins on track to deliver at deadlines to meet HEEM timescale. **March 2015 update:** OD & Workforce Committee has oversight to the action plan, CQC issues raised in October are addressed satisfactorily. In February there were a further 2 HEEM visits where further issues were identified. Additional action plans have been formulated and developed, and the oversight is with the OD & Workforce Committee. **April 2015 update:** OD& Workforce Committee has received the action plan in April, and continues to be progressed through the committee. **May 2015 update:** oversight maintained through the OD&Workforce Committee **July 2015 Update:** GMC visit to ED took place in June '15. Currently awaiting final report. HEEM visit to opthalmology: new action plan developed to address concerns. Final visit to T&O taking place 23rd July - Workforce and OD committee to monitor	ICE results review. Cardiology review – Consultant vacancies. Action plan	A
		Job Planning	Trust wide	13.5	Review Job Planning Toolkit to ensure it remains fit for purpose and supports delivery of contracted activity and 7 day services	Executive Medical Director/ Executive Director of Human Resources	Executive Medical Director/Executive Director of Human Resources	11/10/2014	31/03/2015	Job planning processes which support delivery of safe patient services in a cost efficient manner.	7 day services project has identified areas to be enhanced in relation to Job Plans. **Update 09.12.14** Dialogue with LNC re 2015-16 toolkit with business case for introduction of the Allocate e system in Mar 2015 for rostering, ;eave planning and job planning. **15.01.15 -** RAG rating reassessed as GREEN, on track **26.01.15** - Project Manager to implement the Allocate system has been recruited. Meeting arranged for the 9 February 2015 to launch the project. **February 2015 update:** Allocate are on site training staff, project manager has been appointed who has previously worked with Allocate software. **March 2015 update:** We have re-drafted the job planning toolkit and this is being ratified through LNC. Allocate are on site to complete the training. **April 2015 update:** Allocate project remains on track. **May 2015 update:** As above **July 2015 Update:** action plan in place by end of July that includes seven day and hot week working.	Job Planning Toolkit. 7 Day service in job plans. Plan & implementation of Allocate esytem	G
		Absence Management	Trust wide	13.9	Continue roll out of Stress Education Programme (for managers and staffs - in groups or individually) and effective signposting for managers and staff.	Executive Director of Human Resources	Rebecca Garner Senior OH Nurse	01/06/2014	30/03/2015	Improved management of stress related absence and improved awareness of symptoms of stress to allow early intervention.	Support provided on request with resilience training. **26.01.15 update:** Reviewed activities to reduce stress remains ongoing and monitored through the Health & Wellbeing Group **February 2015 updates:** Stress Management Focus Groups hae been taking place across the Trust regarding approaches to Stress Management in relation to staff. Interim updates were considered by the H&S Committee in January 2015, and a report was considered by OD & Workforce Committee in February, and further work was requested to triangulate the results with the outcomesfrom the staff survey. An action plan will then be developed and presented to the committee in March 2015. **April 2015 update:** Occupational Healht provides a developing resilience education session in addition to the stress awareness education session to either groups in the workplace or individual staff. The resilience training has been emebedded into the Trust Leadership and Management course since December 2014, and from March 2014 to March 2015 76 staff have attended a session.	Minutes from OD & Workforce Committee	G
Effective	Hospital Inspection	Clinical Pathways	Trust wide	14	Improve the effectiveness and responsiveness of services through the use of evidence based clinical pathways	Executive Medical Director	EC & M and PC & S Divisional Clinical Directors	01/05/2014	31/12/2014	Clearer guidance and improved pathways of care in line with evidence based guidance.	Pathway review of 3 surgical specialties underway. Elective transformation programme in place. EC&M reviewing Newark pathways and all 'external transfer protocols visible on the intranet.		G

	SMART action plan	NICE Guidance	Trustwide	14.1.2	Limited evidence of adoption of NICE guidelines	Executive Medical Director	Clinical policies lead	30/01/2015	27/03/2015	Roll out implementation of appropriate NICE guidelines across all specialities	**30.01.15 (from SMARTaction plan) -** Discussed monthly at Clinical Audit and Effective Committee. Backlog being tracked and escalated to divisions **March 2015 update:** The implementation of relevant new NICE guidance will be tracked at 12 weeks after publication and monitored via the Clinical Audit and Effectiveness Committee. An outline proposal for a 360 Assurance audit of our NICE Guidance processes has been agreed. **May 2015 update:** Backlog of NICE guidance completed and the risk register has been updated to reflet this. **July 2015 Update:** Significant progress made in relation to implementation of NICE guidelines. Of the 'Must Do' guidance types we had 58 in the backlog, 17 have now been closed and 23 escalated to risk register and 18 remain in progress. Of the optional guidance types there were 17 in the backlog, 15 have been closed and 2 are in progress.	Clinical Audit and Effective Committee papers	G
	SMART action plan	Clinical Pathways	Trustwide	14.2.2	Agree and implement process for developing and approving localised clinical pathways	Executive Medical Director	Executive Medical Director		02/02/2015	To establish a robust mechanism for ongoing pathway development	**30.01.15 (from SMART action plan) -** Discussion with the Head of Governance to agree a one off process to authorise updated pathways urgently. **13.02.15 (from SMART action plan) -** All pathways developed and agreed for publication. Intranet Pathway site now includes updated pathways for respiratory care and others to be uploaded by the end of February. **March 2015 update:** Pathways in standard format with version control uploaded to a single point of access on the Trust's intranet. These will provide optimised management for common presentation which is consistent. These were developed from discussion with Heads of Service at the Medical Managers weekly forum and a task and finish group established in November. A communication plan is in place to target junior doctors, heads of service and divisions over the next 9 weeks. An initial review of the uptake of the pathways will be performed in May 2015. **April 2015 update:** Audit planned for May 2015. **May 2015 update:** 3 clinical pathways are to be audited, NoF, GI Bleed and Suspected PE, auditors identified, and project plans to be produced. **July 2015 Update:** We have audited 3 clinical pathways: • Gastro-intestinal Bleed • Initial management in the Emergency Department and pre endoscopy was good • Improvements required in risk scoring assessment • Ambulatory Care – suspected Pulmonary Embolism • Good compliance overall with completion rates of baseline tests, initiation of blood thinning treatment and radiological assessment in over 90% • Improvements required in risk scoring • Fractured Neck of Femur • Good compliance overall • Improvements required in post operative rehabilitation, falls assessment and ongoing bone health assessment We will be re-auditing these in July, and updating the milestone plans. We have presented the Fractured Neck of Femur to the Trauma & Orthopaedic Clinical Governance on 30 June 2015, and arrangements are in place for this to be presented monthly. We will be presenting the Gastro-intestinal bleed audit to the Gastroenterology Clinical Governance meeting in July. Our junior doctor team in Emergency Care will be auditing the ambulatory care pathways and presenting at the Emergency Care Clinical Governance meeting in July.	Pathways from the Pathway site	G
	SMART action plan	Clinical Pathways	Trustwide	14.2.3	Develop and agree a mechanisme for ongoing review and refinement of localised clinical pathways	Executive Medical Director	Executive Medical Director			To establish a robust mechanism for ongoing pathway development	**13.02.15 (from SMART action plan) -** All pathways developed and agreed for publication. Intranet Pathway site now includes updated pathways for respiratory care and others to be uploaded by the end of February. **March 2015 update:** The process for approving pathways is established via the Clinical Audit and Effectiveness Committee. All pathways have version control, date written, date of next review and author on the pathway. **May 2015 update:** 3 clinical pathays to be audited initially **July 2015 Update:** Visit to Bath for clinicians. Services asked to review top 10 pathways for their service		G

Caring	Hospital Inspection	Family & Friends (F&F)	Trust wide	15	Increase patient feedback by collating a higher level of Family and Friends responses.	Executive Director of Nursing	Deputy Director of Nursing	01/06./4	31/10/2014	To increase the overall response rate for F & F to 50%	Currently the Trust uses a paper system for obtaining responses to F& F's. Failure to provide additional provision for patients to record their views is limiting our ability to increase our response rates. The Trust is currently tendering for an external provider to provide a provision for: · NHS Staff F & F plus quarterly pulse surveys · NHS Patient F & F plus quarterly pulse surveys · Doctor revalidation feedback · Registered Nurse revalidation feedback		G
		Family & Friends (F&F)	Trust wide	15.1	Secure a system which meets NHS England FFT requirements , provides user friendly survey methods whilst providing a real time reporting system which drills down to individual wards and departments	Executive Director of Nursing	Deputy Director of Nursing	01/06/2014	31/10/2014 **Revised** 31/03/2015 **Revised** January 2016	Achieve the internally set response rate of 50%	Currently in the final stages of tendering for a provider to facilitate FFT (staff and patient). The cost is currently far greater than planned. **November** Procurement exercise reinitiated as OJU limits exceeded in first round of tendering. The Trust is implementing its own promotion material to increase its response rate. At the end of October 2014, the response rate was 40%- being the best recorded rate since F&F commenced. Further work is required in Maternity and ED. Use of tools like IPads and stands are being explored. This milestone is reassessed as Amber. **Update 16.12.14** From an organisational perspective we have been unable to secure a provider to facilitate FFT across the trust. Following a meeting with the current provider we have clarified that the current contract for provision of FFT will expire January 16. We are therefore working with the current provider in the interim to increase our response rates across all areas. **February 2015 update:** Continue to work with current providers whilst considering the options currently available. Rebranding of all the FFT infromation, posters, banners and electronic signage distributed throughout the Trust. Implementation of the pilot of the Android App for FTT in ED and OPD from February 2015. **March 2015 update:** The current contract is in place until January 2016, and the Patient Experience is considering other FFT systems. **April 2015 update:** The Trust is currently exploring a number of procurement options to support FFT however, no decision has yet been made. **May 2015 update:** The Trust is continuing to explore a number of procurement options to support a joint procurement for patients and staff FFT. RAG rating reassessed GREEN **July 2015 Update:** Currently in talks with Optimum/Meridian who supply our Nursing Metrics solution to scope possibility of purchasing 'bolt on' IT solution for FFT whlst working with Outpatient Programe Board to explore options around Saviance as a solution.		G
			Emergency Department	15.2	Implement ED focused F&F action plan	Executive Director of Nursing	Deputy Director of Nursing	01/07/2014	30/09/2014 **Revised** 01/03/2015	Improve ED response rates	Meeting convened with Department Leader and Matrons to discuss and increase overall response rates. CQUIN workers deployed to ED to support and improve response rates. We have recently met with the current provider in order to discuss ways in which we can increase our FFT response rate in ED. We have requested some technical advice form the provider regarding the installation and compatibility of an app in order to secure responses electronically either via an IPAD or Android tablet. We have in addition redeployed our CQUIN workers to ED in order to support an increased uptake of FFT and have via our comms team produced a series of posters and banners to promote patient feedback. As part of the overall communication strategy we are liaising with the local press and social media to increase overall awareness and uptake of FFT. **February 2015 update:** Dedicated workers supporting ED to improve response rates. Customer Service Excellence Training has been delivered to 9 ED staff. **March 2015 update:** From February 2015, the Android online Application has been implemented in ED and received well by the staff and patients, it is anticipated that there will be an increase in the response rates. **April 2015 update:** CQUiN support worker has been redeployed to support FFT. The conintued use of the android application in ED has proven to be successful. ED response in February 6.7%; March 17.2%. **May 2015 update:** CQUIN support worker continues to support the FFT. ED response in April needs further action and an action plan will be developed **July 2015 Update:** CQuIN worker continus to support. Action plan in place for ED. Response rates and delays are tracked and monitored through the patient experience team weekly.	Action plan	A

Responsive	Hospital Inspection	End of Life	Trust wide	16	End of Life Care is responsive to the needs of our patients (and their carers), delivered by competent, knowledgeable staff who respect and meet individual preferences.	Executive Director of Nursing	Mark Robert, Consultant, , Lead Nurse for End of Life & Cancer	01/07/2014	30/11/2015	Patients requiring end of life care receive a responsive service that is timely and personalised to their needs	End of Life strategy developed – currently being finalised for consultation. New guidelines and documentation implemented to replace the Liverpool Care pathway. A further 2 wards have commenced the AMBER care bundle, 2 more wards have registered on the Gold Standards Framework in Acute Hospitals Programme and the service specification for fast track / rapid discharge is being reviewed. **November update (received after TB)** End of Life strategy has been developed and is being taken to the Trust Board in December. New guidelines and documentation implemented to replace the Liverpool Care pathway. A further 2 wards to commence the AMBER care bundle in January 2015, 2 more wards have registered on the Gold Standards Framework in Acute Hospitals Programme and the service specification for fast track / rapid discharge is being reviewed.		G
		End of Life	Trust wide	16.4	Implementation of End of Life Care key enablers e.g. AMBER care bundle; Gold Standards Framework in Acute Hospitals to enable staff to develop guidance for patients in their last days of life.	Executive Director of Nursing	Consultant, Lead Nurse for End of Life & Cancer	15/07/2013	30/11/2014 **Revised:** ongoing	Phased implementation of Gold Standards Framework in Acute Hospitals Programme based on 2 Wards per year. Phased implementation of AMBER care bundle based on 4 Wards per year.	The Trust is currently in the second phase of implementation of the Gold Standards Framework in Acute Hospitals Programme (GSFAH). With a further 2 wards registering on the GSFAH Programme in July 14. **November update (received after TB)** The Trust is currently in the second phase of implementation of the Gold Standards Framework in Acute Hospitals Programme (GSFAH). With 4 wards now implementing GSFAH into practice. The Trust is currently in the second phase of implementation of AMBER care bundle. unfortunately the further 2 wards planning to commence the AMBER care bundle has been deferred to January 2015 due to the EOLC Team having difficulties in supporting the wards with training and education. **February 2015 updates:** Additional resource has been provided to the team by EC&M, and this will assist with the pace of delivery. **March 2015 updates:** Four wards are registered on the Gold Standard Framework delivering training to 2 wards who have recently joined the programme. Continue to monitor progress on the first 1 wards. Amber Care Bundle will be phased rolled out programme, 100% rollout by April 2016. **April 2015 update:** Gold Standard Framework - 4 wards enrolled onto a 2 year programme. Amber Care Bundle - phased rollout programme, aiming for 50% completion by September 2015. **May 2015 update:** Gold Standard Framework being rollout out over 4 wards. Reviewed by the Medical Lead for End of Life Care. RAG rating reassessed - GREEN **July 2015 Update:** Training completed for all staff in 2 more wards (Gold Standards Framework) - 4 wards in total now compliant with GSF. Discussions underway regarding use of Ceilings of care or amber care bundle, existing roll-out plan continuing during this time.	Implementation plan. Attendees from National event.	G
		End of Life	Trust wide	16.5	All formal arrangements are in place to ensure all patients nearing the end of life have access to an effective, safe and coordinated fast track/rapid discharge.	Director of Operations	EoL Lead Nurse	13/10/2014	30/04/2015	Fast Track/Rapid Discharge processes allow patients nearing the end of their life to have access to an effective, safe and coordinated fast track/discharge. Audits will demonstrate how many patients were discharged to their preferred place of care, or the time it took to discharge patients .	Reviewing the current service specification to ensure all formal arrangements are in place. Exploring the possibility of designated Palliative Care beds at SFH for those patients who choose to die in hospital, to ensure they are cared for in a less acute environment. Audit programme in place for measuring Preferred Place of Care, anticipatory medication on discharge, time to fast track/rapid discharge, care of the dying patient and advance care planning. **January 2015 update:** 12.01.15 - 2 policies on fast track to be written. IDAT team to support 1 day a week. **February 2015 update:** The Discharge Policy is currently under review to update the fast track/ continuing health care and rapid discharge home to die section of the policy. **March 2015 update:**Discharge policy updated to incorporate fast track rapid discharges. Flowchart has been developed to support decision making. IDAT team have increased workforce to support fast track rapid discharges. **April 2015 update:** Reassessed RAG rating as GREEN. Policy written - flowchart to be reviewed. Continuing Health Care to review service specification. Montioring Rapid discharges and adjusting the audit form to capture the timeliness **May 2015 update:** Reviewed by the Medical Lead for End of Life Care. Fast Track audits are collected monthly and reported quarterly to the End of Life Strategy Group and into the Clinical Quality and Governance Committee	Audit of preferred place of care	G

