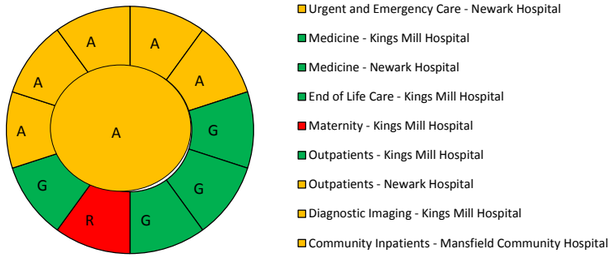
CQC Dashboard

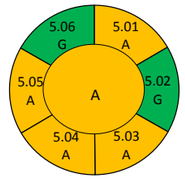
Sherwood Forest Hospitals
NHS Foundation Trust

Overall

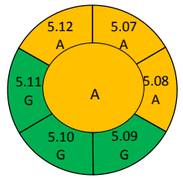


- Urgent and Emergency Care - Kings Mill Hospital
- Urgent and Emergency Care - Newark Hospital
- Medicine - Kings Mill Hospital
- Medicine - Newark Hospital
- End of Life Care - Kings Mill Hospital
- Maternity - Kings Mill Hospital
- Outpatients - Kings Mill Hospital
- Outpatients - Newark Hospital
- Diagnostic Imaging - Kings Mill Hospital
- Community Inpatients - Mansfield Community Hospital

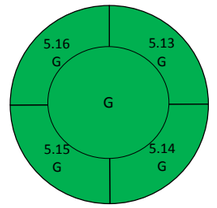
Urgent and Emergency Care - Kings Mill Hospital



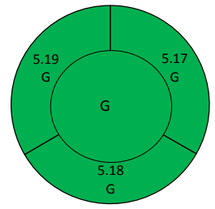
Urgent and Emergency Care - Newark Hospital



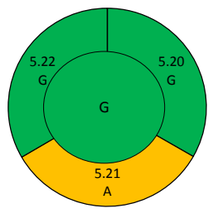
Medicine - Kings Mill Hospital



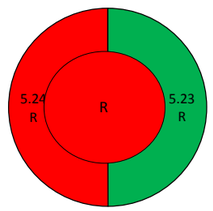
Medicine - Newark Hospital



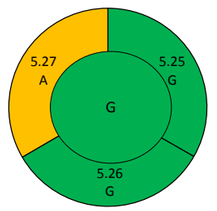
End of Life Care - Kings Mill Hospital



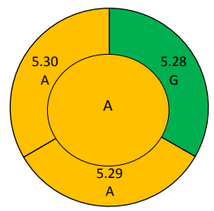
Maternity - Kings Mill Hospital



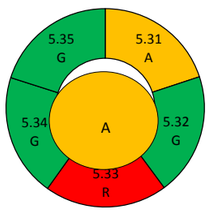
Outpatients - Kings Mill Hospital



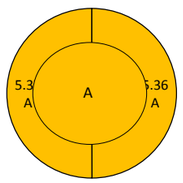
Outpatients - Newark Hospital



Diagnostic Imaging - Kings Mill Hospital

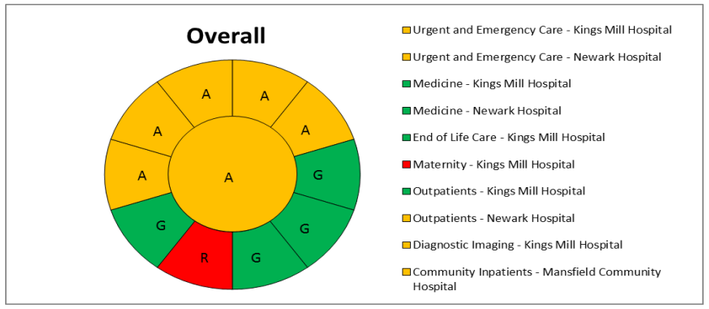


Community Inpatients - Mansfield Community Hospital



Campaign 5: CQC 'Should Do' Actions

Campaign Leads	Dr Andy Haynes Suzanne Banks Elaine Jeffers	Date:	22/11/2018
		Version	v11.18.0
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		



NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Key

R	Action Needed
A	Action Agreed
G	On Track
B	Embedded

Ref.	Objective	Measure of Success	Action	Action Owner	By When	Date completed	Progress	RAG	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	All security staff working in ED will have received training to understand the fundamentals of mental health issues, enabling them to provide appropriate support to patients and staff when required	The Trust will work with Medirest to confirm an appropriate mandatory training package on mental health awareness for new and existing staff	Ant Rosevear	31/03/2019		Meeting with Medirest - Linda Barsby, James Gillham - 14 Nov	A			
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.	All patients presenting at ED with a physical illness will be assessed for underlying or previous mental health issues	The Trust will undertake a review of ECDS mental health coding and based on findings implement an ECDS data quality improvement plan	Ant Rosevear	31/03/2019		Quarterly ECDS Data Quality Audit. ECDS DQ Improvement Plan monitored through CQUIN 4.	G	July 2018 ECDS DQ audit:	ECDS DQ Improvement Plan monitored through CQUIN 4	05/11/2018
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.	Psychiatric assessments will be provided in a safe environment meeting current guidance and enabling staff to summon assistance whenever required	The Trust will undertake a health and safety assessment of the clinical areas currently utilised for psychiatric assessments, reviewing current provision against guidance, specifically considering installation of a strip alarm, and based on findings complete improvements	Ant Rosevear	31/03/2019		Meeting with Rob Dabbs 8 Nov. RD to undertake H&S assessment and produce recommendation report with Estates costs by end of Nov	G			
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.	All consultants will be aware of the divisions identified guardian of safe working hours in order to support trainee doctors	The identity, role, responsibilities and contact details of the divisions guardain of safe working hours will be confirmed and communicated to all staff	Ant Rosevear	31/03/2019		To be confirmed at UEC triumvirate meeting, subsequent comms written and staff engaged by Dec	A			
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.	ED staff will be able to access the mental health records of patients attending ED	The Trust will work with Notts Healthcare Trust to progress development of agreed protocols and systems to enable access to mental health records for patients attending ED	Ant Rosevear	31/03/2019		Meeting with MHSOP and RRLP 7 Nov - arrange meeting with Robin Binks and Sarah Littler re work ongoing - contact Chris Packham (NHCT MD) re GP access to MH reocrds	A			
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.	ED staff will utilise the interpreting service wherever practical and appropriate, particularly in the case of suspected safeguarding issues, vulnerable persons, children and people with mental health issues	The Trust will engage ED staff with the practice of utilising the interpreting service as appropriate and ensure the process and contact information is clearly communicated	Ant Rosevear	31/03/2019		Email to Comms 6 Nov - staff communications plan on track	G			
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.	Care will be provided in a safe environment which mitigates risk for patients at risk of self harm	The Trust will undertake a health and safety assessment of clinical areas, specifically considering ligature risks, and based on findings complete improvements	Siobhan McKenna Favier	31/03/2019		Risk not raised varbally by inspectors during CQC site inspection. CQC report Aug 18 risk ambiguous and not obvious. H&S assessment completed by Rob Dabbs 13 Sep to confirm risk. No immediate risk identified. Estates contacted for costs - no response. Meeting with Rob Dabbs 8 Nov. RD to	R			
5.08	The provider should consider producing local safety standards for invasive procedures as recommended by NHS England.	Local safety standards for invasive procedures will be in place as recommended by NHSE	The Trust will confirm local safety standards for invasive procedures and ensure these are clearly communicated to UCC staff	Siobhan McKenna Favier	31/03/2019		Trust Invasive Procedure Policy including Appendix A default Invasive Procedure Safety Checklist circulated to all UCC staff by email and hard copy available in department. UEC Division decision required on continued use of Trust default safety checklist or development of additional local variation safety checklist to include in Appendix B. To be completed by Dec 18	G			
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.	There will be separate controlled drugs storage solutions for the UCC and out of hours GP services	The Trust will ensure separate CD storage solutions are in place for the UCC and OOH GP services	Siobhan McKenna Favier	31/03/2019		Completed. Separate CD storage solutions now in place for UCC and GP OOH services	G		NA	01/06/2018

