Sherwood Forest Hospitals NHS
NHS Foundation Trust

Plan Name	Improvement Plan
Executive Sponsor	Susan Bowler
Date	29/10/14
Version	6

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

Overall Timescales at Risk

- Action fully implemented
- No progress made or progress is not expected to be made due to barriers
- Progress being made towards completion of the action or overdue on completion date
- Action on track to complete in line with the completion date
- Action not due to commence
- 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**	**01/09/14**	**31/03/15**	**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 appointed August 2014 whilst recruitment for substantive appointment is made.**		**A**
		Board of Directors	Trust Wide	1.1	Commission and implement a Board of Directors Review and Development Programme	Chairman	Chairman	01/09//14	31/03/15	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.	Foresight proposal and evidence of board agreement.	G
		Board Development	Trust wide	1.2	Ensure effective personal development process is in place for all board members.	Chairman & Chief Executive	Chairman & Chief Executive	01/04/14	31/03/15	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 ongoing.	Completed appraisal documentation. Reports to COF and Remuneration and Nominations Committee	A
		Executive Team	Trust wide	1.3	Commission and implement individual and team coaching for Executive Team members.	Chief Executive	Chief Executive	19/09/14	31/03/15	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.	Proposal from OCM and evidence of agreement.	G
		Executive Team	Trust wide	1.4	Appointment of a substantive Chief Financial Officer –	Chief Executive	Chief Executive	June 2014	31/03/15	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		A
		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	01/03/14	30/11/14	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.	Governor Election Milestone plan. Governor Induction programme schedule Presentations from training sessions.	A
		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	01/03/14	29/09/14	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		C
		Newark	Newark	1.7	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 of Operations	Assistant Director of Operations	01/07/14	30/03/15	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	Theatre schedules Activity Plans and outturn	A

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		IT	Trust wide	1.8	IT Hardware and functions fit for sustainably purpose	Dr Andy Haynes Executive Medical Director	Trust IT Lead	01/03/14	Ongoing	Systems accommodate and responsive to clinical requests / need	PC replacement programme over 3yrs to maintain all hardware below 7yrs with adequate memory WiFi 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	Floor walking technicians in clinical areas to deal with live issues. Activity logged. Regular WiFi 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**
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**	**Ongoing**	**Improved staff experience and improved patient experience and care.**	**Listening events have led to the development of our Quality for All Values and behaviors. Staff briefings for more than 1,200 staff completed. Workshop – Leading for Values completed. Currently Team conversations taking place, due to be completed 30.11.14**		**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	01/04/14	30/11/14	A baseline of staff engagement completed which will inform actions going forward.	Procurement exercise initiated.	Staff FFT Survey outcomes.	A
		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	01/01/14	24/11/14	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.		A
		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	01/07/14	30.10.14	To ensure the Trust is living its values and behavior is consistent	Capability Policy currently under review. Training and toolkit for implement being developed.	Agreed Capability Policy published dates for Training Programmes published	G
		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	01/08/14	31/11/14	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.	Team action and defined outcomes.	G
		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	July 2014	16/10/14	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.	Exec Team evaluation of Listening into Action benefits.	G
		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	30/06/14	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	National Advisory Group for Cultural Alignment Report	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	01/10/14	31/01/15	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 Namoi Fulop's research to look at the readiness for quality improvement and the impact of interventions		G

