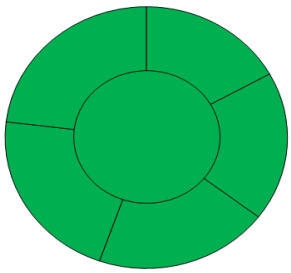
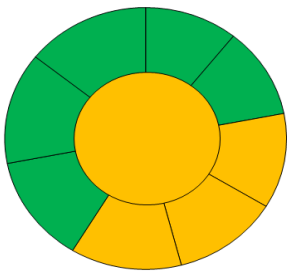
Sherwood Forest Hospitals
NHS Foundation Trust

Quality Stategy Dashboard

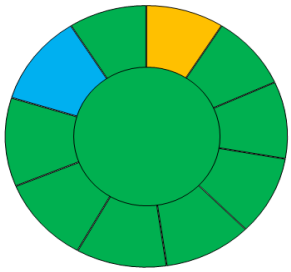
Campaign 1: A Positive Patient Experience



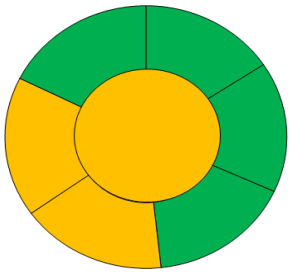
Campaign 2: Care is Safer



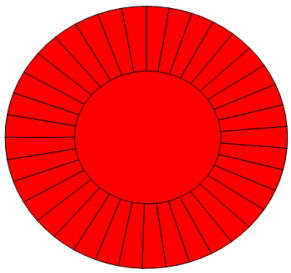
Campaign 3: Care is Clinically Effective



Campaign 4: We Stand Out



Campaign 5: CQC 'Should Do' Actions

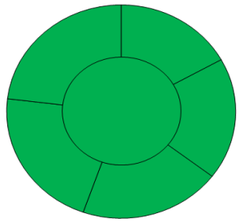


Campaign 1: A Positive Patient Experience

Key	
R	Action Needed
A	Action Agreed
G	On Track
B	Embedded

Sherwood Forest Hospitals
NHS Foundation Trust

Campaign Leads	Andy Haynes Kerry Beadling-Barron	Date:	20/09/2018
		Version	v09.18.0
Objective	Changing behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services we provide		
Goals	1. By 2021 service developments and plans of care are co-designed with patients and service users 2. By 2021 patient stories and diaries are used across pathways to identify touchpoints and 'Always Events'		



Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Embedded
1.1	**Focus on explaining care in an understandable way**	Maintain at least 90% or more patient's satisfied their care was explained in an understandable way	Kim Kirk	30 March 2019	Lack of resource to collect and analyse patient feedback in a timely manner	Inpatient survey received. Analysis underway. Inpatient Survey - aggregated score for the various areas in the trust = 73%	The questions do not exactly match the outcome measure. Kim Kirk to identify a group of questions within the inpatient survey that, together, evidence progress towards this outcome. Inpatient Analysis Report to be presented to Quality Committee in September 2018	G	Inpatient Survey		
1.2	**Engage and involve people in planning and delivering their care**	Achieve at least 85% or more patients reporting they were involved in planning their care	Kim Kirk	30 March 2019	Lack of resource to collect and analyse patient feedback in a timely manner	Inpatient survey received. Analysis underway.	The questions do not exactly match the outcome measure. Kim Kirk to identify a group of questions within the inpatient survey that, together, evidence progress towards this outcome. Inpatient Analysis Report to be presented to Quality Committee in September 2018	G	Inpatient Survey Further information onpateint groups required		
1.3	**Educate and train staff to adopt the principle of co-design in care planning**	Number of staff trained, by Division – OD will have this data from Moodle – monthly reporting from October onwards – monthly to AQB 5% increase in staff reporting that they are involved in improvements from current baseline in NHS Staff Survey – annual reporting to AQB	Ceri Feltbower	30 March 2019	The Holistic Improvement proposal is not accepted by the Trust as the service Improvement methodology of choice	Under development	August: Toolbox Talks on Sherwood Six Step to start in October 18. 12 clinical staff from SFH representing the Urgent Care Pathway attending 5 day QSIR Practitioner level training in September - November as part of a regional QI approach. The QSIR training underpins the STP QI/OD strategy. 'My bright idea' QI website shaped around SFH to be formally lanched in November 18. QI training delivered to Clinical Leaders Programme from 5th November.	G	Ceri Feltbower to advise Service user strategy needed Self assessment re: user inovolvement and gap analysis (nationally this is a voluntary requirement) QI Toolbox talks on e-learning system.	Executive Team Meetings	