Ref.	Objective	Measure of Success	Action	Action Owner	By When	Date completed	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
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.	All non-clinical staff working in the UCC will have received training to recognise and escalate urgent medical conditions	The Trust will confirm an appropriate mandatory training package on urgent medical condition recognition and escalation for new and existing non-clinical staff	Ant Rosevear	31/03/2019		Sheila Burscough PDM coordinating BLS training for ED and UCC reception staff - date TBC. UEC A&C staff induction pack including recognition of sick patients in development - will be completed Dec 18	G			
5.11	The provider should consider including questions about religious and cultural beliefs in patient documentation.	The religious and cultural beliefs of patients attending UCC will be considered and documented	The Trust will undertake a review of ECDS demongraphics coding and based on findings implement an ECDS data quality improvement plan	Ant Rosevear	31/03/2019		ECDS to be implemented at Newark UCC in Dec 18. Demographics to be included in quarterly ECDS audit and ECDS DQ Improvement Plan from Jan 19.	G		ECDS DQ Improvement Plan monitored through CQUIN 4	
5.12	The should take action to improve the response times for mental health patients requiring an assessment by specialist mental health staff.	Mental health patients attending UCC will receive a responsive assessment by specialist mental health staff within a clinically appropriate timeframe	The Trust will work with Notts Healthcare Trust to review and improve access to specialist mental health assessments for patients attending UCC	Ant Rosevear	31/03/2019		Local pathway for mental health presenters to Newark UCC in place. 24/7 telephone access to RRLP support and advice available. For face to face assessment - transfer to KMH for assessment within one hour. No commissioned service for on site face to face specialist MH assessment at Newark	G	http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=54713	ED Governance	07/11/2018
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.	All areas with lockable medical notes trolleys and standard operating procedure in place	Daily checks conducted and audited by ward manager and matron	Dale Travis	31/03/2019		All wards have lockable trollies and/or have lockable rooms for storage. Message reiterated re safe storage of notes to all ward sisters	G			
5.14	The provider should ensure staff have training in relation to FGM.	All clinical facing staff will have completed the one day Think Family training	The Trust will continue to provide the one day Think family Training that includes specific FGM Training	Dale Travis	31/03/2019		Named Midwife in post as Trust FGM Lead. Liasies with the external Safeguarding Board and provides monthly data. A FGM awareness session was held in the summer 2018 with an annual briefing re the risk of FGM presented prior to the summer holidays	G			
5.15	The provider should ensure staff have practical fire safety training sessions.	All staff complete the mandatory fire safety training	Included within Trust mandatory training portfolio	Dale Travis	31/03/2019		Included in yearly mandatory update	G			
5.16	The provider should ensure the consistent use of the 'This is Me' document.	Use of 'This is Me' document for all patients with dementia or additional needs	Full stock now available across the Trust and on all wards. An audit of compliance due early 2019	Dale Travis	31/03/2019		Available on all wards and offered as part of admission process - icare sent on 3/10/18 all users on learing and benefits of THIS IS ME. Agenda item at the Trust dementia Steering Group and importance of including the document for relevant patients reiterated on Trust Induction and within mandatory Dementia Training	G			