											July 2015 Update: Monthly audits underway for FastTrack discharge/rapid discharge - results reported as above and to the General Palliative Care & End of Life Strategy Group. This is also monitored as a CQuIN through CCG reporting. This work is being supported in practice by band 6 discharge coordinators.		
Responsive	SMART action plan	Adult Safeguarding	Trust wide	17	Ongoing concerns from differing sources regarding existing safeguarding arrangements	Executive Medical Director	Executive Medical Director	01/03/2015		Evaluate the investment to date in training and establishing ward champions, measuring the impact on practice. CQC lead inspector to receive a detailed doucmented brief to include audit findings and the improved process by which safeguarding investigations are now undertaken. A detailed action plan ensuring continual improvments of safeguarding systems and processes to be agreed with CCGs and shared with CQC.			G
	SMART action plan	Adult Safeguarding	Trustwide	17.1	Local training and support has been revised to optimise improvement in practice. Implement Safeguarding ward champions	Executive Medical Director	Executive Medical Director/ Executive Director of HR	01/03/2015	31/05/2015	Ensure training investment target to maximise practice. Evaluate the investment ot date in training and establishing ward champions, measuring the impact on practice.	**30.01.15 (from SMART action plan) -** Meeting scheduled between Executive Director of Human Resources and medical Director to review safeguarding training provision. **March 2015 update:** Safeguarding training is delivered within mandatory training, as targeted specialist training to particular staff or areas and supplementary additional support. Mandatory training for adult safeguarding was at 92%, mental capacity 94% , learning disabilities 96% and Prevent awareness 80% in Q3. In addition 75 staff have attended supplementary vulnerable adults study days this year and over 200 additional staff have been trained on consent, deprivation of liberty and mental capacity. An additional session has been provided at the surgical divisional governance meeting on the 26 March 2015 for those needing specialist level 3 children's safeguarding. Clinical Champions have been trained and established for all wards with a resource pack to assist with local knowledge and expertise to raise awareness, audit and understanding. **April 2015 update:** Clinical champions in all wards are assisting with organisational learning, audits and supporting safeguarding referrals. **May 2015 update:** Clinical champions identified and training scheduled. **July 2015 Update:** Action plan agreed with external consultant to review and optimise effectiveness of training. this should completed by October.		G
	SMART action plan	Adult Safeguarding	Trustwide	17.2	Explore CQC concerns regarding the identification of learning from incidents and provide assurance	Executive Medical Director	Executive Medical Director	01/03/2015	30/06/2015	Audit results considered at Clinical Quality & Governance Committee until confident improvements sustained. CQC are assured of local processes and capacity to maintain standards.	**30.01.15 (from SMART action plan) -** The output of a Safeguarding investigation into 4 incidents shared with the CQC. **13.02.15 (from SMART action plan) -** Updates discussed with Helen Vine, aware of progress. Monthly meetings with CCG and local CQC includes safeguarding discussions. **March 2015 update:** Voluntary unannounced visits have been made to emergency admission areas to review safeguarding procedures and awareness. The findings were improved compared to the CQC inspection in April 2014 and the action plans have been developed to further consolidate. Our Serious Incident investigation process has been reported by the Coroner to be explemary in the East Midlands. We have aligned our safeguarding investigation process to this to ensure consistency, Duty of Candour, legal review, an executive sign off process, a tracked divisional action plan and organisational learning. **April 2015 update:** Investigations are shared with the CCG and CQC. Wards receive feedback from incidents, ie, 7 unexplained fractures, and staff awareness has been raised. **May 2015 update:** Fortnightly meetings with CQC, concerns have reduced. RAG rating reassessed as GREEN		G

	SMART action plan	Adult Safeguarding	Trustwide	17.3	To demonstrate assurance regarding local safeguarding processes and communication with partner organisations	Executive Medical Director	Executive Medical Direction	01/03/2015	16/02/2015	Agreed action in place with CCGs assured and confident of local systems and processes for assuring safety of vulnerable patients.	**30.01.15 (from SMART action plan) -** Requested strategic safeguarding support to help develop action plan. **March 2015 update:** Our Serious Incident investigation process has been shared with the CQC and the CCG in an updated report to Helen Vine and Elaine Moss. We need to enhance the dialogue between the trust and CCG via the monthly Quality and Performance meeting. **April 2015 update:** Safeguarding reports on '7 unexplained fractures' will be shared with the CQC and the CCG **May 2015 update:** as per 17.2. RAG rating reassessed as GREEN **July 2015 Update:** Action plan agreed with external consultant		G
	SMART action plan	Adult Safeguarding	Trustwide	17.5	Obtain strategic support to strengthen the Trust safeguarding processes	Executive Medical Director	Executive Medical Director	01/03/2015	31/05/2015		**February 2015 update:** Local CCG contacted to ask for help in review the safeguarding arrangements at the Trust - unsuccessful. Persuaded of the possibility of help from Chesterfield Royal Hospital. **March 2015 update:** Previous consultancy colleague contacted will speak to Weston Hospital to establish support. **9 March 2015 update:** RCN regional lead contact tofind senior support. Bath Hospital also asked to support **10 March 2015 update:** RCN have established a name, line of enquiry being persued. **April 2015 update:** We have appointed an external Consultant Professor Mandy Ashton to undertake a strategic review of safeguarding at the Trust. **May 2015 update:** Review complete, setting of medium term goals with team on the 15 May 2015. RAG rating reassessed as GREEN. **July 2015 Update: Completed**		C
Effective	Hospital Inspection, Keogh and SMART action plan	Infection Control	Trust wide	18		Executive Medical Director	Executive Medical Director	Jun-13	31/01/2015				A
		Infection Control	Trustwide	18.1.1	Implement a strengthened approach to infection, prevention and control through: · Establishing a county wide C Difficile task and finish group	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist	01/10/2014	31/12/2014 **Revised:** 19.01.15 **revised 20/07/15: ongoing**	Shared understanding and learning with community colleagues to understand and reduce the risk of colonization pre hospital admission. Medical engagement in RCA process.	Community wide task and finish group planned. **Update 09.12.14** Meeting with CCG to discuss Community C diff scheduled 19.12.14. Antibiotic Pharmacist met counterpart in community. New drug chart implemented with focus on antibiotic prescribing. Infection Control Mandatory Training for consultants over 90% Continuing deep clean programme with new fogging machine due on site next week. **January 2015 update:** 09.02.15 - meeting with Nurse Consultant to review actions, to attend the next Quality Improvement Meeting - 19.01.15 to assure the QI members. **26.01.15 update:** Patient Safety Colloborative reviewing progress in February 2015 following meeting with CCG. **February 2015 update:** Second meeting for the Joint CCG and SFH C-diff group is planned. Actions agreed at the meeting. External review of internal assurance measure to take place in February 2015 by Patient Safety Collaborative. **March 2015 update:** Two meetings have now taken place. New community anti-microbal precscribing policy is being written, which will have some input from Consultant Microbiologist and Consultant Nurse from Sherwood Forest Hospitals. Review of anti-microbal prescibing, and the community is to review their practice. Peer review of antimicrobal prescribing suggests that our practice is good. **April 2015 update:** Still awaiting the Patient Safety Collaborative report.	IPR September 2014 Quality & Safety. RCA Datix report, HCAI agenda & minutes. Evidence of county wide task & Finish Group – agenda/ ToR/ minutes. RCA evidence/ presentation. Job planning. Meeting notes from CCG meeting. New drug chart. Infection Control Mandatory training for Consultants. Deep Cleaning Programme. Examples of RCAs anonymised.	G
											May 2015 update: The third meeting is due to take place week commencing 11 May 2015. The Patient Safety Collaborative report has been received and an action plan has been developed, this will be monitored through HCAI and IPCC Committee and fed into the Clinical Quality and Governance Committee. **July 2015 Update:** The task and finish group remains operational. The next meeting is 11th August 2015. The group continues to review of RCA's across community and acute settings to ascertain trends and themes. Patient safety collabrative report has been incorporated into the annual IP&C plan		

		Infection Control	Trustwide	18.1.2.1	HCAI & IPPC meetings as a minimum include medical clinical representation from each of the three divisions as evidenced by attendance records	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			Strengthen the membership of the IPCC to ensure clinical engagement	**26.01.15 update:** Nurse Consultant for IP&C reviewing ToR and membership **February 2015 update:** ToR and membership to be reviewed in order to increase clinical attendance. **March 2015 update:** Changes to the dates in order to allow clinical representation, and there is now no clashes with other sub-committees. Executive support required to ensure clinical representation. **April 2015 update:** Continues to face the challenges of clinical representation at the IPCC and HCAI meetings. **May 2015 update:** Continues to face the challenges of clinical representation at the IPCC and HCAI meetings. Clinical Directors and Divisional General Managers asked to discuss with the medical and nursing representation. **July 2015 Update:** Nursing attendance has improved at this meeting. Medical representation is good. More work is required to encourage surgical representation - Discussions are being held at Medical Managers meeting.		A
	SMART action plan	Infection Control	Trustwide	18.1.2.2	HCAI & IPCC discussion are cascaded effectively across divisions to inform practice as evidenced by changes in practice as a result of information flow	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			Meed tp omcrease omf;iemce and organisational impact of HCAI & IPCC	**March 2015 update:** IP&C team attens EC&M and D&R's clinical governance meetings. Consultant Nurse to discuss with Clinical Governance Lead for PC&S. IP&C is a standing agenda item on EC&M and D&R Clinical Governance, which has been in place for the last 3 months. **April 2015 update:** Nurse Consultant continues to attend EC&M and D&R's Clinical Governance meetings, Awaiting invitation to attend PC&S. **May 2015 update:** IP&C Nurse Consultant continues to attend EC&M and D&R's Clinical Governance meetings. Clinical Director for PC&S to take the appropriate action to ensure that there is IP&C representation on all of the Dvisional Clinical Governance meetings. **July 2015 Update:** Regular attendance at divisional and speciality tgovernance meetings with the exception of PC&S who we are awaiting dates for these meetings.	Clinical Governance agendas	A
		Infection Control	Trustwide	18.1.3.1	Establishing and implementing clear escalation procedures to Medical Director & Nurse Director when breaches to IFC policy are repeatedly observed	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist	01/10/2014	31/12/2015	To provide clarify regarding escalation of concerns	Expectation that either the relevant medical consultant or infection control lead should input to and attend RCA presentations. Review of infection control leads within job planning process and evidence at appraisal of attendance at relevant meetings. Good level of discussion in RCAs. **26.01.15 update:** RAC documentation needs to record clinical input which will include medical presentation. **February 2015 update:** Root Cause Analysis documentation is being reviewed in order to record the clinical input which will include medical presentation. This will strength the 48 hour rapid review reporting. **March 2015 update:** Escalation for medical staff is managed via the Medical Director. In nursing the escalation is through the ward sisters, Matrons, Divisional Matrons. **April 2015 update:** Escalation directly to the DIPPC after the breach. **May 2015 update:** There is formulised escalation procedures for both medical and nursing. RAG rating reassessed - GREEN. **July 2015 Update:** advise move to complete	Breach escalation example	G
	SMART action plan	Infection Control	Trustwide	18.1.3.2	Evidence of use of escalation process and effective executive response	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist		20/07/2015	To provide clarify regarding escalation of concerns	**March 2015 update:** Medical Director attends the Junior Doctors forum to discuss issues, and the importance of IP&C is reiterated in the staff's appraisals. **April 2015 update:** Escalation of hand hygiene taken through to Medical Managers, consultants have since continued IP&C team to arrange training on hand hygiene. Hand hygiene was discussed at the Team Brief in April. **May 2015 update:** As above. Hand hygiene training will be focussed on a whole day of training within May 2015. On 5 May 2015 the IP&C team held a 'Save Lives - Hand Hygiene' in line with the World Health Organisation's Hand Hygiene day. **July 2015 Update:** Evidence of recent escalation shows to be effective - escalation response has been demonstrated. RAG as complete.	Meeting minutes from the Junior Forum Team Brief - April	G