Inpatient Survey 2017.pdf

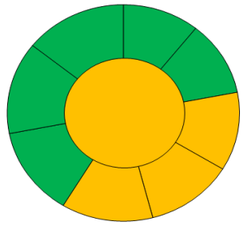
Inpatient FFT April-June 2018.pdf

1.4	**Service users will be active participants of PSQB, Quality Committee and Divisional Governance Groups**	Patient's/Service Users will attend and participate in proceedings of PSQB and Quality Committee	Elaine Jeffers	30 September 2018	Unable to recruit suitable numbers of patient representatives to cover all meetings.	No patient service users currently attend PSQG, Quality committee or Divisional Governance Groups	Member of Trust Forum for Patient Involvement has indicated an interest in piloting attendance at PSQG from September 2018. Training Programme to be developed to support the post Further consideration to be given as to how to include hard to reach communities	**G**	CF/EJ to advise		
1.5	**Patient stories and pathway diaries used to better understand patient experience and identify touch points and Always Events**	Always Events pilot completed and impact on patient experience evaluated	Kim Kirk	30 March 2019	Always event pilot data shows a negative impact on patient experience/outcomes	Always events are not currently monitored at SFH	Reconnection with the National Always Event Improvement team - September 4th Initial Always Event pilot to be identified	**G**	#Hellomynameis - Audits, staff feedback, patient feedback		
		Implement pathway diaries in services to better illustrate experience and different points in the journey	Kim Kirk	30 March 2019	Lack of patients engagement to complete diaries	Patient diaries are not currently widely used at SFH	Kim Kirk meeting with Cancer Services to understand how patient diaries are used there with a view to piloting in other areas.	**G**			

Janet Duffin (cancer team)

Campaign 2: Care is Safer

Campaign Leads	Suzanne Banks Andy Haynes	Date:	20/09/2018
		Version	v09.18.0
Objective	Focussing on frailty and learning disability we will adapt to meet the healthcare needs of an increasingly elderly patient population and, by delivering 'better basics', reduce exposure to harm or complications of care		
Goals	1. By 2021 have the lowest number of serious incidents of any East Midlands NHS acute care provider 2. By 2021, achieve 12 consecutive months or more without a Never Event		



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Sherwood Forest Hospitals NHS Foundation Trust

Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
2.1	**Achieve high reliability of risk assessment and effective care planning for patients at risk of falls**	92% or more compliance with implementation of falls care plans for at risk patients	Joanne Lewis-Hodgkinson	31 March 2019	Lack of Clinical Nurse Specialist Capacity to monitor compliance for all patients identified as at risk of a fall	Falls metric questions requires 85% compliance to be Green. Areas not performing are offered educational input. Areas performing well share good practice. June 2018 Total for all wards is 92%. May 2018 Total for all wards is 90%. The final ward assurance score is for the set of questions together and not just care planning alone.	The percentage for the ward metrics for Falls is 92% for June. Looking at using the falls alert stickers throughout the Trust. The pilot did not go ahead. There are RCA themes and trends that require actions and the falls alert stickers may address the issue . There is now an audit on meredian developed from the RCP National falls audit which will ask different questions to the ward metrics and will enable data to be pulled for specific areas and regular or adhoc audits to be carried out.	G	Falls Exception Report 17/18 data analysis	Strategic Falls Group Harms Group Nursing and Midwifery Board Quality Committee Board of Directors	
2.2	**Achieve high reliability of risk assessment and effective care planning for patients at risk of hospital acquired pressure ulcers**	92% or more compliance with implementation of pressure sore prevention plans for at risk patients	Stephanie Anstess	31 March 2019	Staff miss at risk patients and pressure sore prevention plans are not completed	June performance: 93% May performance: 92%	TV questions (PU and wound care) for metrics agreed with Task and Finish Group Adaptation of safeguarding screening tool, successfully trialled. Stakeholders agreed to implement onto Datix and share with MASH Implementation of new skin care wipes and continence pads to start 11.7.18. Education by TVT to TV and ICP Link Nurse groups Meetings with new Ward Sisters and Charge Nurse re PURPOSE T assessment, audits and TV support Bespoke reconciliation slips to be trialled by the TVT WC 10.7.18. Virtual clinic set up for non clinic attendees	G	Trust Wide Tissue Viability KPIs Nursing and Midwifery Board Tissue Viability Highlight Report Pressure Ulcers Report	Harms Group Nursing and Midwifery Board	
2.3	**Focus on safety culture in operating theatres and other areas where interventional procedures are undertaken**	100% compliance with WHO Checks	Steve Jenkins	31 March 2019	Staff do not understand the importance of the WHO checks and they are not routinely completed.	Daily exception reporting of compliance with WHO Checklist being collected. June 2018 - 100% May 2018 - 100% April 2018 - 98.94%	Performance was 100% for July 2018.	G	Surery SOF		
		Every 'query' raised before or during procedure results in a 'stop moment'	Steve Jenkins	31 March 2019	Queries and stop moment data is not accurately recorded	To be determined	Unplanned stop moments discussed in the theatre de-brief. An exampl eof a datix incident being raised is attahed as evidence.	A	Datix reports		