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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**	**June 14**	**31/03/15**	**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. Workshop completed and action plan developed to improve organizational effectiveness. Leadership development programmes evaluated and recommissioned.**		**G**
		Leadership	Trust wide	3.1	Medical Engagement Programme Developed and Implemented	Executive Medical Director	Executive Medical Director	June 14	Ongoing	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	MES survey Outcomes Action plan	A
		Leadership	Trust wide	3.2	Leadership Strategy and action plan developed and implemented	Executive Director of Human Resources	Executive Director of Human Resources	01/09/14	30/11/14	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	Published Leadership Strategy	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	01/08/14	29/02/15	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.	Training needs analysis process currently being developed	Training Needs Analysis	G
		Leadership	Trust wide	3.4	Provide clinical leadership development opportunities	Executive Director of Human Resources	Deputy Director – Training and Development	01/04/14	31/03/15	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	Programme details published	G
		Medical Leadership	Trust wide	3.5	Provide medical leadership and management development opportunities	Executive Director of Human Resources	Deputy Director – Training & Development	01/04/14	31/03/15	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	Draft programme outline	G
		Medical leadership	Trust wide	3.6	Identify Roles and Responsibilities for Heads of Service	Executive Medical Director	Executive Medical Director	01/04/14	31/10/14	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	Role discussed at Trust Wider Leadership event 19.09.14 with actions within 6 weeks Output from Medical Managers discussions	A
		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	01/10/14	01/10/16	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.		G
		Medical leadership	Medicine	3.8	Recruit a substantive Clinical Director for Emergency Care & Medicine	Chief Executive	Director of Operations	01/10/14	30/03/15	A substantive Clinical Director in place	Current Clinical Director is due to leave the Trust January 2015. A replacement is currently being advertised	Advert GH – does date need extending if looking to recruit external candidate?	A
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**	**01/07/14**	**28/02/15**	**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.**		A

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		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	01/05/14	31/12/14	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)		G
		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	01/05/14	31/12/14	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.		G
		Risk Management	Trust wide	4.3	Approve revised Risk Management Policy at November Board of Directors meeting	Executive Director of Nursing	Head of Governance	01/07/14	30/11/14	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		G
		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	01/10/14	01/12/14	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		A
		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	01/10/14	30/11/14	Consistency in recording risks using unified assessment	Draft to be circulated for comment and consultation w/c 10 October		G
		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	01/12/14	21/01/15 & ongoing	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		A
		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	01/08/14	15/12/14	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).		A
		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	01/07/14	28/02/15	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		G

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		Risk Management	Trustwide	4.9	Establish a Risk Committee reporting to TMB	Chief Executive	Executive Director of Nursing	01/12/14	31/03/15	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		R
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**	**01/07/14**	**31/12/14**	**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
		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	01/04/14	31/12/14	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.		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	01/09/14	30/11/14	Improved recording of complaints subject and sub subject and lesson learnt to be completed.	Week commencing the 6th October agreed field for the patient experience module of Datix. Training of the patient experience team to start the 17th October with a view to go live the 10th November.		G
		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	01/10/14	31/12/14	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		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	01/08/14	31/01/15 and ongoing	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 programem of training will be rolled out across the Trust. To include RCA training report writing and being open policy.		A
		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	01/09/14	31/12/14	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.	Divisional Governance Packs Se	G
		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, Medical Director	Assistant Director of Nursing for Quality,	01/08/14	27/09/14	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	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	01/10/14	30/11/14	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		A

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		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	01/01/15	31/01/15	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		A
		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	31/10/14	31/03/15 and ongoing (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)	Study day agenda , notes and evaluation forms	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	01/08/14	11/11/14	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		A
		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	16/01/14	31/12/14	Learning boards for every clinical area are in place	The mock CQC learning event and Quality Summit have identified this as a need		R
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**	**01/01/14**	**01/04/15**	**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	01/04/14	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.	Trust Board Paper and minutes. UNIFY data. Monthly Nurse staffing Trust Board reports. Notes from DN & DoPs meeting	A
		Medical Consultants	Trust wide	6.2	Develop a robust Workforce plan for medical consultants from the current workforce stagey	Executive Medical Director	Executive Medical Director	31/10/15	31/03/15	Substantive clinical expertise available for all medical specialties	This is within the OD workforce strategy		A
		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	01/01/14	01/04/15	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		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	01/04/14	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	Monthly Trust Board Papers. AUKUH assessment – July 14 Spread sheet with inpatient ward new staffing levels	G