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.	Medical records will consistently be clear, legible and well organised	The Trust will confirm a programme of documentation audits and based on findings implement an improvement plan	Ant Rosevear	31/03/2019		Medical and nursing team documentation audits on Meridian to be tabled and monitored through the monthly the Newark Clinical Staff Engagement Meeting with an improvement plan as required	G	? Turn blue following review of next month's audits	Newark Clinical Staff Engagement Meeting	
5.18	The provider should consider improving the ward environments to make them more suitable for patients living with dementia.	The ward environment will be suitable for patients living with dementia	The Trust will undertake improvements to the ward environment making it safer and more welcoming for patients living with dementia	Ant Rosevear	31/03/2019		Ward refurbishment programme underway, phase one completed 1 Nov, phase two completion 15 Dec, phase three completion Spring 19	G		Project group, Charitable Funds Committee update reports, PLACE assessments.	
5.19	The provider should ensure all risks on the risk register are reviewed and given their next review date.	All risks on the risk register will be reviewed, actions identified, risk scores adjusted and next review dates recorded	The Trust will engage with risk owners with training and support to ensure good risk management practice is embedded	Ant rosevear	31/03/2019		General risk management training - number of courses within mandatory training suite (see Mandatory Training Policy), Risk Management and risk registers is included in H&S section of general staff induction programme and new managers training, elearning risk management module, Datic clinics, Risk profiles and relationship with BAF to SLT and Nursing, Midwifery & AHP Business meeting Nov 18, Newark Team Leaders meeting Oct 18	G		Newark Clinical Staff Engagement Meeting	
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.	New "DNARCPR" Policy. Change from AND to ReSPECT tool. Change to medical and nursing eol care documentation system.	Policy approved for implmentation 2019; Implementation Group establishment. Issue new clinical documentation	Ben Lobo Deb Elleston	31/03/2019	policy complete, other actions are in progress and on track	On track for full implmentation of new process: policy approved; change from AND to ReSPECT in progress and on track supported by Trust wide Implementation Group for 2019; Training sessions planned for 2018-19 to achieve critical competency mass pre-launch. documentation changes on track for 2019	G	policy, implementation group progress and outcomes, attendance at training sessions, presence of new documentation	Yes, being reported trhough DPG to PQSG	
5.21	The trust should ensure the mental capacity assessment paperwork reflects the requirements of the mental capacity act legislation.	Change in medical and nursing documentation to more explicitly meet this requirement. Wider culture and practice relating to MCA improves across the Trust, suported by doumentation and exisiting policy	To identify and make changes to documentation systems	Ben Lobo Deb Elleston	31/03/2019	in progress	There is a planned change to make it more explicit the requirements of the act in the systems of documentation: it is in part aleready part of the new ReSPECT tool format	A	completion of new documentation, use and compliance to quality stadards in audit	Yes, being reported trhough DPG to PQSG	
5.22	The trust should ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.	clear roles and requirements are set out in in the specific policy and reflected in practice / documentation stadards	Approved policy and these will require monitoring of this policy using audit systems with the implementation of ReSPECT	Ben Lobo Deb Elleston	31/03/2019	policy complete	the existing policy met these requirements, the new policy has been agreed that meets these standards and is orientated to support the implementation of ReSPECT	G	policy and audit data	Yes, being reported trhough DPG to PQSG	
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.	all rota gaps are covered in a timely fashion and well communicated to the junior teams	fortnightly workforce meetings in place with rota team to review rota gaps and agree/track actions	Lisa Gowan	31/03/2019			G			