Falls Exception report June 2018

Falls 1718 data.xlsx

PU report June 2018

Trust Wide PU KPIs.docx

TV Highlight report June 2018.pptx

Surgery SOF_June 2018.xlsx

5F518064.msg

2.4	**Reliable daily completion of charts and calculation of +/- fluid balance**	≥90%		31 March 2019			To agree metrics within Nervecentre for determining compliance with Fluid Balance Reports through DPG	**A**	Daily Observations via NerveCentre when available Nursing Metrics DPG Dashboard	Deteriorating Patient Group Patient Safety and Quality Group		
2.5	**Reducing the incidence of post-partum haemorrhage ≥1.5L in Maternity Services**	≤3.2%	Alison Whitham	31 March 2019		Running average is currently 3.95% for 2018/19	There were 12 patients (4.9%)who had a Post partum haemorrhage >1.5LT in June 2018. This is reflected on the Maternity dashboard that is discussed monthly at the Maternity and Gynaecology Governance Meeting.	**A**	Maternity Dashboard	Divisional Performance meetings Patient Safety and Quality Group		Maternity Dashboard Report June 2018.xls
2.6	**Delivering harm-free care**	≥95%	Yvonne Simpson	31 March 2019			Harm Free Care continues to be monitored and remains above 95% for July 2018. The Perfect Ward continues to be rolled out, and implementation remains on track.	**G**		Nursing and Midwifery Board		
2.7	**Safe staffing:**											
2.7.1	**(i) Reduce the incidence of staffing levels as direct causal factor in harmful incident reports**	Establish 2017/18 baseline of harmful incidents involving staffing levels as cause	Yvonne Simpson	31 March 2019		In May 1 incident relating to staffing shortages was reported but following further investigation it was determined that no harm was caused to the patient.	No incidents have been identified.	**G**	Unify Data Safe Staffing Board Report	Nursing Taskforce Steering Group Board of Directors (Unify Data)		June 2018 Unify Data Safe staffing Board paper - July 18 (June's data).docx
		Reduce by 3% (based on 2017/18) number of harmful incidents involving staffing levels as a cause	Yvonne Simpson	31 March 2019			No incidents have been identified.	**G**		Nursing Taskforce Steering Group Workforce Planning Group Performance Group		
2.7.2	**(ii) Focus on avoidance of rota 'tipping points';**	Zero breaches of tipping points under 'normal' operating conditions1	Yvonne Simpson	31 March 2019	Operational pressures and excessive staffing demands breach the agreed Trust staffing tipping points	June: No tipping points have been breached during June	There has been no breaches of the tipping points of the Safe Staffing Standard Operating Procedure.	**G**		Nursing Taskforce Steering Group Workforce Planning Group Performance Group		
2.7.3	**(iii) Focus on maximising fill rates in rotas;**	Overall fill rate for SFH ≥95%	Yvonne Simpson	31 March 2019			Nurse staffing rotas continue to be closely monitored and the Care Hours Per Patients Day (CHPPD) continues to demonstrate a overfill rate of GREEN and BLUE indicating 100% + fill.	**G**		Nursing Taskforce Steering Group Workforce Planning Group Performance Group		
2.7.4	**(iv) Sequentially reduce Band 5 vacancies**	≤12%	Yvonne Simpson	31 March 2019	Failure to recruit sufficient RNs and HCAs to the nurse bank to support required fill rates	June: There are currently 150 vacancies of band 5 nurses. This is predicted to reduce to approximately 100 by October 2018.	In September/ October 2018, there is a large cohort of Newly Qualified Registered Nurses commencing - 58 in total. In August a further wave of International Recruitment from the Phillippines has commenced. There is further work ongoing reviewing the role of the Nursing Associate for the Trust.	**G**		Nursing Taskforce Steering Group Workforce Planning Group Performance Group		RR Update Report 030718.pptx