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Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	01/04/14	31/03/15	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		A
		Staffing	ED	6.4.1	Review ED workforce model to match demand profiles	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/04/14	30/11/14	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 all middle grade posts have been filled (awaiting commencement)		A
			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	20/07/14	31/10/14	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	Bench marking paper produced Monthly establishment available from finance	A
			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	01/03/14	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		R
			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 or 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, all acute physician posts and ED middle grade posts have been filled with candidates starting to commence.	Evidence of staff commencing in post and start dates for those awaited	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	01/06/14	31/12/14	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	Daily staffing tool used to review and evidence staffing Levels. Daily bed state identifies bed occupancy	A
		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	01/07/14	31/10/14	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	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	01/06/14	31/03/15	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	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	R
		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 Specilaties	01/07/14	31/10/14	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 modeling.	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	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	01/04/14	30/03/15	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.	Monthly establishments produced. Monthly tracker produced for overseas recruitment	A

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Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	EC & M and PC &S Divisional General Manager	01/10/14	29/11/14	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	CIP Paper	A
		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	01/05/14	30/11/14	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		G
			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		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	01/04/14	30/03/15	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.		G
		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	01/04/14	30/03/15	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 review will conclude in October and an action plan implemented in Q3 and Q4.	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	01/07/14	31/10/14	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	Frances team outcomes Radiology rota	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.3	Ensure radiology reporting KPI's are met	Director of Operations	D & R , Divisional General Manager	1/7/13	31/7/13	Reporting times met KPI's	Outsourcing utilised to support reporting times. Radiographer reporting extended. Robust reporting issues escalation process implemented	Radiology reporting reports. Escalation process	C
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.4	Recruitment of Radiologists	Director of Operations	D & R , Divisional General Manager	01/07/14	31/03/15	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	Recruitment of Radiologists	R
		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	01/06/14	31/03/15	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		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	01/04/14	31/10/14	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.		A
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**	**02/06/14**	**01/12/14**	**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

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	02/06/14	25/10/14	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		G
		Equipment Management	Trust wide	7.2	Introduce a standardised medical device reporting system	Director of Operations	Medical Physics Manager	02/06/14	30/11/14	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	Evidence of compliance	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	01/10/14	30/11/14	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		G
		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	01/05/14	31/12/14	Clear standards and procedures for checking daily of resus equipment.	Programme in place to replace resus boxes and trolleys to enhance checking procedures. Out of hours visit (23rd September checked resus trolleys with very few gaps). Mock CQC visit 16th October demonstrated very few gaps, with majority fo wards achieving 100%		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**	**01/07/14**	**30/03/15**	**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 trialing a new swipe card access for bedside lockers, to improve security. Drug trolleys ordered for outstanding medical wards.**		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	01/06/14	31/12/14	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 trialing 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	Meeting minutes and action log Signed off competency packs	G
		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	01/09/14	Ongoing 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	Training presentation Competency Framework Signed off competency packs	G
		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	31/12/14	All medicines stored securely at all times not allowing unauthorised access.	Issue has been highlighted previously, but has remained an ongoing concern. Audits taking place on wards and departments to assess medicines security. Nursing metrics audited monthly re medicines storage. Outcome guardian visits being undertaken	Audit outcomes Metrics outcomes	A

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	31/03/15	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.	Business case, meeting notes	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	06/08/14	Ongoing 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 trialing a new swipe card access bedside lockers, awaiting feedback Additional keys to be organized forward areas that have insufficient for each nursing team	Audit Outcome guardian and metrics	A
		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	10/11/14	A highlighted focus on medicines management across the Trust	3 Posters have been designed and changes made at the MTFG Costings have been established for posters	Posters in place across wards , clinics and medical and nursing areas	G
		Missed & delayed doses	Trust wide	8.7	Medicine Champions to be implemented across the Trust	Executive Director of Nursing	Katie Smalley, Practice Development Matron	06/08/14	31/11/14	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	Meeting notes from Task and Finish Group Staff in place in all relevant areas	G
		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	01/10/14	31/03/15	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 .	Package available on Intranet Training access monitored	G
		Missed & delayed doses	Trust wide	8.9	To reduce the amount of missed and delayed doses	Executive Medical Director	Chief Pharmacist	01/02/14	Ongoing	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. 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	Meeting notes Audit results Nursing metrics New drug charts implemented	A
		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	Chief Pharmacist	22/10/14	3/11/14	Reduce missed and delayed doses, improve prescription legibility.	Nurses to pick up discrepancies and issues. Highlight legibility issues with prescribers.	Metrics Audit	A
		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	15/09/14	01/12/14	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.	Incident reports	G