	SMART action plan	Infection Control	Trustwide	18.1.4	Each patient with a hospital acquired infection (starting with C-Diff and MRSA) will have a RCA undertaken within 72 hours of diagnosis, with a cause and action required reported immedicately to the Executive	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			To provide learning from each acquired infection will inform policy development, local procedures and investment decisions	**30.01.15 (from SMART action plan) -** Rapid Response from Infection Control Consultant and team within 48 hours. We are liasingi with colleagues across the region to understand how they complete full RCS's within 48 hours. Provisional finding discussed with the Medical and Nursing team and will now be circulated to the Medical Director for review. **13.02.15 (from SMART action plan)** - All RCAs visible to Medical Director. Patient Safety Collaborative review due 6 March. CCG review due 23 February. **March 2015 update:** Full RCA within 10 days and reported to the HCAI. mini RCA to look at lapses in care and to identify causes, which are reported directly to the Medical Director. Nurse Consultant is developing an action log for RCA monitoring and outcomes. **April 2015 update:** Continues to support the RCA process. **May 2015 update:** Mini RCAs are completed within 72 hours which includes IP&C team member, nursing and medical staff. Full RCA's are completed within 10 days. Log of RCAs are kept by the IP&C Nurse Consultant to monitor themes, trends and outcomes. RAG rating reassessed as GREEN **July 2015 Update:** Achieving this for 95% of mini-RCAs. To contnue to monitor this - Weekend and Bank Holiday delays need to be better understood.	RCA action log	G
	SMART action plan	Infection Control	Trustwide	18.1.5	To develop a systematic method of taking timely and appropriate specimens introluced	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			To ensure that specimens are in Pathology in a timely manner	**March 2015 update:** A5 specimen card produced which has a stool sample proforma on the reverse, which goes with the sample to the laboratory. **April 2015 update:** new specimen forms have been introduced and are being used on the wards. This new process is currently being audited. **May 2015 update:** new specimen algorithm has been introduced and is operational, awaiting further auditing by the IP&C team. RAG rating reassessed as GREEN **July 2015 Update:** This has had repeat audited completed. This is being monitored on an on-going daily basis by the ICP team.	speciment proforma	G
		Infection Control	Trustwide	18.1.6	Implement hand hygiene stations within the Trust	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			To promote hand hygiene for the staff, visitors and patients within the Trust.	**March 2015 update:** Nurse Consultant ordering 14 hand hygiene stations which will be placed in areas such as the main reception, outpatients, the lift lobbies, outside Costa and the Voluntary Coffee Bar, and in ED. This will be launched through a communication plan which will include a twitter account. IP&C will respond daily to the tweets, on #handhygiene. **April 2015 update:** Hand hygiene stations are being rolled out and this will be completed by w/e 12 April 2015. **May 2015 update:** Hand hygiene stations have been rolled out on all sites. Newark Hospital requires an additional station for the Eastwood Entrance. **July 2015 Update:** This is implemented and completed.	Photos of Hand hygiene station from Twitter account - patient	G
	SMART action plan	Infection Control	Trustwide	18.1.6	To improve C-diff trajectory going into 2015/16	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			To improve the C-diff numbers for 2015/16 to ensure that the trajectory is met. To maintain low prevalence of lapses of care	**March 2015 update:** Currently over trajectory in 2014/15. Agreed number for 2015/16 - 48 cases. Lapses of care for 2014/15 are Q1 - 4 lapses; Q2 - 4 lapses; Q3 - 4 lapses and Q 4 - 2 lapses in care to date. **April 2015 update:** 48 cases of C-diff has been agreed with the CCG. **May 2015 update:** There were 4 cases of C-diff in April 2015, which is within the trajectory. **July 2015 Update:** Q1 - 16 cases against a target of 12. In May there was an outbreak of 3 cases in one ward - this has been fully nivestgated and reported against.	2015/16 - quarterly trajectory for C-diff	A

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Plan Name	Improvement Plan
Executive Sponsor	Susan Bowler
Date	29/07/2015 14:52
Version	v15.0
Trust Board	Jul-15

Key:

High level Actions - to be published
CQC Specific recommendation or Keogh outstanding action
Granular actions required to deliver

Overall Timescales at Risk

Colour	Meaning
Blue	Action fully implemented
Red	No progress made or progress is not expected to be made due to barriers
Amber	Progress being made towards completion of the action or overdue on completion date
Green	Action on track to complete in line with the completion date
Lilac	Action not due to commence
White	Action / BRAG to be determined

Number of Blue RAG rating	85

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
DOMAIN – WELL LED													
Well Led	Hospital Inspection & Keogh	Leadership	Trust wide	1	Recruitment and retention of a credible and competent Board of Directors equipped with the skills to deliver the strategic priorities of the Trust	Chairman & Chief Executive	Chairman & Chief Executive	01/09/2014	31/03/2015	A credible and competent board in place with the necessary skills to competently deliver the strategic priorities as outlined within the Strategic Plan	Board Review and Development Programme commissioned September 2014. Individual and team coaching commissioned for all Executive Team members September 2014. Appropriately experienced and competent interim Chief Financial Officer – post offered December 2014		A
		Board of Directors	Trust Wide	1.1	Commission and implement a Board of Directors Review and Development Programme	Chairman	Chairman	01/09//14	31/03/2015	Board assessment completed, capacity and capability gaps identified and action plans put in place to address.	Foresight Partners commissioned to undertake Well Lead Board Health Review and detailed Board Review and development programme. Observations and self-assessments have commenced. 26.01.15 update: Review completed. February 2015 update - RAG rating reassessed - COMPLETED	Foresight proposal and evidence of board agreement.	C
		Executive Team	Trust wide	1.3	Commission and implement individual and team coaching for Executive Team Members.	Chief Executive	Chief Executive	19/09/2014	31/03/2015	Executive team recognises their individual strengths and weaknesses, plans are implemented to close identified gaps. Team demonstrates effective team working.	The OCM Commissioned to undertake both team and individual coaching. **January 2015** Individual coaching commenced. Team coaching session scheduled in December 2014 and 2 February 2015, this will include personality type indicators. **February 2015 update:** Two team coaching session uhndertaken, future dates planned, individual coaching ongoing. **03.03.15 update**: Individual and team coaching sessions in place. RAG rating reassessed - completed BLUE	Proposal from OCM and evidence of agreement.	C
	SMART action plan	Executive Team	Trust wide	1.4.1	Appointment of a substantive Chief Financial Officer –	Chief Executive	Chief Executive	Jun-14	31/03/2015	Appropriately skilled and competent substantive CFO appointed	Substantive recruitment to the post remains a challenge. Re-assessment of process to be undertaken end October 2014, chief Executive and Executive Director of Human Resources. Appropriately skilled and competent interim CFO appointed – to remain in post until 30/04/15. One round of interviews for substantive appointment unsuccessful. Second round scheduled for 08/12/14. **09.12.14 Update** Preferred candidate identified following interview, intention to offer the post substantively by 12.12.14. **January 2015:** Post offered and accepted, awaiting start date - confirmed date 23.03.15 **02.02.15 -** Newly appointed DoF participated in the team coaching exercise. **03.03.15 update**: DoF to commence 23.03.15. Recruitment process for Deputy Director of Finance commenced RAG rating reassessed - completed BLUE	Email between Executive Director of HR and appointed CFO	C
	SMART action plan			1.4.3	Appointment of a substantive Non-Executive Director	Chairman	Chairman	Mar-15	30/06/2015	Appropriately skilled and competent Non-Executive Director	**03.03.15 -** We are working with Odgers to recruit a new NED, interviews are likely to be end of March. Timeline has been agreed. Potential candidates identifed. Renumeration and Nomination Committee with Governors arranged for 23 March 2015. **April 2015 update:** References taken, appointment to be ratified through Council of Governors 16 April 2015. Existing NED remains in post, 31 May 2015. **May 2015 update:** Non-Executive Director approved. Existing NED remains in post until the 31 May 2015.	Email confirmation	B
	SMART action plan			1.4.6	Appointment of a Turnaround Director	Chief Executive	Chief Executive	Mar-15	31/03/2015	Appropriately skilled and completed Turnaround Director	**12.03.15 -** Turnaround Director appointed and working with the Trust	Email confirmation	C

		Governors	Trust wide	1.5	Ensure current and the new public governors elected in October are inducted into the Trust through a robust induction process and by attending planned Governor training events. Clarifying the role and duties of governors and how this differs from the role of Non-Executive Directors	Director of Corporate Services	Deputy Director Corporate Services	01/03/2014	30/11/2014	A strong Council of Governors which represents the membership understands the Trust's business and has the knowledge and expertise to hold the Board of Directors to account. Robust and professional interaction between board members and Governors building strong relationships.	Governor elections underway – 4 vacant posts results of election 24th October. Governor Induction programme for new governors to commence 27th October. Governor training programme implemented 2 remaining sessions for 2014. 5th October – Estates and Facilities - to enhance the governors understanding of PFI, soft FM e.g. the role of Medirest across all hospital sites 5th November – Media/Comms & Volunteers/Fund raising – to ensure governors are aware of the role of the Comms team and how governors should respond to media enquiries an external speaker from the local press will also present. The lead for Volunteers and fund raising will Inform the Governors of the work of the volunteers, how these support the hospital and contribute to the fund raising activities. **November** Four new public governors successfully elected. Governors have received full induction programme and have met the chair and director of Corporate Services for briefing. The Governor development programme has been developed for 2015 with input from the lead Governor. This milestone has moved fromAMBER to BLUE - completed.	Governor elections, milestone plan, profiles for new governors. Governor Development Training programmes Part 1 & 2 Register of Governors attended	C
		Governors	Trust wide	1.6	Strengthen links between Quality Committee and Patient Safety and Experience Governor Committee. Through improved quality reporting, which highlights 'governor relevant' information, triangulates quality information and highlighting progress against regulatory requirements	Executive Director of Nursing	Head of Governance Support Unit	01/03/2014	29/09/2014	Fully informed governor committee which is able to provide robust scrutinised reports enabling the Council of Governors to hold the Trust Board to Account to Council of Governors	Chair of Governor Patient Safety and Experience committee is observer at Quality Committee	Quality Committee papers with evidence of chair. Agenda of Quality Committee.	C
	SMART action plan	Newark	Newark	1.7.2	Designated Director for Newark Hospital Required	Interim Director for Newark Hospital	Interim Director for Newark Hospital	26/01/2015	30/04/2015	Confirm excutive director to lead for Newark to ensure continuity and momentum of strategy development and implementaion.	**30.01.15 (from SMART action plan) -** Current arrangement s of experienced CEO holding this role continue and these arrangements are to be further discussed next week with the post holder; **13.02.15 (from SMART action plan) -** Existing arrangements continuing pending completion of wider Newark workforce review. **March 2015 update:** Workforce Consultation currently underway on a 30 day consultation. **April 2015 update:** Workforce consultation completed o nthe 24 March 2015, new structure in place from 7 April, Assistant Director of Operations and a Matron. **May 2015 update:** The Assistant Director of Operations will be responsible for Newark Hospital. Workforce changes have been completed.	New structure for Newark Hospital	B
Well led	Hospital Inspection & Keogh	Values led Culture	Trust wide	2	Our culture is focused on delivering 'Quality for All' and staff feel valued and empowered to do an excellent job and proud to work for our trust.	Executive Director of Human Resources	Executive Director of Human Resources	01/07/2014	On going	Improved staff experience and improved patient experience and care.	Listening events have led to the development of our Quality for All Values and behaviours. Staff briefings for more than 1,200 staff completed. Workshop – Leading for Values completed. Team conversation exercise completed. Ongoing progress in @quality for All' by development.		G
		Values Led Culture	Trust wide	2.2	Revise HR processes to support values based recruitment, selection and retention	Executive Director of Human Resources	Deputy Director of Human Resources	01/01/2014	24/11/14 **Revised** 31/12/14 **Revised:** 31.01.15 **Revised:** ongoing	Improved recruitment processes focusing on selecting individuals who demonstrate trust values as well as pre-requisite skills and experience.	Work completed with NHS Employers in order to review assessment material and training necessary for recruiting managers. **November** Recruitment and selection training programme updated to reflect Quality for All values and behaviours. Recruitment paperwork currently been updated will completed by December 2014. **Update 16.12.14** As in November paper work to be completed by end of December. **7 January 2015:** Revised RDS paperwork completed. Rollout in place. **15.01.15 -** RAG rating reassessed as GREEN on track **April 2015 update:** Reviewed all recruitment paperwork, and have re-circulated. Training is in place. **May 2015 update:** RAG rating reassessed - COMPLETED	Work from NHS Employers. Recruitment & Selection agenda. New Recruitment documentation	C
		Values Led Culture	Trust wide	2.3	Positive performance management campaign driving improved performance and referring to quality for all values and behaviours	Executive Director of Human Resources	Executive Director of Human Resources	01/07/2014	30.10.14 **Revised** 31/12/14 **Revised:** 31.01.15	To ensure the Trust is living its values and behaviour is consistent	Capability Policy currently under review. Training and toolkit for implementation being developed. November Capability policy agreed by OD and Workforce Committee on 4.11.14, toolkit for managers in development. Update 16.12.14 Tool kit to be agreed with staff side by 31/12/14 and published on intranet. 7 January 2015: Policy and toolkit agreed. Rollout to be completed by 31 January 2015. **March 2015 update:** New capacity policy and toolkit have been rolled out with training, in conjunction with the Appraisal Policy reflecting the Qualit y for All values. **April 2015 update:** Policy and training delivered. RAG rating reassessed - COMPLETED - BLUE	Agreed Capability Policy published dates for Training Programmes published. Workforce & OD Committee papers Toolkit.	C