Campaign 3: Care is Clinically Effective

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NHS
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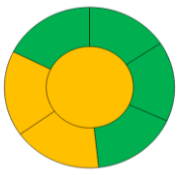
NHS Foundation Trust

Campaign Leads	Andy Haynes Suzanne Banks Simon Barton	Date:	20/09/2018
		Version	v09.18.0
Objective	Patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.		
Goals	1. By 2021 remain at or below expected levels on all mortality indices 2. By 2021 we aim to benchmark in the top quartile for lowest Length of Stay 3. By 2021 we aim to benchmark in the top quartile for lowest number of readmissions within 28-days of discharge for the same HRG		

Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded	
3.1	**Reducing overall length of stay**	Top 25% of trusts for lowest length of stay To achieve top 25% based on Sept 2017 - Feb 2018 data our length of stay needs to be <3.62 against similar trusts, or <3.74 against all acute trusts.	Dale Travis	31 March 2019	Interventions do not result in a reduction in length of stay	Our current average length of stay is 4.03 days (Sept 2017-Feb 2018) Apr 18-June 18: LoS = 4.05 Sept 17-Feb 18 : LoS = 4.03 2017/18 average LoS = 3.95	We have the data which shows significant improvements to be made in Cardiology, Respiratory ad Diabetes and Endochrine. In Stroke we are better than peers with little to go at when broken down. We have taken the data further and looked at HRG for COPD and pneumonia in Respiratory, syncope in Cardiology and will develop action plans for these. For Diabetes and Endochrine the issue was not in the specialty but in the sub specialties where patients may not be on the base ward e.g. a Respiratory patient on a Diabetes and Endochrine ward. The issue we need to address is how we get patients onto correct ward and make sure when outlied they don't incur a longer LOS.	A	Patient Flow Improvement Plan - Length of Stay AQP National LoS Comparison Data	Patient Flow Group FIP Working Group		AQP LOS National Comparison May 2018.xlsx Pateint Flow - LoS - Projects KPIs and Actions
3.2	**Reducing harm for those using our services who have a learning disability**	Establish 2017/18 baseline of harms involving those who have a learning disability	Ruth Harrison	31 March 2019	If incident reporting rate was low in 17/18 baseline figures may be inaccurate	300 incidents reported for 2017/18.	Review of 17/18 incidents complete 20/04/2018	B	LD Datix data	Safeguarding Group Patient Safety and Quality Group		LD incidents 1718 data
		Reduce by 10% (based on 2017/18) number of harmful incidents involving learning disabled patients	Ruth Harrison	31 March 2019	If incident reporting rate was low in 17/18 baseline figures may be inaccurate and we may see an increase in 18/19	July 2018 - 12 incidents (July 2017 - 14 incidents) Q1 2018 - 42 incidents in total (see attached graph) May 2018 - 11 incidents (May 2017 - 7 incidents) April 2018 - 10 incidents (April 2017 - 2 incidents) LD Q1 2018 incidents by category.pdf	July 2018 and July 2017 data compared - 12 incidents in July 2018 compared to 14 in July 2017.	G	Gap analysis against National Strategy	Safeguarding Group Patient Safety and Quality Group		
3.3	**Preferred venue at the end of life**	Maintain at least 85% or more alignment with patient's preferred discharge venue at the end of their life	Ben Lobo Deb Broadhurst	31 March 2019	Operational pressures negatively influence disharge processes preventing effective and timely decision-making for the patient and their families Lack of suitable discharge options available	Our base line as recorded from quarter 1 is 79% of those applied for fast track achieved it. This is comparable to our mean for last year of approx 78%.	Performed a review of the timeliness of discharge for those that achieved discharge. This is an interesting statistic as a potential problem of excess delay impacts on the chance of discharge, some patients die waiting. We will continue to consider this as we report into the AQP. Seasonal variation noticed, usually achievement can be negatively influenced during the winter months. Working with the IDAT team and Better Together to address the underperformance of the whole system and the elements within.	G	Mortality Annual Summary report Mortality Data - Dr Foster HSMR	End of Life Group Patient Safety and Quality Group Quality committee Board of Directors		20B685E4.msg Mortality Annual Summary Report May 2018.doc Presentation
3.4	**Mortality**	Within 1% of expected range	Elaine Jeffers	31 March 2019	Crude mortality increases beyond expected	Consistently within the expected range since April 2016	Currently achieving within 1% of expected range. Specialty Mortality reports in development.	B		Mortaity Sterring Group Deteriorating Patient Group Quality Committee Board of Directors		