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	15/10/14	15/12/14	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	Meeting notes White Boards	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	06/08/14	31/12/14	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	Medicines policy Induction programme	G
		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	15/10/14	01/12/14	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	Audit Incidents Drug chart	G
		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	15/10/14	15/12/14	Helps ensure that missed doses are appropriately dealt with e.g prescription review, source the medicine.	Flow chart in draft	Meeting notes Flow chart once completed	G
		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	01/06/14	31/12/14	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	Training packs Evidence from attendance/completion of packs	A
		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	15/10/14	30/11/14	All prescriptions are clear and patients receive the intended medicine on time.	Standards are listed in medicines policy Specific empowerment campaign to be initiated	Medicines policy Meeting notes Prescription charts Annual documentation audit which covers drug charts	A
		Missed & delayed doses	Trust wide	8.18	Implement e-prescribing	Executive Medical Director	Chief Pharmacist	2010	2016	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	E- Prescribing system Meeting notes	A
		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 2014	31/12/14	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.	Meeting notes The policy Potential disciplinary hearing records	G
		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 2013	31/12/14	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	Audit results	A

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
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.**	**01/07/14**	**31/12/14**	**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**		A
		Medical Admissions Documentation	Trust wide	9.1	Rationalise admission documentation (to improve data quality and standardize)	Executive Medical Director	ECM Divisional Director and ED Head of Service	01/09/14	30/11/14	Ensure admissions booklet is completed by ED and Acute Medicine in a consistent manner	Review of structure and content of existing booklet to create areas for ED and Acute Medicine by EC&M. Revision of comorbidities page Plan for completion by end of November	Progress monitored via Medical Managers Forum Implementation monitored via Documentation audits	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	31/12/14	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	Reporting forms and letters to clinical teams	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	01/05/14	01/01/2015	100% compliance by Dec 2014. Eliminate surgical never events	Compliance dramatically improved in latest August audit to 70% Compliance in who checklist improved	Ongoing audit	A
	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	01/11/14	31/12/14	Consent procedures are compliant	Divisional meeting with Consultants Meeting with CEO /MD and Consultants scheduled	Ongoing audit	R
		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	30/09/14	30/11/14	Accessible checklist on the intranet	Sue Dale has liaised with Sharon Baxter to organize		A
		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	30/07/14	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	Consent Ctte Ongoing Audit	A

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	06/06/14	31/12/14	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	The recordkeeping booklet Improvement in the documentation audit results Staff can verbalise what they have changed within their practice	A
		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	01/09/14	01/12/14	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	Audit tool and results	A
		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	15/10/14	30/11/14	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	Observed practice	G
		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	01/11/13	30/11/14	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	Observed practice	G
		Nursing Records	Trust wide	9.10	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	30/03/14	31/11/14	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	Observed practice	G
DOMAIN - EFFECTIVE													
Effective	Hospital Inspection & Keogh	Recognition of the deteriorating patient	Trust wide	10.0	Ensure the processes for the recognition of deteriorating patients are robust and appropriately acted upon	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	June 2013	31/01/15	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.	VitalPac 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 VitalPac implementation, demonstrating earlier identification of deteriorating patients		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	01/06/14	31/01/15	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.	VitalPac Board minutes	A
		Recognition of the deteriorating patient	Trust wide	10.2	Consolidation and optimisation of the early benefits of VitalPAC (phase 1) through learning clinics, working with Critical Care Outreach Team, Practice development and clinical leads	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/14	31/01/15	Staff use all current "live" aspects of the VitalPAC system to a consistently high standard ensuring accurate record keeping and monitoring of acutely ill patients			A
		Escalation of the deteriorating patient	Trust wide	10.3	Implement VitalPAC 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	01/06/14	31/01/15	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		A