		Values Led Culture	Trust wide	2.4	Quality for All Team based conversations take place across the Trust.	Executive Director of Human Resources	Executive Director of Human Resources	01/08/2014	31/11/14 Revised 31.12.14	To ensure that the values and behaviours are being embedded into Trust culture	Team cascade briefings have taken place. Team conversation documentation developed and available. Evidence of team conversations taking place. **November** Action Plans are being received evidencing team conversations are taking place. Enhanced communication campaign has been established with refreshed intranet site. **Update 16.12.14** Team Values conversations have taken place with many teams across the Trust. To date 67 team actions have been received – these will be shared across the Trust and further team actions will be secured by the end of December. **7 January 2015:** Team conversation exercise completed. To be shared across the Trust. **26.01.15 update:** Action completed. Further action plan being developed and monitored through the OD & Workforce Committee, to ensure 'Quality for All' is embedded into all we do. **March 2015 update:** Continues to be developed with a detailed action plan	Team action and defined outcomes. Team cascade evidence Evidence within the Trust on Team Values conversations.	C
		Values Led Culture	Trust wide	2.5	Explore the possibility of a buddy relationship with a 'Listening into Action' Trust to undertake an assessment and gap analysis of 'Quality for All' against Listening into Action outcomes	Executive Director of Human Resources	Executive Director of Human Resources	Jul-14	16/10/2014	Executive Team fully understands and has considered the benefits that Listening into Action can bring and have assessed this again the Quality for All approach.	Extensive conversations with Listening into Action lead at UHL. Benefits assessment currently being undertaken. **November** Assessment against Quality for All undertaken, the outcome of which was that Quality for All encompasses the majority of benefits of Listening into Action and that developing staff focus groups will ensure Quality for All that the scheme brings equitable benefits. **Update 15.12.14** Change RAG rating to **COMPLETED**	ETM action notes 15.09.14 Item 19	C
Well Led	Hospital Inspection	Leadership	Trust wide	3	Implement our leadership strategy with appropriate focus at divisional and service lines to support our leaders to deliver the strategic objectives	Executive Director of Human Resources	Executive Director of Human Resources	Jun-14	31/03/2015	Divisional and service line structures in place with clarity of roles and responsibilities. Leaders with the capability to deliver the strategic priorities.	Leadership Strategy currently being developed (final draft by 31 January 2015). Workshop completed and action plan developed to improve organizational effectiveness. Leadership development programmes evaluated and recommissioned.		G
		Leadership	Trust wide	3.3	Undertake capability review of middle managers and implement required improvement actions	Executive Director of Human Resources	Deputy Director – Training and Development	01/08/2014	28/02/2015 - TNA completed Focus Group 31/03/2015	Leadership and management training needs analysis completed that assess the leadership and management training capabilities	Training needs analysis process developed and completed. Focus groups with service and middle managers established to ensure a better understanding of issues faced by manager. To enable action plan to be developed.	Training Needs Analysis	C
		Leadership	Trust wide	3.4	Provide clinical leadership development opportunities	Executive Director of Human Resources	Deputy Director – Training and Development	01/04/2014	31/03/2015 **Revised 15.01.15**	Band 6/7 clinical leadership programme/RCN clinical leadership programmes are in place. Clinical leaders have the necessary skills to competently perform their roles.	12 deputy ward sisters have completed a Band 6 Clinical leader's programme. 2nd cohort of band 7 Ward Sisters are currently undertaking the RCN leadership programme in collaboration with NUH. Continue to provide leadership opportunities for clinical managers. **15.01.15 -** RAG rating reassessed as BLUE completed	Programme details published Agenda and register of attendees RCN leadership timetable and attendees	C
		Medical Leadership	Trust wide	3.5.1	Provide medical leadership and management development opportunities	Executive Director of Human Resources	Deputy Director – Training & Development	01/04/2014	31/03/2015	Revised and dynamic medical leadership programme in place. Medical clinical leaders have the necessary skills to competently perform their roles.	Medical Leadership Programme has been refreshed from input from the Medical and Clinical Directors. Meeting with the provider in November to finalise approach and content Programme is due to commence February 2015. **26.01.15 update:** On track to commence in February 2015. **February 2015 update:** Executive, medical staff and Consultant shadowing programme has commenced. 12 medical leaders attended the Private Board. **March 2015 update:** Medical Leadership Programme commenced 20 February 2015 . RAG rating reassessed COMPLETE	Draft refreshed programme outline	C
		Medical leadership	Trust wide	3.6.1	Identify Roles and Responsibilities for Heads of Service	Executive Medical Director	Executive Medical Director	01/04/2014	31/10/2014 **Revised:** 28.02.15	Clarity of expected outcomes delivered by the role, identification of support required and performance management to create consistency.	Draft Job Description for all HOS and this was taken to medical managers following the meeting requested HOS for the training requirements as part of medical engagement work. **26.01.15 update:** Draft Job Descriptions will be with the Medical Director on Friday 30.01.15 **February 2015 update:** Currently with the Medical Director for comments, to be discussed at the Medical Manager's meeting next week. **March 2015 update:** Head of Service job descriptions are to be ratified at LNC.	Email confirming – Identify roles and responsibilities for Head of Service, copy of job description, meeting notes and HoS training requirements.	C
		Medical leadership	Medicine	3.8.1	Recruit a substantive Clinical Director for Emergency Care & Medicine	Chief Executive	Director of Operations	01/10/2014	30/03/2015	A substantive Clinical Director in place	Current Clinical Director is due to leave the Trust January 2015. A replacement is currently being advertised. **November** interviews for the appointment of a new clinical director are scheduled for completion on 28.11. 2014. **Update 09.12.14** New appointment made with the new candidate receiving a 2 week handover with the outgoing post holder.	Advert Formal offer being drawn up Offer letter.	C
	SMART action plan	Medical leadership	Diagnostic & Rehabilitation	3.8.2.1	Recruit a substantive Clinical Director for Diagnostic & Rehabilitation	Chief Executive	Director of Operations		31/03/2015	A substantive Clinical Director in place	**30.01.15 (from SMART action plan) -** Medical Director and Director of Operations have met to discuss and agreed need to recruit to post. **13.02.15 (from SMART action plan) -** Approved JD and authorisation progressing through due process **March 2015 update:** Post advertised on the Trust's job bulletin, intranet and NHS jobs. No applicatns, therefore to be re-advertised or a further two weeks. **April 2015 update:** Dialogue between the Medical Director and a potential candidate is ongoing. **May 2015 update:** The post has been readvertised and there is an applicant from within D&R. **June 2015 update:** Dr S Gill has been appointed to the clinical Director of D&R. RAG rating reassessed, BLUE COMPLETED		C

Well Led	Hospital Inspection and Keogh	Risk Management	Trust wide	4	Ensure Trust Risk Management processes are robust including appropriate identification of risks, incidents, mitigation and learning at all levels in the organisation	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow & Patient Safety Manager	01/07/2014	28/02/2015	Risk registers and BAF adequately reflect current risks. DatixWeb implemented to increase the opportunity for improved information and opportunities for giving feedback and sharing of trends and themes to services and individuals. Evidence of Divisions learning and improvement from incidents through Clinical Governance Committee and Quality Committee	Risk Manager appointed. Review of divisional risk registers undertaken. Corporate risk register currently being revised to ensure risks are reported and scored appropriately and reflect the BAF. BAF currently being redesigned – To be presented at November '14 Trust Board. DatixWeb implemented and new level of information being obtained – being reported to Quality Committee and Clinical Governance & Quality Committee.		G
		Risk Management	GSU	4.1	Appointment of a Risk Manager to support the organisations management of clinical risks and make improvements in the way the Trust learns and share lessons across the divisions, service lines, departments and organisational boundaries.	Executive Director of Nursing	Head of Governance	01/05/2014	31/12/2014	Successful recruitment of a Risk Manager	Initial recruitment failed to appoint a suitable candidate. Interim in post for three months. Advertised post July. Risk Manager appointed – due to commence Mid November. Working x2 days a week to help establish systems and processes for learning. In process of confirming that risks currently on Datix Risk Module (Rich Client) and within the interim RM's excel spread-sheet are live/current and appropriately scored. (This exercise has commenced via the Clinical Governance Co-ordinator network in conjunction with the directorate management teams) **Update 01.12.14** Action **COMPLETED.**	Job description Offer Letter	C
		Risk Management	GSU	4.2	Appointment of Clinical Governance Co-ordinators within the GSU with a responsibility within the JD to support effective risk management and learning.	Executive Director of Nursing	Head of Governance	01/05/2014	31/12/2014	Successful recruitment of Divisional Clinical Governance Co-ordinators. Monthly reporting of Risk Register Activity in divisions.	All divisions have an appointed Clinical Governance Co-ordinator (all appointed in July – August 2014) Template for reporting monthly on risk register activity drafted and first risk reports to form part of divisional governance packs in November 2014. Divisional CGC's currently reviewing risks on risk register to ensure risks are appropriately described, controls recorded and for each risk any additional actions to mitigate/minimise the risk. CGC's are "handlers" on Datix for risks to help and support the risk leads in division. The role out of DatixWeb will give speciality leads access to their risks-to improve management at service level. **Update 01.12.14** Action **COMPLETED**	Names of Clinical Governance Co-ordinators. Templates for reporting risks. Clinical Governance meetings from each divisions to demonstrate risk is discussed. Copy of Clinical Governance Co-ordinator's job description	C
		Risk Management	Trust wide	4.3	Approve revised Risk Management Policy at November Board of Directors meeting.	Executive Director of Nursing	Head of Governance	01/07/2014	30/11/2014	Approved Risk Management Policy with detailed understanding of the Risk Management Process contained therein.	Currently being fully consulted on to include TMB, CQ&GC, QC, Divisional and Specialty Governance Groups. Amend the draft Risk Management Policy to: - fully reflect the NPSA grading matrix throughout - Expand on the 4 levels of risk management/escalation (ownership) - Remove the procedural elements including the Datix User Guide **November** Approved at TMB, CQ&GC and Quality Committee. On agenda for BOD. Approved in principle by BOD – amendments to include establishment of Risk Committee.	Risk Management policy. Papers from TMB, CQ&G Committee, Quality Committee where is was approved. ToR and agenda for Risk Committee. 2015 dates for Risk Committee. Risk Management Committee annual workplan	C
		Risk Management	Trust wide	4.4	Create a supporting Risk Management Procedure which will also serve as a training hand-out to include: - The SFH approach to identifying, assessing and managing risk - User friendly screenshots of DatixWeb Risk module & how to upload and subsequently manage risks (including action plans and archiving obsolete risks)	Executive Director of Nursing	Head of Governance	01/10/2014	01/12/2014	Approved Risk Management Procedure which will also serve as a training hand-out	Currently sitting as an appendix to the revised draft risk management policy, however agreed to have stand alone. Timescales dependent upon appropriate changes being made to DatixWeb as screenshots will be used for the procedure. **November** Draft circulated for comment to Clinical Governance Co-ordinators and HoG by the Risk Manager. This will be given out at training. Timescale will be met. This has been reassessed as green. **Update 16.12.14** Action **COMPLETED**	Risk User Guide – needs version control, author, approval process adding.	C
		Risk Management	Trust wide	4.5	Introduce a Risk Assessment form* which can be used to capture clinical & non-clinical risks. This form will be contained within the Risk Management Procedure.(* currently the only form is one used by the H&S Department).	Executive Director of Nursing	Head of Governance	01/10/2014	30/11/2014	Consistency in recording risks using unified assessment.	Draft to be circulated for comment and consultation w/c 10 October. **November** SFH Risk Assessment Form created to support the content of the Risk Management Policy: • Generic (Clinical & Non-clinical) • Standard 5 x 5 matrix • 4 T's included • Action Planning element • At-a-glance Tier Level ownership & monitoring requirement Action **COMPLETED** **Update 16.12.14** Action **COMPLETED**	SFH Risk Assessment Forms	C

		Risk Management	Trust wide	4.6	Launch the Risk Management approach (Policy & Procedure) - To form part of the GSU Communication Plan - A Risk Management TNA will be agreed & implemented offering different levels of training to different groups of staff - Specific DatixWeb Risk module training including running of reports and use of Dashboards will be delivered to areas with supporting reference material.	Executive Director of Nursing	Head of Governance	01/12/2014	21/01/15 & on going	Staff competent in the identification, assessment and management of risk according to their sphere of responsibility	Events, courses, awareness sessions and various media activity which will be continual – plans already being made for initial launch. **Update 16.12.14** The three levels of RM training have been added to the Trusts TNA and commence in January (there will be two Level 1 sessions pcm, two Level 2 pcm and 1 Level 3 pcm). Reassessed as RAG rated GREEN **February 2015 update:** The Risk Management policy has been published and communicated to a wide audience. A new generic risk assessment tool has been introduced and the feedback is positive. The Risk Management training has commenced and initial feedback is encouraging. A Risk Management and Datix Risk User Guide has been introduced. **23.02.15 update:** RAG rating reassessed as BLUE - completed.	Launch details of Risk Management comms plan. Risk Management training plan, dates and registers. Risk Management training - 3 levels of training presentations	B
		Risk Management	Trust wide	4.7	Ensure DatixWeb reflects the content and approach set out within the Policy & Procedure (including links with incidents, claims and complaints). Transfer agreed risks onto DatixWeb version	Executive Director of Nursing	Head of Governance	01/08/2014	15/12/2014 **Revised** 31/01/2015	Risk module of Datix Web will have improved functionality, particularly in terms of reporting risks and source of risk, aligning risks to strategic objectives and CQC outcomes, risk status, response to risk e.g. 4T's (treat, tolerate, transfer or terminate), ownership of risk and escalation of risk.	Risk Management Module of Datix Web is being piloted at Newark and of specialty areas within ECM. A number of amendments are necessary and some work to align the old version of Datix (Rich Client) with DatixWeb. (NB: the timescale assigned reflect the fact that the Datix Administrator is attending the DCP course late October and the quality check of incidents on the incident module of Datix takes up a significant amount of the D.A. role). **November** Meeting with Datix administrator 14/11/14 and progress being made with Datixweb. **Update 16.12.14** The majority of the changes have been made to DatixWeb Risk it is expected to be early January it will have the fields required. The Risk Manager needs to test it fully before proper launch. As soon as that happens and everything works OK the Risk Manager will use the ICT training suite to undertake 2 x Datix risk sessions per month (from February) and from April 1 x dashboard session pcm **15.01.15 -** RAG rating reassessed as GREEN on track **February 2015 update:** The DatixWeb reflects the policy and risks are available on Datix. The RAG rating has been reassessed as BLUE - completed	Link to Datix homepage where information to this nature has been communicated across the Trust. Datix Web Risk Project plan. Risk User Guide	B
		Risk Management	Trustwide	4.9	Establish a Risk Committee reporting to TMB.	Executive Director of Nursing	Executive Director of Nursing	01/12/2014	31/03/2015	Risk Committee in place.	Committee structure defined. A decision to include a Risk Committee within the reporting structures made w/c 20/10/14. New risk management due to commence 03/11/14. Role will be to support the establishment of this committee. **November/December** Terms of Reference drafted for new Risk Committee. First meeting planned for December to agree ToR, membership yearly planner. Meetings planned for monthly. In early 2015 the Datix Risk Dashboard will be in a position to be either projected live at the meeting with dashboard reports prior to the meeting as papers. The ensuing discussion will satisfy the "monitoring performance" aspect of the Risk Committee. This milestone has been reassessed as Amber. **January 2015** - Two committees have been held. Terms of Reference agreed. Report sent to TMB completed. RAG rating reassessed as BLUE completed **March 2015 -** Three Committees held Risk Registers for EC&M and PC&S reviewed in depth.	Risk Management Committee ToRs Datix Risk Dashboard Committee dates. Minutes from meeting. Trust Management Board minutes and agenda	C
Well Led	Hospital Inspection	Learning	Trust wide	5	Ensure that staff receive appropriate and timely feedback from incidents and complaints and that actions taken and lessons learnt are shared across the divisions to improve quality and safety	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow, Patient Safety Manager	01/07/2014	31/12/2014	Staff feel they are receiving appropriate and timely feedback. Improved quality and safety as a consequence of sharing and learning	DatixWeb in place across the whole Trust. This version increases the opportunity for incident reporters to receive feedback whilst also improving the depth and sensitivity of information to aid learning. Quality Summit shared best practice from Maternity, Critical Care and C&YP. Examples of 'what works well' from individual service lines discussed. Development of Medical Matters, use of iCare2 and safety bulletins. Strengthened SI process to support sharing and learning being implemented across the Trust. Learning from incidents and complaints strategy being developed.		A
		Complaints learning	Trust wide	5.3	Introduce a complaint response action plan tracker (for every upheld or partially upheld complaint there will be a SMART action plan which will be monitored until last action complete). Themes will be collated monthly and form the basis for replicating learning across the Trust.	Executive Director of Nursing	Patient Experience Manager	01/10/2014	31/12/2014	Robust action plan tracker with evidence of escalation when actions exceeded timescales for completion. Auditable tracker of actions completed enabling improved evidence of lessons learnt.	Action tracker implemented. **15.01.15 -** RAG rating reassessed as BLUE completed	Action tracker.	C