		Avoidable factors associated with mortality ≤3%	Elaine Jeffers	31 March 2019	Learning opportunities are not identified and the same avoidable factors continue to contribute to mortality	Baseline data within Annual Summary Report 2017/18	Work has commenced to capture the number of mortality reviews that undergo a (Phase 2) Structured Judgement review (this is data has not previously been captured on the Learning from Deaths Report.	B		Mortaity Sterring Group Deteriorating Patient Group Quality Committee Board of Directors		
3.5	**Improve effectiveness of discharge planning and resilience of discharge venue**	Achieve at least 85% or more patients reporting they were involved in planning their discharge	Kim Kirk	31 March 2019	patients have poor experience of discharge due to continued uninvolvement in key decision-making	Baseline data being collected	All inpatient FFT surveys have questions around patient involvement in planning their discharge. The 2017 Inpatient Survey is currently being analysed. Report to be presented to the Quality Committee in September 2018.	G	Inpatient Survey Discharge Lounge FFT			Discharge Lounge Inpatient FFT April-June 2018
		Reduce by 5% (based on 2016/17) number of incidents or complaints concerning unsatisfactory/unsafe discharge	Kim Kirk	31 March 2019	patient, families and external stakeholders continue to perceive/experience inadequate and unsafe discharges	Baseline data being collected	Work is taking place with Datix Manager to undertsand the benchmark initally - although field for discharge incidents and complaints are not always linked as part of of wider issue.	G	Inpatient Survey			
3.6	**Improving the timeliness of the clinical response to abnormal or unexpected (and clinically significant) radiology or pathology results**	10% fewer incidents (compared to 2017/18) involving failure to detect and act upon (clinically significant) abnormal pathology or radiology findings	Elaine Torr Jayne Burkitt	31 March 2019		3 incidents in 2017/18 relating to failure to respond. Supporitng data will be available from July.	Last remaining SOP was ratified at W&C Governance Meeting on 13/08/2018.	G		Radiology Governance Meeting Patient Safety and Quality Group		
3.7	**Implementation of NICE Guidelines**	All specialities are reporting their position on uptake of NICE guidelines	Jackie Robinson	31 March 2019		Quarterly report provided to Patient Safety Quality Group Baseline 01/04/2017 - 31/03/2018 - 100%	80% - 2 x assessments not responded to (IPG611, IPG612), 3 x assessments completed and work underway but update not yet due (NG96, CG192, CG137)	G		Patient Safety and Quality Group Quality Committee Board of Directors		
		≥75% of Clinical Specialties completed baseline assessment against all applicable NICE guidelines	Jackie Robinson	31 March 2019		Quarterly report provided to Patient Safety Quality Group Baseline 01/04/2017 - 31/03/2018 - 100%	80% - 2 x overdue (IPG611, IPG612)	B		Patient Safety and Quality Group Quality Committee Board of Directors		
3.8	**Ensuring all patients have a review by a consultant within 14 hours of hospital admission**	≥95%	Andy Haynes	31 March 2019	Claire Maddon, Practice Development	Audit data collection and submission in line with nationa requirements. SFHFT currently performing in top 25% nationally and top of East Midlands Sept 2017 - 74% March 2017 - 93% Sept 2017 - 80%	March 2018 audit completed and submitted. Feedback expected later in the year.	G	14 hour review data	Board of Directors		14 hr review 2017 data
3.9	**Compliance with CAS Alerts**	≥98% closure on or before deadline day	Jackie Robinson	31 March 2019		Circulated through identified person per Alert type for action. Responses tracked via CAS system/ database in GSU and evidence received before closure Baseline 01/04/2017 - 31/03/2018 - 100% July 2018 - 100% June 2018 - 100% May 2018 - 100% April 2018-100%	Performance YDT is 100% closure on or before the deadline day	B		Patient Safety and Quality Group		
3.10	**Culture of enquiry and continuous improvement**	≥70% of staff report they are able to contribute to improvements at work (staff survey)	Lee Radford Ceri Feltbower	31 March 2019	Lack of engagement of staff to complete the Staff Satisfaction Survey/staff FFT	76% (2017)	Q1 Staff FFT published. Team SFH Bullletin 54 outlines results and issues for further consideration. 23 August 2018 Staff Bulletin also reports the findings. Q2 Staff FFT is currently live and closed on 26 August 2018. 12 SFH clinical staff involved in the Urgent Care Pathway to undertake QSIR Practitioner level training from September	G	Staff Survey Workforce Strategic Plan	Board of Directors		Workforce Strategic Plan 2018