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		Weekend mortality	Trust wide	10.4	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	Monitored via Trust Mortality Group, Divisional bed to Board report will incorporate this Reported to Board Quarterly	A
		Infection Control	Trustwide	10.5	Implement a strengthened approach to infection, prevention and control through: • Establishing a county wide C Difficile task and finish group • Establishing and implementing clear escalation procedures to Medical Director & Nurse Director when breaches to IFC policy are repeatedly **observed** • Revisiting and strengthening membership of the IPCC to ensure clinical engagement	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist	01/10/14	31/12/14	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 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	Monitored via HCAI and IPCC meetings	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**	**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 18 weeks programme of work in place to sustain improvements in problematic pathways, T & O, ophthalmology & urology**		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		A
		Patient flow	Trust wide	**11.1.1**	Improve discharge education and training of ward teams, ward leadership improvements	Director or 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		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.		G
		Patient flow	Trust wide	11.1.3	Open a substantive discharge lounge	Director or 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 in place	C
		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 nos 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	Attendance of CHP colleagues within areas Urgent Care Working Group Papers and SRG Plan	R
		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 nos 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	Attendance of CHP colleagues within areas Urgent Care Working Group Papers and SRG Plan	R

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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		G
		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
		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		A
		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	>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		A
		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	01/06/14	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	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		G
				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		**A**
		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		C
		Referral to treatment time	Trust wide	11.2.2	Complete reviews with National Intensive Support Team (IST) for to improve the 18 week pathways, including a full review of cancer pathways	Director of Operations	Director or Operations	01/07/2014	02/06/14	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		C

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	01/03/14	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	Review at capacity meeting weekly and incidents/concerns/issues	G
		Patient information system	Trust wide	11.3.1	Optimise benefits of PAS implementation: Single system for tracking named consultant	Executive Medical Director	Executive Medical Director	01/05/14	30/10/14	Consistent and accurate consultant attribution at entry to and transfer from EAU	Go Live 3.10.14		**A**
		Patient information system	Trust wide	11.3.2	Optimise benefits of PAS implementation: Single system for case note tracking Improved business reporting formats	Executive Medical Director	Executive Medical Director	01/05/14	19/10/14	Single electronic system for case note tracking. Business Intelligence report suite in place	Go Live 3.10.14		**A**
		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	31/10/14	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	Newton outpatient tool Patient experience responses	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	95% ofcase notes to be available for short notice (2ww) clinics. 98% of case notes to be available for planned clinics<DNA	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	Project team action plan KPIs	G
Effective	**Hospital Inspection**	**Training**	**Trust wide**	**12**	**Improve delivery of mandatory and targeted training for staff**	**Executive Director of HR**	**Executive Director of HR**	**01/04/14**	**31/03/15**	**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.**	**Task and finish group establish re training in practice. Employee Self Service launched April 2014 Mandatory training e-learning workbooks developed**		G
		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	01/08/14	27/10/2014	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.		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	01/04/14	31/12/14	Confidence that appraisal data is accurate.	Evaluation of current data to provide assurance of accuracy of data.		G
		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	01/08/14	30/11/14	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.		G
		Mandatory Training	Trust wide	12.4	Enhance electronic monitoring systems - Employee Self Service	Executive Director of Human Resources	Deputy Director of Training and Education	01/04/14	29/12/2014	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.		A
		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	01/06/14	31/12/14	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.		G
		Mandatory Training	Trust wide	12.6	Target medical training for fire lectures, C-diff and MRSA	Executive Medical Director	Divisional Clinical Directors	01/04/15	30/11/14	>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		A