		Sharing and learning	Trust wide	5.5	Review Divisional Governance Performance Information to ensure it is in a format which facilitates sharing and learning for Divisional Governance Meetings.	Executive Director of Nursing	Head of Governance Support Unit	01/09/2014	31/12/2014	Divisional Governance Information is reviewed to ensure it provides robust, timely information for ; risks to be clearly identified, opportunities for best practice to be discussed and themes and trends to be shared with service lines and individuals.	Meeting held 23/09/14 and agreed divisional pack core content. Meeting notes available upon request. Core agenda agreed. Specialty governance packs being reviewed with core agenda to be finalised in line with divisional agenda. TORs being reviewed w/c 6/10/14. The Trust has purchased Datix dashboards and the GSU will work with Ward and Dept leads to create dashboards relevant to their service. Plan to facilitate this by the end of December 2014. **February 2015 update:** Standardised format is being used at all the Clinical Governance meetings this is being driven by the Clinical Governance co-ordinators. **March 2015 update:** All divisions now hold their divisional governance meeting in the fourth week of the month. Meetings were moved from earlier in the month to provide more time for leads to produce the relevant data for the divisional governance packs. The data packs do contain the required level of data to facilitate discussion of the priorities, the risks, for best practice to be discussed and for themes and trends to be shared with service lines. **April 2015 update:** Frameworks in place and divsional meetings follow the Board/Committee schedule. **May 2015 update:** Frameworks in place, information from key areas are received and discussed. RAG rating reassessed - COMPLETE	ToR, Action notes 23.09.14. Governance Programme of Work Divisional Governance Meeting Data.	B
		Sharing and learning	Trust wide	5.6	Quality Summit to bring clinical leaders together to establish mechanisms for improving sharing and learning - incorporating successes in Maternity, Critical Care and C&YP (Good Outcome in last hospital inspection visit).	Executive Director of Nursing/ Executive Medical Director	Assistant Director of Nursing for Quality,	01/08/2014	27/09/2014	Quality Summit presented. Maternity, Critical Care and C&YP all presented at the summit. Learning and sharing opportunities collated.	Quality Summit identified individual, service line and Trust Wide learning opportunities – to be included within Learning from Incidents strategy.	Agenda and notes from quality summit. Learning from Incidents strategy.	C
		Sharing and learning	Trust wide	5.7	Task and finish group established to formulate a Trust Wide Strategy for improving sharing and learning of themes and trends and individual learning points which mitigate risks and improve outcomes.	Executive Director of Nursing	Patient Safety Manager	01/10/2014	30/11/14 **Revised** 31/01/2015	Sharing and learning strategy developed with evidence of individual learning.	Project initiation plan presented to Patient Safety Improvement Group and being shared at Clinical Quality and Governance Committee on 15 October 2014. Bite size feedback reviewed at Newcastle. **Update 16.12.14** Task group continue weekly. The Patient Safety Lead has been meeting with many leads of departments / harms etc. and still have other scheduled this week to update on work and ask them to identify what messages that they can produce on say monthly/bi monthly/quarterly basis some already have that can adapt. Objective being have a library of learning that can be used for learning boards condensed version s for screensavers etc. Ward leaders forum on 9.12.14 looked at what they do now which will be collated into a visual. One development that came out of this was to have nurse and AHP gran round. It was agreed at the meeting on 15/12/14 that his will be held twice a month and will commence with the first on in January. Will be able to have a message within SMART that is being worked up now. iCare2 shared learning event planned for 17th March. Consistent format for patient safety newsletter completed and shared 15/12/14 with divisions. **15.01.15 -** RAG rating reassessed as GREEN completed **February 2015 update:** iCare learning event is planned for March 2015 and is being driven by the Patient Safety Lead. Organisational leaning weekly meetings have developed a 'good idea' tracker. Organisational learning is a standing item on groups/ committee agendas. **April 2015 update:** Task & Finish Group is now fortnightly with the last meeting in the month dedicated to the Good Ideas Group. Learning Boards are informed through these meeting. Themes are developed from Serious Incidents, complaints and safeguarding. Grand Rounds are occuring monthly with themes of deteriorating patient (January 2015); Serious falls (February 2015) and Medicine Safety (March 2015). **May 2015 update:** Task & Finish Group scheduled and working well. RAG rating reassessed - COMPLETE	Clinical Quality & Governance Committee minutes and reports. Patient Safety Improvement Group notes. Ward Leader forum agenda/ minutes – 9 December 2014. iCare2 shared learning event 17 March 2015.	C
		Sharing and learning	Trust wide	5.9	Implement a series of Trust Wide Nursing and Midwifery time out days to ensure every nurse and midwife complete learning workshops around the 6C's and the CARE values.	Executive Director of Nursing	Head of Professional Practice	31/10/2014	31/03/15 and on going (will take 12 month to complete)	A series of workshops are delivered which delivers clear messages regarding consistency in practice, whilst also conveying a ' pride to be a nurse' message	Workshops planned for next 12 months. First workshop to commence on 31/10/14 and then 2/52 for next 12 months (allowing a break during winter pressures). **15.01.15 -** RAG rating reassessed as BLUE completed	Study day/workshop agenda , notes and evaluation forms. Register attendees.	C
		Sharing and Learning	Trust wide	5.11	Explore the option of implementing learning boards for every clinical area.	Executive Director of Nursing	Patient Safety Manager	16/01/2014	31/12/2014	Learning boards for every clinical area are in place.	The mock CQC learning event and Quality Summit have identified this as a need. **November** The Patient Safety Manager is taking the lead on developing a Sharing and Learning strategy for the Trust. A weekly task and finish group supported by the Director of Nursing is meeting to pull together and pilot ideas. The wards are piloting a learning template. A trust wide learning board has been designed and is being debated at the task group-this will be ready for wider consultation and development by 7th December. Screen savers with key messages and 'message of the week' will commence by December 7th. This milestone has been reassessed as Amber. **January 2015 -** Leaning Boards now in the clinical environments RAG rating reassessed as GREEN on track. **February 2015 update:** All ward areas have learning boards, and some non-clinical areas, with some amendments. RAG rating reassessed as BLUE - completed	Notes from Task & Finish Group. Learning template. Screen saver – message of the week.	C

DOMAIN - SAFE													
Safe	Hospital Inspection & Keogh	Staffing	Trust wide	6	Build safe and effective staffing levels with escalation processes to meet unpredicted demand.	Executive Director of Nursing/ Executive Medical Director	Executive Director of Nursing, Executive Medical Director	01/01/2014	01/04/2015	Staffing levels reflect the needs of patients and are sufficiently flexible to support variability in demand.	Acuity review completed for all inpatient wards. Nurse staffing numbers and skill mix collated and reviewed daily. Staffing information is uploaded onto UNIFY and Trust Board receive monthly reports which relates staffing shortfalls to incidents. Recruitment campaign in situ, with overseas recruitment established. Successful recruitment of Consultant Posts over past 6 months. Proactive recruitment of newly qualified nurses and increased numbers of HCA's on the nurse bank.		A
		Nurse Staffing	Trust wide	6.3.1	Undertake staff and skill mix reviews 6 monthly which is subject to Board Oversight.	Executive Director of Nursing	Deputy Director of Nursing	01/04/2014	Every 6 months	Trust Board receive monthly and 6 monthly staffing position (UNIFY return, 6 month acuity assessment and ward rota's) as recommended within NICE guidance.	Ward by ward staffing position reported monthly to the Trust Board since 01/04/14. Full establishment review with acuity assessment received by Trust Board with 6 month update planned 30/11/14. Acuity assessments undertaken July 14. All inpatient ward establishments reviewed and communicated to ward sisters during October 14. **15.01.15 -** RAG rating reassessed as BLUE completed	Safe Staffing levels Oct 14 TB Report	B
			ED	6.4.2	Review ED night nurse staffing. Benchmark numbers and skill mix with organisations that have similar demand profiles.	EC & M Divisional Matron	ED Matron	20/07/2014	31/10/2014	To provide a comparison of staffing levels within other ED Departments of similar profile and assist making future informed decisions.	Benchmark against 4 other ED completed. Recruitment to commence to increase RN overnight by 1 per shift. Additional Band 6 shift leaders now in post. **Update 01.12.14** Action **COMPLETED**	Workforce review ED Benchmark report ED rota – additional staffing	C
			ED	6.4.3	Monitor ED escalation plan daily and review issues weekly at Capacity and Flow meeting.	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/03/2014	24.10.14. commence weekly capacity meeting	To ensure that resources are deployed effectively to manage surges in demand.	Escalation reviewed as part of the 10am capacity meeting and review of issues identified are raised directly with the Service Director and Divisional management team. The establishment of a formal capacity meeting from 24 October. **November** Weekly capacity and flow meetings commenced 24/10/14. This milestone has been reassessed as green. **February 2015 update:** Escalation monitor by gold on-call at all the bed meetings, and escalation for discussion at the Capacity and Flow meeting. **March 2015 updat:** The ED escalation is reviewed at each bed meeting and weekly in the Capacity & Flow meeting. **April 2015 update:** Daily review at 3 x daily bed meetings and weekly Capacity & Flow meeting is in place. RAG rating re-assessed as COMPLETE - B:LUE	Notes from Capacity & Flow meeting. Diary evidence of meeting ED Escalation plan	B
		Nurse Staffing	EAU	6.5.1	Recruitment of a second Band 7 Sister/Charge Nurse to the Emergency Admissions Unit.	EC & M Divisional Matron	ED Matron	01/07/2014	31/10/2014	To provide additional senior support and leadership to the Emergency Admissions Unit. To lead on governance within the department.	Experienced EAU Charge Nurse recruited with vast experience of EAU working and governance.	Monthly establishment produced via finance. Monthly ESR data produced by HR	C
		Nurse Staffing	Medicine	6.6.1	Review acuity and dependency in all medical wards to identify the workforce mix required.	Executive Director of Nursing	Matron, Medical Specialties	01/07/2014	31/10/2014	Acuity and dependency review completed. Staffing requirements reviewed and the staffing model for each ward assessed to reflect the outputs of SNCT professional view and Telford modelling.	SNCT on all medical wards completed during July 14. 50:50 and 60:40 establishment and skill mix numbers for individual wards set and communicated individually to all ward sisters. During October, numbers will be reviewed in light of SNCT results but minimal changes anticipated. **February 2015 update:** Safer Nursing Care Tool assessed in January 2015, which will inform the next six months staffing. **March 2015 update:** Acuity and dependency being reassessed on Sconce Ward (Newark Hospital) to understand potential acuity and dependency changes - snapshot audit.	SNCT paper and results. October Trust Board paper.	C
		Nurse Staffing	Medicine	6.6.2	Proactive overseas recruitment of Band 5 Nurses to help fill current vacancies.	Deputy Director of Human Resources	EC & M and PC & S Divisional Matrons	01/04/2014	30/03/2015	To supplement rolling recruitment programme with international workforce to meet required increased demand in RGN.	24 Overseas RGN's in post. Practice Development Nurse appointed to lead on international recruitment and provide orientation support. Further overseas recruitment planned for Ireland and Greece in Oct/Nov. **January 2015 -** 50 international nurses in post. RAG rating reassessed as BLUE - completed **March 2015 update:** new overseas recruitment campaign being reviewed.	Monthly establishments produced. Monthly tracker produced for overseas recruitment. International recruitment.	C
		Staffing	Trust wide	6.9	Offer flexible working arrangement for both substantive and temporary staff.	Executive Director of Human Resources	Executive Director of Human Resources	01/06/2014	31/03/2015	A flexible workforce with the capabilities necessary to achieve successful outcomes in an ever changing environment.	Contract and working arrangements being reviewed to meet both the needs of individuals and the Trust. **26.01.15 updated:** Reviewed activities and continues to be on track **March 2015 update:** Flexible working policy was ratified at the OD & Workforce Committe on the 3 March 2015, there are now opportunities for staff to work flexibily. **April 2015 update:** RAG rating reassessed - COMPLETE - BLUE	Flexible working policy.	C
Safe	Hospital Inspection	Equipment Management	Trust wide	7	Ensuring equipment maintenance programmes are fully compliant and operate systems to identify, assess and manage risks relating to the health, welfare and safety of service users and others.	Director of Operations	Medical Physics Manager	02/06/2014	01/12/2014	Staff are aware and following the Trust equipment maintenance programme, The medical device management policy has been strengthened, staff are using standardised reporting systems and a system of escalation for missing items is established.	Policy been approved. Comms team and MEMD will re-launch the policy to highlight key areas of change.		G