Campaign 4: We Stand Out

Campaign Leads	Julie Bacon Peter Wozencroft Andy Haynes Simon Barton	Date:	20/09/2018
		Version	v09.18.0
Objective	Being a leader and striving for excellence on our journey to outstanding.		
Goals	1. By 2021 we aim to be rated outstanding by the Care Quality Commission 2. By 2021 we aim - at a system level – to keep patients with long term conditions well, as independent as possible and avoid foreseeable crisis points which often result in hospital admission		



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Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
4.1	**Staff engagement / Satisfaction**	KF1: Staff recommendation of the organisation as a place to work is ≥3.95 (79%)	Lee radford	31 March 2019	Lack of engagement of staff to complete the Staff Satisfaction Survey/staff FFT	Staff FFT: Q1 18/19 - 77% (1140 responses) Q4 17/18 - 77% (1050 responses) Q3 17/18 Staff Survey - 70% Q2 17/18 -73% Q1 17/18 - 71%	Q1 Staff FFT published. Team SFH Bullletin 54 outlines results and issues for further consideration. 23 August 2018 Staff Bulletin also reports the findings. Q2 Staff FFT is currently live and closed on 26 August 2018.	G	Staff Survey		
		KF2: Staff recommendation of the organisation as a place to receive care or treatment ≥4.15 (83%)	Lee radford	31 March 2019	Lack of engagement of staff to complete the Staff Satisfaction Survey/staff FFT	Staff FFT: Q1 18/19 - 88% (1140 responses) Q4 17/18 - 89% (1050 responses) Q3 17/18 Staff Survey - 87% Q2 17/18 - 90% Q1 17/18 - 86%	Q1 Staff FFT published. Team SFH Bullletin 54 outlines results and issues for further consideration. 23 August 2018 Staff Bulletin also reports the findings. Q2 Staff FFT is currently live and closed on 26 August 2018.	G	Staff Survey		
4.2	**Open and learning culture**	Top 25% of Trusts for levels of incident and near miss reporting	Yvonne Simpson Ceri Feltbower	31 March 2019	Different criteria used by different Trusts for incident reporting could skew performance	Data to be measured on our own performance. NRLS average reporting days has improved from 37 days in April 16 to Sept 16 to 26 days April 17 to Sept 2017 .	New Head of Governance commences in September 2018, and to work inconjunction with Deputy Director of Service Improvement. Benchmarking of Trusts in the Top 25 for levels of incident and near miss reporting in October/ November 2018.	G	NRLS report GSU data Safety Culture Results		
4.3	**Getting to the learning faster: response to serious incidents**	≥75% of incidents scoped within 72 hours of incident occurring or sooner	Yvonne Simpson	31 March 2019	Staff engagement	Currently 86% of all incidents are scoped within 72 hours of the incident ocurring (May 2018) Baseline 1/4/2017 - 31/3/2018 - 71%	In July the Scoping Meetings were moved to twice weekly and this has allowed more detailed information being brought to the Scoping Meetings. There remains capacity within the meetings, and there is active discussion and debate.	G			
4.4	**Learning from adverse events**	5% reduction (based on 2016/17) in number of reported instances of High-risk medication errors	Joanna Freeman	31 March 2019	If current incident reporting levels are poor, there will be an increase in the number of incidents reported before any reductions are possible	Baseline data needed.	As per July - still planning. MST alternative proposal drafted for discussion at relevant committees in Sept/Oct. Dashboard content to be agreed early Sept. Proposal for regional anticoagulation audit put forward to the regional group and EMCPN for consideration in September.	A	Dashboard under development		
4.5	**Create an integrated system-wide patient pathway for long term conditions such as diabetes**	Establish baseline admission rates for Diabetes, Heart Failure	Devaka Fernandez/Elaine Jeffers	31 March 2019	Dr Devaka Fernando/ Paul Harding		Meeting with Dr Devaka Fernando 07/08/18	G			
		Pathways for Diabetes are 'process mapped' to isolate potential crisis points and act on the analysis	Devaka Fernandez/Elaine Jeffers	31 March 2019	Dr Devaka Fernando/Paul Harding			G			
		Scope and rapidly adopt technological innovations that could promote and support integrated whole-person care (such as home monitoring, smartphone apps etc.)	Devaka Fernandez/Elaine Jeffers	31 March 2019	Dr Devaka Fernando/Paul Harding			G			
		Patient experience evaluated: service users positively report less fragmentation and a clear shift in emphasis towards self-care	Devaka Fernandez/Elaine Jeffers	31 March 2019	Dr Devaka Fernando/Paul Harding			G			
4.6	**Stakeholders are involved, engaged and able to contribute to improving the quality of care**	Patient and Public Involvement Forum providing an effective 'reference point' for obtaining service user perspectives and feedback	Elaine Jeffers Kerry Beadling-Barron	31 March 2019	Lack of patient and public engagemnet	Forum for Patient Involvement is well attended by patients and public	The group met and discussed the potential Home First campaign and gave feedback on a discharge leaflet language as well as the Annual Summary text.	B			
		Patient's/Service Users routinely attend and participate in proceedings of PSQB and Quality Committee	Elaine Jeffers Kerry Beadling-Barron	31 March 2019	Lack of patient and public engagemnet	No patient service users attend PSQG, Quality committee or Divisional Governance Groups	The member of the Forum for Patient Involvement who expressed an interest in joining PSQB has been approached and an initial meeting to discuss this further is being organised for September.	G			