Ref.	Objective	Measure of Success	Action	Action Owner	By When	Date completed	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
5.24	The provider should ensure there is a dedicated theatre list for women undergoing a planned caesarean section.	Agreed separate elective lists in place	Outline Business case to be re-presented to Trust Exec colleagues as part of business planning for 19/20	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.	Cleaning schedules in place	To ensure nurses are aware of location of cleaning schedules and undertake spot audits	Elaine Torr	31/03/2019			G			
5.26	The provider should commence temperature checks in the rooms where medicines are stored.	Temperature checks being undertaken and monitored, with appropriate action if not within stated parameters	Plans being developed to install thermometers in OP. Priority being given to ward areas	Jo Freeman and Mandy Toplis	31/03/2019			G			
5.27	The provider should have a policy to provide guidance regarding the transition of children into adult outpatient services.	Trustwide OP Policy agreed and in place	OPD Matron to meet with Paediatric matron to develop a Policy for children transitioning into adult OP servuces	Lynn Smart and Mandy Toplis	31/03/2019			A			
Outpatients - Newark Hospital											
5.28	The provider should ensure cleaning schedules are readily available in all areas to ensure consistency of standards.	Cleaning schedules will be visible ensuring consistent standards	A visible cleaning schedule and recording process will be implemented	Ant Rosevear	31/03/2019		Completed. Cleaning schedule for all OPD areas in place, visible in staff area	G		Weekly cleaning schedule monitoirng by OPD Team Lead	29/10/2018
5.29	The provider should consider reviewing the storage facilities to ensure there is sufficient storage available to meet the needs of the service.	Storage solutions will sufficiently meet the needs of the OPD service	The Trust will review the storage facilities in OPD and ensure sufficient solutions are put in place	Ant Rosevear	31/03/2019		Email to Mandy Topliss and Lynn Smart, D&O Division, 5 Nov	A			
5.30	The provider should ensure staff receive training and information on FGM.	All staff will working in OPD will have received training and information on FGM	The Trust will confirm an appropriate mandatory training package on FGM for new and existing staff	Ant Rosevear	31/03/2019		FGM is comprehensively covered in the Safeguarding Think Family training for existing staff and within the Safeguarding induction training for all new staff to the organisation. Safeguarding FGM Lead who links with safeguarding Boards. Annual FGM orgnisational brief at high risks periods	G		Trust Board Safeguarding reports	05/11/2018
Diagnostic Imaging - Kings Mill Hospital											
5.31	The provider should ensure access to patients requiring MRI scans is improved.	Target for DMO1 is 1% across all modalities (tolerance of patients not being booked within DMO1 target)-for MRI this will be 13-14 patients depending on demand. Target for cancer 14 days-90% and 80% for 7days. Businerssss case for static scanner to be completed and sent to IGG	To fully utilise the mobile MRI van with contrast injector. To increase capacity for MRI on both mobile and static van. To utilise the Park Hospital. Utilise imaging assistants to cannulate to free up more capacity.	Elaine Torr	31/03/2019			A			
5.32	The provider should ensure the risk register consistently reflect risks that were managed through local and divisional governance processes.	Radiology will have an up-to-date risk register which is reviewed regularly in line with Trust guidelines.	Once risks have been identified and discussed with both governance and the wider Radiology team these will be recorded on the register immediately.	Elaine Torr	31/03/2019			G			
5.33	The provider should ensure that patients from wards are brought to the radiology department with their notes.	Case note for in-patients are brought down with in-patients or there is access to nerve centre.	KMH-To ascertainfrom local Trusts whether case notes are brough down for all in-patients. Chief AHP to discuss with Nusring/AHP Board meeting the implications of bringing notes down. To look at the possibility of using Nerve Centre to identify patients on AND. NWK/MCH- As this is a smaller number of patients this is easier to implement. For plain film at NWK, this is already in place.	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.	All documents will be in date and reviewed	Radiology have a well-managed system for identifying documents which are approaching out of date. Authors are notified and a register of all documents is maintained regularly	Elaine Torr	31/03/2019			G			
5.35	The provider should consider how to make the waiting areas throughout the department more patient centred.	Patient's views will be ascertained on what they would like the waiting rooms to look like. Changes will be made to address ideas/requirements to ensure the waiting areas are suitable.	To order more high back chairs. Pictures have already been put up by Skanska that had a budget approval and general manager approval prior to the CQC visit for installing the pictures on waiting room walls. To ascertain the views of patients about how they would like the waiting rooms to be more patient focussed.	Elaine Torr	31/03/2019			G			
Community Inpatients - Mansfield Community Hospital											

Ref.	Objective	Measure of Success	Action	Action Owner	By When	Date completed	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
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.	Appropriate capacity available for therapists to participate in audit and research work, including Mansfield Community Hospital	Working with D&0 (Therapist sit in D&0) to understand concerns and the role of our Audit department, time management and tool box trainging to support audit procesess	Dale Travis	31/03/2019			**A**			
5.37	The provider should ensure staff have the support and resources they need to continue developing audit and patient outcomes work.	Appropriate capacity available for therapists to participate in audit and research work, including Mansfield Community Hospital	On going discussions with teams understand concerns and publisise the role of our Audit department who can offer support, time management and tool box training to support audit procesesses. Introduction of new roles to include Audit and research element to role.	Dale Travis	31/03/2019			**A**			