		Equipment Management	Trust wide	7.1	Revise the Medical Device Management Policy to strengthen learning from medical device incidents and processes around medical device maintenance Programme to publicise new medical device management policy and train staff in new policy arrangements.	Director of Operations	Medical Physics Manager	02/06/2014	25/10/14 **Revised** 05/01/15	Medical device policy revised, redistributed and communicated.	Policy been approved and comms team and MEMD will re-launch the policy to highlight key areas of change. **Update 01.12.14** Comms Strategy Developed. Launch Date revised to Jan 2015. **Update 15.12.14** Completion date revised to 5.01.15. RAG rating reassessed as AMBER. **January 2015 -** policy ratified and being communicated. RAG rating reassessed as GREEN - on track **February 2015 update:** Launched through the Communication Department on the 10 February 2015. The policy was also presented to the Ward Leader's forum and it was received favourably. **March 2015 update:** RAG rating reassessed - BLUE completed	MEMD Comms Plan 2014-15 Revised 10.12.14 CQ&GC minutes where MD policy approved. Medical Device Policy.	C
		Equipment Management	Trust wide	7.2	Introduce a standardised medical device reporting system.	Director of Operations	Medical Physics Manager	02/06/2014	30/11/2014	Standardised medical device reporting system introduced to ensure there is no discrepancy between reporting arrangements.	Standardised system established. All wards using a log book supported by guidance. MEMD team is monitoring compliance. MEMD are currently testing an electronic reporting system for fault reporting as part of an upgrade to the medical device information system. This will be more robust than log books as all wards can see status of equipment at any time. Final testing of system underway and improvements to be made by software developers Friday 10th October. Pilot wards to test during late October/Early Nov. **Update 01.12.14** Piloting in Audiology and Ward 23. Next roll out will be in ED – w/c 06.12.14. Link to reporting system will be issued to all users in the new year as a rolling programme of roll out. Ensuring MEMD are not overwhelmed by reports. **January 2015 update:** Hospital roll-out of this system with communications in January 2015. To update the QI meeting weekly throughout January to monitor delivery. **February 2015 update:** posters are on the learning boards, update from Medical Physics manager at the end of February 2015. **March 2015 update:** RAG rating reassessed - BLUE completed	Evidence of compliance - report Evidence of electronic trial on Ward 23 Feedback report.	C
		Resuscitation Equipment	Trust wide	7.4	Ensure fully working resuscitation equipment is available in all clinical areas and is checked daily.	Executive Director of Nursing	EC & M and PC & S, Divisional Matrons	01/05/2014	31/12/2014	Clear standards and procedures for checking daily of rhesus equipment.	Programme in place to replace resus boxes and trolleys to enhance checking procedures. Out of hours visit (23rd September checked rhesus trolleys with very few gaps). Mock CQC visit 16th October demonstrated very few gaps, with majority of wards achieving 100% **February 2015 updates:** Procurement tender completed, and awarded to successful company. Resuscitation Officer has discuss the new trolleys and the new way of working at the Ward Leader's forum. Weekly implementation meeitngs have been established, with a project plan to be completed by the end of August 2015. Six trolleys have been supplied by the succesful supplier and a further 75 trolleys to follow, these will be used to familiarise staff with the equipment, and for training purposes. **March 2015 update:** Beaver Healthcare have been awarded the procurement tentder for the Resuscitation trolleys. The capital funding is to be raised, and Beaver will provide some trolleys for staff training and familiarisation. An implementation plan is in place.	Mock CQC Report. Metrics Resus checking.	C
Safe	Hospital Inspection	Medicines Management	Trust wide	8	Improve the systems and processes for the storage and administration of all medicines. Reduce the incidence of medicine omissions.	Executive Medical Director	Chief Pharmacist	01/07/2014	30/03/2015	Drugs are managed in line with Trust policy and legislative and omitted medications are appropriately managed. Patients receive all prescribed medications.	Task group chaired by DoN meeting weekly. Ward Medicine Champions identified. Ward 51 trialling a new swipe card access for bedside lockers, to improve security. Drug trolleys ordered for outstanding medical wards.	Agenda minutes and action log for Medicines Task and Finish Group. Medicines Optimisation Strategy. Medicines Policy Communication. Champions list of names	A
		Safe and legal supply/administration of medicines	Trust wide	8.1	Patient Group Directions (PGDs) – An updated process in line with NICE guidelines to be implemented across the Trust to ensure we are following best practice.	Executive Director of Nursing	Chief Pharmacist	01/06/2014	31/12/2014 **Revised: 31/03/2015**	All Nurses to carry out PGD competency pack for PGD's specific to their area.	PGD policy to be signed off by the Trust Medicine Safety Policy Group. Ophthalmology clinic are trialling the new competency training paperwork which is based on the NICE competency framework. Draft competency pack has been circulated around the Medicine Task & Finish Group(MTFG) members for comment. **Update 01.12.14** New policy implemented and training commenced this will be completed in the new year. **January 2015 update:** 12.01.15 - PGD and ward based discharges training taking place. **02.02.15 update:** Training continuing, new NICE guideline policy in place. **March 2015 update:** Policy complete and on the intranet. Wards and departments are undergoing training. Wards and clinics to feedback the information to Pharmacy. **April 2015 update:** RAG rating reassessed - BLUE - COMPLETED	Meeting minutes and action log. Signed off competency packs - Ophthalmology Trust Medical safety policy Group - minutes	C
		Safe and legal supply/administration of medicines	Trust wide	8.2	Nurses to complete competency around pre-pack medications.	Executive Director of Nursing	Chief Pharmacist	01/09/2014	On going for all nurses affected	The Medicine Champion will ensure all staff have completed their pre-pack competency before carrying out this role.	Policy being updated. Maternity have produced a draft competency framework which will be adapted to be used Trust Wide. Tom Bell producing a short training presentation which will be shown to the Medicine Champions to cascade training. **02.02.15 -** Training maintained. **March 2015 update:** as above. **April 2015 update:** Further training and plan to be discussed at the next Medicine Safety Task and Finish Group. **May 2015 update:** RAG rating reassessed - COMPLETE	Training presentation. Competency Framework. Signed off competency packs.	C

		Missed & delayed doses	Trust wide	8.6	Posters designed to help promote good medicines administration and reduce missed doses to be displayed around the Trust on Medicines Management. One poster aimed at patients/visitors, one at nurses and one at doctors.	Executive Medical Director	Chief Pharmacist	01/03/2014	10/11/2014	A highlighted focus on medicines management across the Trust.	3 Posters have been designed and changes made at the MTFG. Costing's have been established for posters. **Update 01.12.14** Posters were distributed 19th November and are on display.	Posters in place across wards , clinics and medical and nursing areas.	C
		Missed & delayed doses	Trust wide	8.7	Medicine Champions to be implemented across the Trust.	Executive Director of Nursing	Katie Smalley, Practice Development Matron	06/08/2014	31/11/14 **Revised: 01/12/2014**	Highlighted focus on Medicine Management driven by Medicine Champions.	Medicine Champions identified within all areas, predominately band 6 or senior band 5 nurse. A Standard Operating procedure is currently in draft, to be signed off at the MTFG. **Update 01.12.14** This action is **COMPLETED.**	Email confirm Strategy ready to be launched. Names of Champions Pharmacy cover in day case and maternity. Milestone plan for Pharmacy cover in day case and maternity.	C
		Missed & delayed doses	Trust wide	8.8	Trust Medicines Safety E-learning pack to be developed and introduced Communication campaign across the organisation promoting Medicines Management.	Executive Medical Director	Debbie Dean, Training and Education Katie Smalley, Practice Development Matron	01/10/2014	31/03/2015 **Revised: 31/12/2015**	Staff to complete e-learning medicine safety pack to highlight the focus of Medicines Management across the Trust.	E-learning package being developed by Training and Development for consultation once completed. **February 2015 updates:** e-learning package for insulin available for staff to access in the ward environment. **March 2015 updates:** The Director of Nursing will advise all Ward Sisters that all nurses are to carry out the Virtual College e-learning pack on Missed and Delayed doses of medicine and Safer use of Insulin. All preceptorship nurses have started to undertake these packs within the first 18 weeks of working on the Preceptorship focus days. The new mandatory update on medicines will include a workbook on storage and security of medicines. **April 2015 update:** Virtual college platform, nursing, medical, pharmacy and ODPs are being directed to complete **May 2015 update:** RAG rating to be reassessed - COMPLETE	Staff Bulletins – w/e 15/08/14 Optimisation Strategy. Evidence of packages and consultation. Register of staff completed.	C
		Missed & delayed doses	Trust wide	8.11	Controlled drugs ordering stationery to be kept locked away unless in use. Not left on ward stations.	Executive Director of Nursing	Chief Pharmacist	15/09/2014	01/12/2014	Ensure security of CDs and reduce missed doses due to lack of stock being ordered.	Trial of cone shaped notice for porter staff to alert that there is a CD order that needs transportation. **Update 01.12.14** Task and finish group in 2 weeks will provide update of roll out of Cone notice for porters. Medicine Safety audit (outcome in 2 weeks) will provide evidence. **02.02.15 update:** Continues to demonstrate improved practice. **March 2015 update:** Continues to be monitored, not demonstrating issues presently.	Incident reports. Results of trail for CD ordering. Evidence of Task & Finish Group. Medicine Safety Audit - results.	C
		Missed & delayed doses	Trust wide	8.12	Individual ward performance regarding missed medicines doses to be displayed on ward performance areas.	Executive Director of Nursing	Chief Pharmacist	15/10/2014	15/12/2014 **Revised: 31/03/2015**	Share wards performance with patients, carers and other staff helping to drive improvement.	Discussed at task and finish group 15/10/14. Information re Drug administration to be displayed on learning boards. **Update 01.12.14** New Ward Communication boards which include performance regarding missed medicines doses will be rolled out at the beginning of December 2014. **January 2015** - reassessed and RAG rated GREEN **02.02.15 update:** This is being shown as datix incidents which are 'critical doses' - continue to monitor **March 2015 update:** Information is displayed on the wards.	Meeting notes White Boards Evidence of New Ward Comms boards.	C
		Missed & delayed doses	Trust wide	8.14	Communicate with prescribers the requirement to ensure that doses not required are clearly marked with an X or score line to prevent the appearance of a missed dose. (The new chart also has prescribed time to help prevent this).	Executive Medical Director	Chief Pharmacist	15/10/2014	01/12/2014 **Revised: 28/02/2015**	Improvement in prescribing, reduced "false" missed doses.	Included on the posters. Work to be undertaken for communication. New Drug chart at printers. To be included in medicines policy as part of prescribing requirements. E-prescribing will prevent this problem. **Update 01.12.14** New Drug chart will be back from printers within 2 weeks. **02.02.15 update:** Jo Richardson to address Medicine's safety and missed doses at the February's Grand Round **March 2015 update:** Communicated on iCare 2 and on the posters. Highlighted at the Grand Round in February 2015. **April 2015 update:** RAG rating reassessed - BLUE COMPLETED	Audit Incidents Drug chart Communications plan e-Prescribing roll out plan iCare2 for medical staff – evidence from Jo Richardson	C
		Missed & delayed doses	Trust wide	8.15	Produce a flow chart that describes actions to be taken should a medicine not be able to be given.	Executive Medical Director	Chief Pharmacist	15/10/2014	15/12/2014 **Revised: 31/03/2015**	Helps ensure that missed doses are appropriately dealt with e.g prescription review, source the medicine.	Flow chart in draft. **Update 01.12.14** Will be included on agenda of ward leaders development day 9th December 2014. **02.02.15 update:** Flow Chart with the Deputy chief pharmacist **March 2015 update:** Flow Chart in final draft. Awaiting approval. **April 2015 update:** RAG rating reassessed - BLUE COMPLETED	Meeting notes Flow chart once completed	C

		Missed & delayed doses	Trust wide	8.16	Ensure nurses are administering in-line with NMC guidance and know what medicines being administered are for, side-effects, correct dose etc.	Executive Director of Nursing	Divisional matrons/practice development matrons	01/06/2014	31/12/2014 **Revised:** ongoing	Nurses understand what a medicine is for, the correct dose, side-effects and administer appropriately understanding whether the medicine is a critical medicine. The likelihood of incorrect administration and missed administrations is reduced.	Pilot work on ward 23 with training specific to drugs in use on ward. Needs to be expanded. **March 2015 update:** All ward areas have the 5 Rights posted circulated. There has been the Red Apron campaign to encourage nurses to concentrate on medication rounds and prevents other interruptions, and this is now mandatory across the Trust. There are posters developed by Pfizer, the first is aimed at patients to inform them that we are taking steps to tell them more about their medications which encourages patients to ask questions about the medications. The second poster encourages nurses to ensure they do not miss any doses of medication by minimising interruptions, ordering medicines promptly, and carrying out theaccountability handover. All intravenous, intramuscular and subcutaneous injections are now two nurse procedures. **April 2015 updates:** PDM for Medicine Safety continues to work with the nursing staff. **May 2015 updates:** RAG rating reassessed - COMPLETE. Work will be maintained through the PDM work	Training packs Evidence from attendance/completion of packs	C
		Missed & delayed doses	Trust wide	8.17	Empower nurses and other staff to challenge illegible handwriting – it is not acceptable to administer from a prescription if that prescription is not clear. The Trust Medicines Policy standard is that the medicine should be written clearly in BLOCK CAPITALS.	Executive Director of Nursing	Divisional matrons/practice development matrons/Chief pharmacist	15/10/2014	30/11/2014	All prescriptions are clear and patients receive the intended medicine on time.	Standards are listed in medicines policy. Specific empowerment campaign to be initiated. **Update 01.12.14** Included on posters. Documentation audit will provide evidence. **January 2015 -** Evidence of omissions due to poor handwriting **15.01.15 -** RAG rating reassessed GREEN on track **March 2015 update:** Pfizer have produced posters which have been circulated around the Trust to encourage doctos to write prescription legibly. The Medicine Management policy has been updated to reflect this requirement. All clinical areas have medicine champions, and there are 4 medicine champions meetings a year. The new medication chart has a space to write a number in the box for an illegible prescription., the reason why the medication has been omitted should then be written on the new medicine omission sheet and followed up with a doctor. Illegible prescriptions have been discussed at the Medicines Task and Finish Group, which has clinical representation. **April 2015 update:** PDM continues to work with the nursing staff. **May 2015 update:** RAG rating reassessed - COMPLETE. Work will be maintained through the PDM work	Medicines Policy Communication Documentation Audi	C
		Missed & delayed doses	Trust wide	8.19	To produce and implement a Policy for Managing Staff Involved In Medicines Errors/Incidents.	Executive Director of Nursing	Martin Bullock, EC & M Divisional Matron	Feb-14	31/12/2014	The Trust will have a standardised system in place when a member of staff carries out a medication error.	The Policy is currently in the later stages of draft. The policy will include an algorithm for ward leaders and other clinical supervisors/managers to follow when a staff member carries out a medication error. Nursing staff currently undertake a medication pack adapted by PDM Katie Smalley depending on the type of error that has occurred. **Update 01.12.14** Currently going through committee process for consultation and approval. Must ensure is approved by Staff side and subsequently OD & Workforce. SM to send KL the policy. Policy to be agenda item on Ward Leaders Development Day 09.12.14 **February 2015 updates:** Policy going to JSPF next week for final ratification. **March 2015 update:** RAG rating reassessed - BLUE complete	Meeting notes The policy Potential disciplinary hearing records Agenda from Ward \Leaders Development Day 9 December 2014	C
		Missed & delayed doses	Trust wide	8.20.	Implement regular audit of missed and delayed doses of medicines	Executive Medical Director	Chief Pharmacist and Divisional matrons	Oct-13	31/12/2014	For incidents around missed and delayed doses to be reduced across the Trust	Pharmacy carrying out monthly audits, there is to be a larger push and audits are to become fortnightly with nurses undertaking every 2 weeks. **Update 01.12.14** Action **COMPLETED**	Audit results	C
Safe	Hospital inspection	Documentation and Records	Trust wide	9	Ensure patient records are appropriately maintained in line with Trust policy and legislative requirements	Executive Director of Nursing/ Executive Medical Director	Divisional Teams.	01/07/2014	31/12/2014	Confidential patient documentation available to all relevant professionals to support consistency of treatment and interventions to maximise health outcomes	Trust policy for Standards for nursing record keeping has been reviewed setting out the expectations of the organisation. Developed a 'how to' guide for record keeping and frameworks which will help individuals to improve their record keeping. These will be printed and launched by 31/10/14. Developing a new documentation audit tool which is sensitive to the qualitative aspects of record keeping. Currently developing a proposal for a consistent approach to nursing document storage. Care & Comfort champions for each ward identified and focus group dates set. Use of accountability handover process to be audited as part of documentation audit. Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director commenced. Compliance in WHO checklist improved.	iCare2 Clinical Record Keeping – Policy updated	A
		All nursing and medical records	Trust wide	9.2	Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director	Executive Medical Director/ Executive Director of Nursing	Patient Safety Fellow, Patient Safety Lead	11/08/2014	31/12/2014	Clinical teams own monthly safety round	Currently safety team review 1 ward per week. Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director commenced. **Update 01.12.14** Completed	Emailing confirming meetings take place along with copy of notes for meetings to date. Nursing Documentation Audit report 05.08.14 Notes from meeting.	C