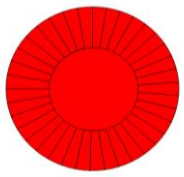
Advancing Quality Programme Information and...

NRLS report April 17 - Septemeber 17.pdf

AQP Updates - Progress GSU

Campaign 5: CQC 'Should Do' Actions

Campaign Leads	Dr Andy Haynes Suzanne Banks Elaine Jeffers	Date:	20/09/2018
		Version	v09.18.0
Objective	Achieving all the 'Should Do' actions from the 2018 CQC Report		
Goals	1. By 2021 we aim to be rated outstanding by the Care Quality Commission		



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Sherwood Forest Hospitals
NHS Foundation Trust

Ref.	Objective	Action	Action Owner	By When	Date completed	Progress	RAG	Outcome	Evidence	Ongoing Monitoring	Date embedded
Urgent and Emergency Care - Kings Mill Hospital											
5.01	The provider should ensure security staff working in the emergency department receive training to understand the fundamentals of mental health issues in order to support both patients and staff when required to do so		Siobhan McKenna Favier	31/03/2019			R				
5.02	The provider should ensure staff assess patients for any underlying or previous mental health issues when presenting at the department for a physical illness.		Siobhan McKenna Favier	31/03/2019			R				
5.03	The provider should consider installing a strip alarm in rooms used for psychiatric assessments to enable staff to summon assistance wherever they are in the room as per current guidance and not rely on the push button alarm currently installed.		Siobhan McKenna Favier	31/03/2019			R				
5.04	The provider should ensure emergency medicine consultants in the department are aware of who has the role as the guardian of safe working hours and exception reporting in order to support trainee doctors.		Siobhan McKenna Favier	31/03/2019			R				
5.05	The provider should ensure further progress is made in agreeing protocols with the local mental health trust in order for the department to allow access to mental health notes of patients attending the department.		Siobhan McKenna Favier	31/03/2019			R				
5.06	The provider should ensure staff do not use family members of patients instead of the telephone interpreting service. This is not considered good practice.		Siobhan McKenna Favier	31/03/2019			R				
Urgent and Emergency Care - Newark Hospital											
5.07	The provider should reduce the ligature risk of the two call bells in the UCC by replacing them with a suitable alternative.		Siobhan McKenna Favier	31/03/2019			R				
5.08	The provider should consider producing local safety standards for invasive procedures as recommended by NHS England.		Siobhan McKenna Favier	31/03/2019			R				
5.09	The provider should ensure storage of the controlled drugs belonging to the out of hours GP service are separated from the UCC controlled drug store.		Siobhan McKenna Favier	31/03/2019			R				
5.10	The provider should consider introducing bespoke training for reception staff to equip them with tools, skills and knowledge to recognise and escalate urgent medical conditions.		Siobhan McKenna Favier	31/03/2019			R				
5.11	The provider should consider including questions about religious and cultural beliefs in patient documentation.		Siobhan McKenna Favier	31/03/2019			R				
5.12	The should take action to improve the response times for mental health patients requiring an assessment by specialist mental health staff.		Siobhan McKenna Favier	31/03/2019			R				
Medicine - Kings Mill Hospital											
5.13	The provider should ensure medical notes on wards are stored in lockable areas, cabinets or trolleys to reduce the risk of unauthorised access to patient information.		Dale Travis	31/03/2019			R				
5.14	The provider should ensure staff have training in relation to FGM.		Dale Travis	31/03/2019			R				
5.15	The provider should ensure staff have practical fire safety training sessions.		Dale Travis	31/03/2019			R				