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
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**	**1/4/14**	**31/03/15**	**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 perceptor programme commenced Sept 2014**		**G**
		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	01/01/14	02/06/14	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	Board report held up regionally and nationally as exemplar Appraiser Forums with high attendance	C
	HEEM	Medical trainees	ED & T&O	13.2	Improve working relationships between ED and T & O	Executive Director of Human Resources and Executive Medical Director	Divisional clinical director PC&S and Head of Service ED	20/10/14	31/03/15	Reported positive working relationships between ED staff and T&O trainees	HEEM feedback – action plan developed Trauma Pathway review completed	Monitored via LETB and GMC surveys at Workforce Ctte Reviewed at Junior Doctor Forums	C
	HEEM	Medical trainees	Trustwide	13.3	Address safety concerns raised by HEEM visit	Executive Director of Human Resources and Executive Medical Director	Deputy Director of Training & Education	20/10/2014	31/03/15	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		**A**
		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	July 14	24/11/2014	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.		**G**
		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	11/10/14	31/03/15	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	Job Planning Toolkit	A
		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	01/07/14	01/09/14	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	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	30/09/14	31/12/14	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.	Copy of preceptor programme	G
		Clinical supervision	Trust wide	13.8	Implement clinical supervision opportunities for nursing staff across the Trust	Executive Director of Nursing	Head of Practice Development	01/06/14	31/12/14	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.	Clinical Supervision guidelines. Training day agenda for supervisees	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	01/06/14	30/03/15	Improved management of stress related absence and improved awareness of symptoms of stress to allow early intervention.	Support provided on request with resilience training.		G

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
		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	01/08/14	31/10/14	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	Completed Risk Assessment Tool	G
		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	01/06/14	29/12/14	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.		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**	**01/05/14**	**31/12/14**	**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**		A
		NICE Guidance	Trust wide	14.1	New process for NICE Guidance agreed	Executive Medical Director	Clinical policies lead	01/06/14	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	Revised policy on intranet New process will be evidenced through governance meetings	C
		Surgical Pathways	Planned Care & Surgery	14.2	Comprehensive review of pathways: T+O Urology Opthalmology Pre Operative Assessment Review of DayCase and Surgical Assessment Unit processes	Executive Medical Director	Divisional Team, Planned Care & Surgery	01/06/14	Ongoing	Safe and efficient access	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		A
		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		A
		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	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		**A**
DOMAIN - CARING													
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**	**31/10/14**	**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**		**A**
		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	01/06/14	31/10/14	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		R
			Emergency Department	15.2	Implement ED focused F&F action plan	Executive Director of Nursing	Deputy Director of Nursing	01/07/14	30/09/14	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		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	01/12/14	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		G
DOMAIN - RESPONSIVE													

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
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**	**01/07/14**	**30/11/15**	**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 finalized 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**		**A**
		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	01/07/14	30/11/14	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		G
		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	15/07/14	31/12/14	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.		G
		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	15/08/14	30/11/15	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		A
		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	15/07/13	30/11/15	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. The Trust is currently in the second phase of implementation of AMBER care bundle with a further 2 wards preparing to commence the AMBER care bundle in November '14.		A
		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	Divisional General Managers	13/10/14	30/04/15	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		A
		End of Life	Trust wide	16.6	Allow Natural Death documentation is fully completed	Executive Medical Director	Divisional Clinical Directors	01/01/14	Ongoing	Patient records are completed sensitively with clear, timely entries	An AND audit was conducted over Quarter 4 period. The results have been presented at the Grand Round 15 October 2014 and to each Divisional Governance Lead. Each Division has been asked to develop an action plan in response to the audit findings by 30 November 2014 to improve current compliance levels, particularly regarding improved communication. The AND audit findings will be tabled at the next Resuscitation Committee meeting to be held on the 6th November 2014 A working group is being convened to look at overlapping areas of concern within areas of specialism such as End of Life Care, patients with learning disabilities and those who lack capacity.		A