		WHO Checklist	Trust wide	9.4	To add the WHO checklist to the SFH intranet under Theatres sub-folder of the Clinical Policies and Guidelines intranet	Executive Medical Director	Clinical Policies and Guidelines Officer	30/09/2014	30/11/2014	Accessible checklist on the intranet	Sue Dale has liaised with Sharon Baxter to organise. **January 2015 -** WHO checklist is on the Trust's intranet **15.01.15 -** RAG rated reassessed BLUE - completed.	WHO Checklist on Intranet	C
		Nursing Records	Trust wide	9.6	Develop standards for record keeping, in line with the NMC Record Keeping Guidance to ensure good record keeping is an integral part of nursing and midwifery practice.	Executive Director of Nursing	EC & M and PC & S; Divisional Matrons	06/06/2014	31/12/2014	The principles of good record keeping are well established and reflect the core values of individuality and partnership working.	Trust policy for Standards for record keeping has been reviewed setting out the expectations of the organisation. Developed a "how to guide" for recordkeeping and frameworks which will help individuals to improve their record keeping. These will be printed and launched by 31/10/14. Setting up workshops and roadshows to educate nurses and midwives about the revised policy and how they can improve their own record keeping. Ward Sisters to do targeted work with individuals who's recordkeeping requires improvement. **Update 01.12.14** Record Keeping Policy approve at CQ&GC November 2014. ICare 2 issued Friday 28.11.14. Booklet completed. PDM's training on policy. **Update 15.12.14** RAG rating reassessed as **COMPLETED**	The recordkeeping booklet. Improvement in the documentation audit results. Staff can verbalise what they have changed within their practice. Records & Record keeping policy. How to guide for record keeping. Evidence of launch. Evidence of workshops/ roadshows. Registers of attendees. Evidence from Ward leaders development day.	C
		Nursing Records	Trust wide	9.7	Develop a new documentation audit tool which is sensitive to the qualitative aspects of record keeping.	Executive Director of Nursing	Clinical Audit Officer, Alison Davidson, PDM	01/09/2014	01/12/2014	An improved documentation audit is utilised to audit nursing records, which acts as one tool to support improvement .	Tool developed and piloted for ratification at the next practice development forum. Aim is to be using the tool by 1st Nov 2014. Sisters to encourage all staff groups to undertake the audit. Registered nurses to undertake a self-audit of their documentation as part of the appraisal process. Create a SOP for the process including actions following the results of the audit. **Update 01.12.14** Audit tool developed but no yet utilised. **Update 15.12.14** RAG rating reassessed as COMPLETED	Audit tool and (results needed). Evidence of approval at Practice Development Forum. Evidence of self appraisal SOPs	C
		Nursing Records	Trust wide	9.8	To promote communication and sharing of information develop a standardised approach to nursing documentation storage, which is utilised in all inpatient areas.	Executive Director of Nursing	EC & M and PC & S Divisional Matrons supported by Denise Clay, PDM	15/10/2014	30/11/2014	A standardised approach to the storage of nursing documentation is evident across the Trust.	Identified and acknowledged risk of all patient documentation being at patient bedside. Cheryl Beardsley to articulate the risk to be entered on the trust risk register. New location for patient documentation to be communicated via divisional teams. Denise Clay with ward sisters from ECM & PCS to mock up folders to present at divisional sisters meetings. When agreed, to be rolled out by 31st Oct. **Update 01.12.14** Action Completed	Extract from Trust Risk Register Evidence of meeting 31 October 2014 Photo of new storage (documentation) Audit results to monitor standardization of documentation storage.	C
DOMAIN - EFFECTIVE													
Effective	Hospital Inspection & Keogh	Recognition of the deteriorating patient	Trust wide	10	Ensure the processes for the recognition of deteriorating patients are robust and appropriately acted upon	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	Jun-13	31/01/2015	Staff are confident in the identification and management of patients whose condition is deteriorating. Patients are recognized and treated in a timely appropriate and safe manner.	Vital Pac rolled out across 23 inpatient wards. 1,500 staff have received training and are using the system. Serious Incidents in relation to failure to rescue reduced. Number of calls to Critical Care Outreach Team have increased since Vital Pac implementation, demonstrating earlier identification of deteriorating patients.	Flash Report	A
Effective	Hospital Inspection	Access Targets	Urgent & Elective Care	11	Ensure safe, appropriate and timely flow of patients from admission to discharge, with the support of good bed management and discharge processes .Achieving and sustaining all 3 18 ww pathways	Director of Operations	Emergency flow Project lead	Dates	31.3.15.	95% sustained Reduced LoS Achieving & sustaining all 3 18 ww pathways.	Review of infection control leads within job planning process and evidence at appraisal of attendance at relevant meetings		A
		Patient flow	Trust wide	11.1.3	Open a substantive discharge lounge	Director of Operations	Divisional Team EC&M	01/06/2014	27/10/2014	Discharge lounge open and fully staffed increase morning discharges by 50%. X number of patients leave ward beds by 10am	Substantive discharge lounge opened in clinic 9 at the beginning of October 2014.	Discharge lounge policy. Utilisation report.	C
		Patient flow	Trust wide	11.1.7	Undertake a full review of the bed model to provide improved planning.	Director of Operations	Emergency flow Project lead	06/06/2014	29/09/2014	Support areas to identify reduced LOS. Support pathways to Improve patient experience.	Bed Review Completed: two versions ide defying likely impact of schemes and support planning.	Bed Review Paper presented to the Executive Team	C
		Out of hours	Trust wide	11.1.10	Review of Hospital At Night activity to identify resource gaps	Executive Medical Director	EC & M Divisional Clinical Director	01/06/2014	27/10/2014	Ensure cover is safe and distributed appropriately	Audit completed Aug 2014 to be presented at TMB. HEEM review in August presented at Medical Managers	Audit and Findings from Dr A-L Schokker. Report on H@N	C
		Patient Flow	Newark	11.1.11	Review Newark and Kings Mill Trauma protocol	Executive Medical Director	ED Head of Service	01/092014	07/11/2014	To ensure these reflect the skills and knowledge of the teams. Reviewed by ECM	Review in progress to be completed by the end of October. **Update 15.12.14** RAG rating reassessed as COMPLETED	Trauma Protocol. Newark MIU Major Trauma Pathway. Speciality Clinical Governance Monthly report for 19.09.14 and 17.10.14.	C

		Referral to Treatment Time	Trust wide	11.2.1	The Trust must achieve and sustain all 3, 18 week pathways by ensuring Capacity and demand analysis for all key specialties, especially those 8 specialties not currently meeting 18 ww access targets, robust PTL arrangements, full pathway review of failing specialties, adherence to the Trust Access Policy and different methods of improving and developing 18 weeks knowledge	Director of Operations	EC & M PC&S, DNR Divisional General Manager	01/05/2014	30/09/2014	>90% RTT – Admitted – achieve & sustain. >95% RTT – Non-admitted – achieve & sustain. > 92% incomplete pathways – achieve & sustain.	Capacity & demand analysed and more robust arrangement in place for enabling continual review using the IST capacity & demand tool. Substantive recruitment where activity is to sustain and insufficient capacity following improvement work. Clinicians currently supporting capacity gaps with additional sessions to meet demand. The weekly PTL meetings are now reviewing all patients to expedite their pathways & ensure issues are dealt with to enable 18 week achievement. This includes ensuring adherence to the Trust Access Policy. The Trust is on track for delivering all 3 pathways by the end of September. An e-learning package for 18 weeks is currently under review.	Capacity and demand summaries. Diary screenshot. Weekly RTT trajectory info taken to GM meetings. 18ww RTT eLearning package.	C
		Referral to treatment time	Trust wide	11.2.2	Complete reviews with National Intensive Support Team (IST) to improve the 18 week pathways, including a full review of cancer pathways	Director of Operations	Director or Operations	01/07/2014	02/06/2014	Full compliance with IST recommendations	The IST has now signed off the Trust with a small number of minor issues e.g. to return to review post implementation of the new PAS system to be completed	SFHT Intensive Support Team – Closure Report.	C
Effective	Hospital Inspection	Training	Trust wide	12	Improve delivery of mandatory and targeted training for staff	Executive Director of Human Resources	Executive Director of HR	01/04/2014	31/03/2015	Staff receives relevant supervision, appraisal and development to enable them to perform effectively in their roles and support delivery of trust strategic priorities. Mandatory training targets are achieved.	OD & Workforce Committee receive reports on approaches of training into practice. Employee supervisor Self Service launched. Mandatory training e-learning workbooks launched.		C
		Training in Practice	Trust wide	12.1	Establish a task and finish group to identify appropriate metrics of how staff use their knowledge from training to improve the quality of patient care	Executive Director of Human Resources	Deputy Director of Training and Education	01/08/2014	27/10/2014 **Revised:** 06.01.15	Evidence of staff utilising their knowledge from training in the provision of high quality patient care	A task and finish group has been established and has met and agreed an approach to measure the impact of mandatory training on patient care. A new training audit will commence in November 2014 and will feedback into the Workforce and OD Committee on a 6 monthly basis . **26.01.15 updated:** Completed 06.01.15	Evaulation of mandatory training Example of questionnaire to collect information	C
		Appraisal	Trust wide	12.2	Provide accurate appraisal data to ensure performance management of compliance rates	Executive Director of Human Resources	Deputy Director of Human Resources	01/08/2014	31/12/2014 **Revised:** 06.01.15	Confidence that appraisal data is accurate.	Evaluation of current data to provide assurance of accuracy of data. **26.01.15 updated:** Completed 06.01.15. RAG rating reassessed	HR dashboard	C
		Mandatory Training	Trust wide	12.3	Provide annual personalised mandatory training report for all employees outlining what their mandatory training requirements/ refresher periods are, what training information is on the OLM system and when their current training expires. Supporting individual compliance and remind staff to arrange attendance	Executive Director of Human Resources	Deputy Director of Training and Education	01/08/2014	30/11/2014 **Revised:** 26.01.15	Improved mandatory training compliance rates. Improved personal accountability for completion.	Additional resource has been engaged to complete this project and personalised training reports have begun to be sent to staff. **November** Personalised letters have begun to be sent out to all staff starting at the end of October. By the 30th November all staff will have received their personal mandatory training letter which should help to improve compliance with mandatory training. **Update 15.12.14** Reassessed as COMPLETED	Examples of individual reports	C
		Mandatory Training	Trust wide	12.4	Enhance electronic monitoring systems - Employee Self Service	Executive Director of Human Resources	Deputy Director of Training and Education	01/04/2014	29/12/2014 Revised 31/03/15	Improved real time mandatory training data, improved mandatory training completion.	Employee Self Service was launched in April 2014 to enable all staff to access their own staff training record and personal details, including mandatory training. Additional resources have been secured to develop supervisor self service to enable managers to access real time and instantaneous staff mandatory training information. This is planned for launch in January 2015. **26.01.15 update:**Reviewed and remains on track. Rolling out training on how to access Employee Self Service. **March 2015 update:** Training is ongoing, and will be completed as planned by 31 March 2015. RAG rating reassessed COMPLETE	Screen shot of electronic system Staff bulletin	C
		Mandatory Training	Trust wide	12.5	Introduce mandatory training workbooks as e-learning - enabling - enabling improved access 24/7	Executive Director of Human Resources	Deputy Director of Training and Education	01/06/2014	31/12/2014 Revised 02/02/2015	Improved mandatory training compliance. East of access to mandatory training.	Mandatory training e-learning workbooks have been developed and will be piloted in 4 areas from 16/10/14 for one month. This will then be evaluated and launched trust wide. **7 January 2015** Workbooks launched by 31 January 2015 **15.01.15 -** RAG rating reassessed as GREEN - on track **02.02.15 update:** RAG rating reassessed - BLUE completed.	Staff bulletin Print out of e-learning workbook Screen shot of e-learning mandatory workbook	C
		Mandatory Training	Trust wide	12.6	Target medical training for fire lectures, C-diff and MRSA	Executive Medical Director	Divisional Clinical Directors	01/04/2015	30/11/2014	>90% compliance	Compliance rates were 30-40% in June, increased to over 70% in September after Medical Matters publicity and now the residual names are being targeted. **Update 09.12.14** Achieved for C diff and MRSA **15.01.15 -** RAG rating reasessed as GREEN - on track **26.01.15** - Now chasing individual Consultants. At the end of December 2014 MRSA 94% and C-difff 91% compliance. **February 2015 update:** RAG rating reassessed - BLUE completed	Medical matters bulletin for target medical training for fire lectures, c-diff and MRSA by division sent to GP's. Training dates for Safeguarding & Mental Capacity/ Prevent.	C
Effective	Hospital Inspection	Individual Staff Performance	Trust wide	13	Strengthen the processes to enhance staff performance; ensuring the availability of skilled and competent staff	Executive Director of Human Resources	Executive Director of Human Resources	01/04/2014	31/03/2015	The appropriate numbers of skilled and competent staff are deployed across the Trust	NHS Medical Appraisal Policy implemented and distributed to all Medics. Eight Practice Development Matrons have commenced in post. New preceptor programme commenced Sept 2014. Work in progress on Stress management. Revised Appraisal policy agreed. Incremental progression protocol agreed.		R