5.16	The provider should ensure the consistent use of the 'This is Me' document.		Dale Travis	31/03/2019			R				
Medicine - Newark Hospital											
5.17	The provider should ensure medical records are clear and legible always and are organised in a way that the latest episode of care can be clearly located.		Dale Travis	31/03/2019			R				
5.18	The provider should consider improving the ward environments to make them more suitable for patients living with dementia.		Dale Travis	31/03/2019			R				
5.19	The provider should ensure all risks on the risk register are reviewed and given their next review date.		Dale Travis	31/03/2019			R				
End of Life Care - Kings Mill Hospital											
5.20	The trust should ensure that the processes for completing DNACPR (Allow a natural death (AND) form) are clear and that where mental capacity assessments are undertaken, they must be done on a situation specific basis and include all relevant parties in that situation specific assessment.		Ben Lobo Deb Elleston	31/03/2019			R				
5.21	The trust should ensure the mental capacity assessment paperwork reflects the requirements of the mental capacity act legislation.		Ben Lobo Deb Elleston	31/03/2019			R				
5.22	The trust should ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.		Ben Lobo Deb Elleston	31/03/2019			R				
Maternity - Kings Mill Hospital											
5.23	The provider should ensure gaps in the junior doctors' rota are appropriately covered to provide a sustainable junior doctors' service to women.		Alison Whitham	31/03/2019			R				
5.24	The provider should ensure there is a dedicated theatre list for women undergoing a planned caesarean section.		Alison Whitham	31/03/2019			R				
Outpatients - Kings Mill Hospital											
5.25	The provider should ensure cleaning schedules are readily available in all areas to ensure consistency of standards.		Elaine Torr	31/03/2019			R				
5.26	The provider should commence temperature checks in the rooms where medicines are stored.		Elaine Torr	31/03/2019			R				
5.27	The provider should have a policy to provide guidance regarding the transition of children into adult outpatient services.		Elaine Torr	31/03/2019			R				
Outpatients - Newark Hospital											
5.28	The provider should ensure cleaning schedules are readily available in all areas to ensure consistency of standards.		Elaine Torr	31/03/2019			R				
5.29	The provider should consider reviewing the storage facilities to ensure there is sufficient storage available to meet the needs of the service.		Elaine Torr	31/03/2019			R				
5.30	The provider should ensure staff receive training and information on FGM.		Elaine Torr	31/03/2019			R				
Diagnostic Imaging - Kings Mill Hospital											
5.31	The provider should ensure access to patients requiring MRI scans is improved.		Elaine Torr	31/03/2019			R				
5.32	The provider should ensure the risk register consistently reflect risks that were managed through local and divisional governance processes.		Elaine Torr	31/03/2019			R				
5.33	The provider should ensure that patients from wards are brought to the radiology department with their notes.		Elaine Torr	31/03/2019			R				
5.34	The provider should ensure that document control is reviewed, and updated documents should be readily available to staff.		Elaine Torr	31/03/2019			R				
5.35	The provider should consider how to make the waiting areas throughout the department more patient centred.		Elaine Torr	31/03/2019			R				
Community Inpatients - Mansfield Community Hospital											
5.36	The provider should review the restrictions in capacity in the therapies team that impact their ability to carry out audits, research and service development.		Dale Travis	31/03/2019			R				
5.37	The provider should ensure staff have the support and resources they need to continue developing audit and patient outcomes work.		Dale Travis	31/03/2019			R				