		Medical Appraisal	Trust wide	13.1	Strengthen Medical Appraisal – to ensure appraisal processes are consistent and performed to a high standard	Executive Medical Director	Executive Medical Director	01/01/2014	02/06/2014	To ensure all medical staff are consistently and professionally appraised annually	Excellent medical appraisal rate (90%+) implemented the NHS England Medical Appraisal Policy and distributed to all medics. Written to all medics confirming their new appraisal date as we have spread appraisals out across the year (which has been welcomed). Reinvigorated the Appraiser Forum which has excellent attendance and this will enable delivery of the Framework for Quality Assurance **February 2015 update:** Medical Appraisals are consistently above 90%, currently in January 2015 at 98%.	Health and Safety Committee Minutes 09.10.14. HoS training, job descriptions. Evidence of medical appraisal. Letter to Consultants. Appraisal Forum.	C
		Appraisal	Trust wide	13.4	Review appraisal documentation to ensure fit for purpose and incorporates Quality for All Values	Executive Director of Human Resources	Deputy Director of Human Resources	Jul-14	24/11/2014 Revised 31/12/14 **Revised: 02/02/2015**	Appraisals are undertaken in a timely manner and reflect the values of the organisation. New appraisal documentation and policy, incremental pay progression policy support embedding our values.	Task and finish group established to complete process review. **November** Appraisal and Incremental pay policy reviewed to reflect quality for all, associated paperwork reviewed and managers toolkit under development. To be presented at Policy sub group JSPF 09/12/14. **January 2015** - RAG rating reassessed as BLUE - completed.	Task & Finish group – notes. Appraisal & incremental pay policy. Minutes from JSPF 9 December 2014.	C
		Practice Development	Trust wide	13.6	Implement a new structure of Practice Development Matrons to support staff in clinical practice to deliver excellence in practice	Executive Director of Nursing	Head of Practice Development	01/07/2014	01/09/2014	A full complement of Practice Development Matrons who support developments and excellence in practice	Eight practice development matrons have commenced in post. They are all allocated to a group of wards, whilst having individual responsibility for leading on documentation, medicine management, policy underpinning practice, development of a journal club, clinical supervision, improving preceptorship I international recruitment, education and training, falls, dementia care, evidence based practice and the RCN leadership programme. .	Structure chart. Workload	C
		Preceptorship	Trust wide	13.7	Implement a new preceptor programme for RN's with increased support and focus on medicines management, access to electronic systems and discharge planning	Executive Director of Human Resources/ Executive Director of Nursing	Deputy Director – Training & Development,, Preceptor Support Nurse	30/09/2014	31/12/2014	A modern preceptor programme that supports the development and retention of newly qualified RN's.	New preceptor programme commenced Sept '14. Support sessions for preceptee are well attended. Task and finish group to develop new preceptor documentation established. Focus groups being established to provide peer support and gain intelligence for further development of the programme. Examining the feasibility of student nurses undertaking IV training pre reg to support preceptees on qualification. **15.01.15** - RAG rating reassessed as BLUE completed	Copy of preceptor programme. Task & Finish Group – notes. Focus group notes. Audits / evaluations	C
		Clinical supervision	Trust wide	13.8	Implement clinical supervision opportunities for nursing staff across the Trust	Executive Director of Nursing	Head of Practice Development	01/06/2014	31/12/2014	All nurses have the opportunity to access clinical supervision	Guidelines for Clinical Supervision to be agreed at October Practice Development Forum. Website created. Scoped current supervisors within the Trust. Training days for new supervisors on 16th and 22nd September. Making links with Chesterfield and NUH to create supervisors outside the organisation for senior staff. **Update 01.12.14** Presented at CQGC November 2014 and uploaded to intranet. **February 2015 update:** Clinical supervision website is operational. Clinical Supervision guidelines has been ratified. There are 12 identified clinical supervisors, and are working with other organisations to identify further opportunities. **March 2015 update:** Clinical Supervisors available via the webiste. Training for Clinical Supervisors has been added to the Training Needs Analysis for the Trust. **May 2015 update:** RAG rating reassessed - COMPLETE	Clinical Supervision guidelines. Training day agenda for supervisees. Evidence of external links for supervision externally. Clinical Quality & Governance Committee November 2014.	C
		Absence Management	Trust wide	13.10.	Develop and implement mechanism for Individual Stress Risk Assessment - ensuring appropriate support plans are developed	Executive Director of Human Resources	Health & Safety Manager	01/08/2014	31/10/2014 **Revised:** 15.12.15	Stress risk management tool assists in the early identification and management of stress related absence.	Risk assessment tool developed and presented to health and safety committee on 9/10/14. **November** Stress Risk assessment form Approved for use at Health and Safety Committee on 9/10/14. **Update 15.12.14** Reassessed as COMPLETED	Individual Stress Risk Assessments. Sickness absence toolkit. Health & Safety Committee.	C
		Absence Management	Trust wide	13.11	Enhance management development opportunities to incorporate recognition of stress and development of support mechanisms	Executive Director of Human Resources	Deputy Director – Training & Development	01/06/2014	29/12/2014 **Revised:** 26.01.15	Manager competently identify stress related issues and respond accordingly	New increasing personal resilience and managing stress module embedded into Trust Leadership Programmes. Managing stress also incorporated into Managing Absence Training. **26.01.15 update:** Updated COMPLETED. RAG rating reassessed.	Trust Leadership Programme. Evidence from managing absence training.	C
Effective	Hospital Inspection	Clinical Pathways	Trust wide	14	Improve the effectiveness and responsiveness of services through the use of evidence based clinical pathways	Executive Medical Director	EC & M and PC & S Divisional Clinical Directors	01/05/2014	31/12/2014	Clearer guidance and improved pathways of care in line with evidence based guidance.	Pathway review of 3 surgical specialties underway. Elective transformation programme in place. EC&M reviewing Newark pathways and all 'external transfer protocols visible on the intranet.		G
		NICE Guidance	Trust wide	14.1.1	New process for NICE Guidance agreed	Executive Medical Director	Clinical policies lead	01/06/2014	27/10/2014	Approved NICE Policy and Process	Policy and process approved at CQ&GC in September and shared with Quality Committee at the September meeting.	NICE policy. New process will be evidenced through governance meetings. Clinical Quality & Governance Committee September 2014.	C
		Surgical Pathways	Planned Care & Surgery	14.2.1	Comprehensive review of pathways: T+O Urology Ophthalmology Pre Operative Assessment Review of DayCase and Surgical Assessment Unit processes.	Executive Medical Director	Divisional Team, Planned Care & Surgery	01/06/2014	Ongoing	To increase implementation of local transformation work. To reduce Length of Stay for specialties identified.	Agreed and in progress from June 2014 – includes access targets and patient pathway improvement (including recovery delays). Engagement events for T+O and Urology held in September. Reported via Elective Programme Board and Transformation Steering Group **26.01.15 update:** Elective Care Transformation team undertaking review of services **February 2015 update:** Completed pathways by Cardiology, Respiratory, Gastroenterology, Endocrinology, Neurology, ENT, Paediatrics, Obstetrics and Gynaecology are signed off and communication plans agreed. **April 2015 update:** RAG rating reassessed as COMPLETE - BLUE.	Quick wins and clinical risk analysis. Attendees at Urology event. Engagement event T&O. Minutes from Transformation elective Programme Board.	C
		Newark MIU Pathways	Newark	14.3	Standardise Newark MIU pathways	Executive Medical Director	ED Head of Service	01/06/2014	27/11/2014	To ensure these are consistent with KMH pathways and reflect the skills and knowledge of the team. Reviewed by ECM	Reviewed by Emergency Care and Medicine. Meeting with GPs and CCG re future of Newark front door **March 2015 update:** Newark MIU now following the Kings Mill ED pathways, standardised across the two sites.	MIU review Evidence of GP/CCG meeting at Newark Hospital	C

		Care Pathways	Trust wide	14.4	Standardise protocols for transfers 'out of Trust to tertiary care'	Executive Medical Director	EC & M and PC & S Divisional Clinical Directors	01/06/2014	27/11/2014 **Revised:** 15.03.15	Safe transfer and handover of sick patients for ongoing care	Pathways visible on intranet in clinical areas and communicated to relevant external agencies. Version control **26.01.15 update:** Pathways are currently being reviewed and standardised. Plans to upload the pathways by mid March 2015. **March 2015 update:** Speciality pathways developed for transfers out of Trust to tertiary centres.		C
Caring	Hospital Inspection	Family & Friends (F&F)	Trust wide	15	Increase patient feedback by collating a higher level of Family and Friends responses.	Executive Director of Nursing	Deputy Director of Nursing	01/06./4	31/10/2014	To increase the overall response rate for F & F to 50%	Currently the Trust uses a paper system for obtaining responses to F& F's. Failure to provide additional provision for patients to record their views is limiting our ability to increase our response rates. The Trust is currently tendering for an external provider to provide a provision for: · NHS Staff F & F plus quarterly pulse surveys · NHS Patient F & F plus quarterly pulse surveys · Doctor revalidation feedback · Registered Nurse revalidation feedback		G
		End of Life	Trust wide	15.3	Develop a prospective survey to capture the bereaved relative's experience	Executive Director of Nursing	Head of Chaplaincy, End of Life, Nurse Specialist	01/12/2014	31/10/14 and ongoing	Bereaved relatives feedback is used to assess the progress and delivery of the end of life strategy	Survey commenced 13/10/14 **05.12.14 Update** The survey has been underway since 13th October. The Bereavement Centre are obtaining the relatives consent to participate and questionnaires are being sent out 8 weeks post bereavement. It is anticipated that a quarterly report will be generated to identify areas for improvement. **March 2015 update:** Commenced the bereavement relative experience survey in October 2014. The Lead for EoL has produced a quarterly report which is positive.	Survey	C
DOMAIN - RESPONSIVE													
Responsive	Hospital Inspection	End of Life	Trust wide	16	End of Life Care is responsive to the needs of our patients (and their carers), delivered by competent, knowledgeable staff who respect and meet individual preferences.	Executive Director of Nursing	Mark Robert, Consultant, , Lead Nurse for End of Life & Cancer	01/07/2014	30/11/2015	Patients requiring end of life care receive a responsive service that is timely and personalised to their needs	End of Life strategy developed – currently being finalised for consultation. New guidelines and documentation implemented to replace the Liverpool Care pathway. A further 2 wards have commenced the AMBER care bundle, 2 more wards have registered on the Gold Standards Framework in Acute Hospitals Programme and the service specification for fast track / rapid discharge is being reviewed. **November update (received after TB)** End of Life strategy has been developed and is being taken to the Trust Board in December. New guidelines and documentation implemented to replace the Liverpool Care pathway. A further 2 wards to commence the AMBER care bundle in January 2015, 2 more wards have registered on the Gold Standards Framework in Acute Hospitals Programme and the service specification for fast track / rapid discharge is being reviewed.		G
		End of Life	Trust wide	16.1	Produce an end of life care strategy to support transforming end of life care.	Executive Director of Nursing	Mark Robert, Consultant, , Lead Nurse for End of Life & Cancer	01/07/2014	30/11/2014	Strategy agreed and implementation evidenced through an improved profile and understanding of end of life care	End of Life Strategy produced which is linked to the six-steps within the National End of life Care Pathway. It is in accordance with the National Transforming End of Life Care in Acute Hospitals Programme framework. Currently being reviewed by End of Life team to prepare for consultation. Nurse Expert (national) currently assessing strategy to ensure it dovetails national direction and thinking. **November update (received after TB)** End of Life Strategy produced which is linked to the six-steps within the National End of life Care Pathway. It is in accordance with the National Transforming End of Life Care in Acute Hospitals Programme framework. Plans are in place to take to Trust Management Board in December for ratification then it will be launched across the Trust. **February 2015 updates:** End of Life strategy was presented to TMB in January with some amendments. The End of Life website is being refreshed with the new End of Life Strategy, documentation. **March 2015 update:** End of Life Strategy agreed, complete with action plan. RAG rating reassessed - COMPLETE - BLUE	End of Life Strategy. Evidence of the 6 steps to National EofL pathway. Trust Management Board – December 2014	C
		End of Life	Trust wide	16.2	Development and implementation of Last days of Life guidelines and care plans across the whole Trust. (This replaces the Liverpool Care Pathway documentation)	Executive Director of Nursing	Mark Robert, Consultant, Lead Nurse for End of Life & Cancer	15/07/2014	31/12/2014	The trust has implemented Last Days of Life Care guidelines and documentation across the Trust to enable staff to provide good end of life care	New guidelines and documentation developed. Launched at ward sisters and Grand Round. Being implemented across all wards with education, training and clinical support from Carolyn Bennett at the beginning of September. **November update (received after TB)** New guidelines and documentation developed and being used on the majority of wards. Launched at induction, ward sisters and ward staff meetings, Clinical Governance meetings, Medical Management meetings, Doctors lunch time meetings and Grand Round. Carolyn Bennett continues to support implementation across all wards by delivering face to face education, training and clinical support. **February 2015 updates:** The Lead Nurse for End of Life care is implementing this throughout the Trust, with the new additional resourse this will be at a faster pace. **March 2015 update:** In the process of being evaluated and will be evaluated and amended continually. RAG rating reassessed as COMPLETE - BLUE	Guidelines & documentation. Launch information. Implementation plan. Approval in Sept 14, evaluation in January 2015.	C

		End of Life	Trust wide	16.3	Implement a programme of multi-disciplinary training to increase the knowledge and skills of staff providing end of life care.	Divisional teams	Lead Nurse for End of Life & Cancer	15/08/2014	31/12/2014 Ongoing	There is trust wide, coordinated multi-disciplinary training in end of life.	Team currently teaching on multi professional induction, ward sisters events, junior doctor's forum, Grand Round and wards and departments through the launch of last days of life guidelines and new documentation. X1 End of Life study day offered to all staff every 3 months. Exploring the option to incorporate End of Life Care module within Mandatory Training Workbook. Ensure all end of life care training delivered is recorded on the Trust-wide database. **January 2015 update:** 12.01.15 - Advanced Communication skills for Consultants and Specialist nurses to be provided End of Life courses will take place for staff - 2 courses arranged. End of Life care is on the Induction programme for all new staff. Looking at junior doctors induction. **15.01.15 -** RAG rating reassessed as GREEN - evidence of training on all the Induction days **February 2015 updates:** Induction of all new starters includes End of Life care, the mandatory workbook now includes End of Life care. **March 2015 update:** Plans in place for delivery of the Gold Standard Framework to Wards 34 and 52. Four dates for the 'Dying to Communicate' in June, September, November and March 2016. Advanced Communication Skills training will be run in May and Octobr 2015. The End of Life team continues to provide 1:1 training on the wards. The team support medical and nursing induction. **April 2015 update:** Looking at exploring communication skills across the lower bands within the Trust. We had 2 x End of Life Champion days in Q4, 1 x Gold Standard Framework session with future session plans. We have access to the National e-learning End of Life programme, with the link o nthe End of Life website. We are encouraging staff to use, and we are developing our own e-learning system. In Q4 at induction 83 staff received End of Life session; and 30 staff on the preceptorship training. **May 2015 update:** RAG rating reassessed - BLUE - COMPLETED.	MDT training plan. Evidence of EofL training in mandatory training. Agenda from Induction programme.	C
Responsive	SMART action plan	Adult Safeguarding	Trust wide	17	Ongoing concerns from differing sources regarding existing safeguarding arrangements	Executive Medical Director	Executive Medical Director	01/03/2015		Evaluate the investment to date in training and establishing ward champions, measuring the impact on practice. CQC lead inspector to receive a detailed doucmented brief to include audit findings and the improved process by which safeguarding investigations are now undertaken. A detailed action plan ensuring continual improvments of safeguarding systems and processes to be agreed with CCGs and shared with CQC.			G
	SMART action plan	Adult Safeguarding	Trustwide	17.4	Senior representation required at district wide regular forums.	Executive Medical Director	Executive Medical Director	01/03/2015	23/02/2015	Senior Representative/ Deputy attends majority of meetings. Partner organisations positively feedback on Trust's engagement and contribution.	**30.01.15 (from SMART action plan)** - Deputy Director of Nursing or Medical Director have attended all scheduled meetings. **March 2015 update:** The Trust has been represented at external meetings by the Deputy Director of Nursing and ongoing arrangement are in place to provide senior representation. **April 2015 update:** Medical Director or Deputy Director of Nursing attends the regular forums. **May 2015 update:** RAG rating reassessed as COMPLETE		C
Effective	Hospital Inspection, Keogh and SMART action plan	Infection Control	Trust wide	18		Executive Medical Director	Executive Medical Director	Jun-13	31/01/2015				A