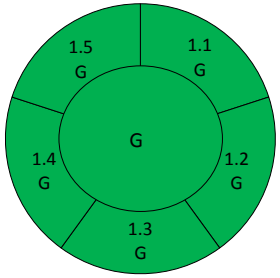
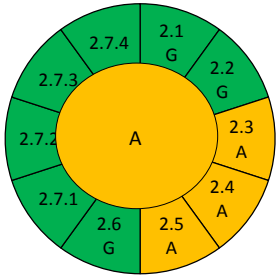
Quality Stategy Dashboard

Sherwood Forest Hospitals
NHS Foundation Trust

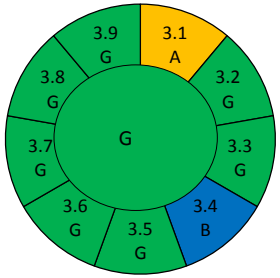
Campaign 1: A Positive Patient Experience



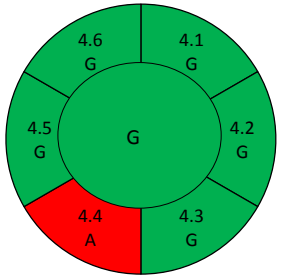
Campaign 2: Care is Safer



Campaign 3: Care is Clinically Effective



Campaign 4: We Stand Out

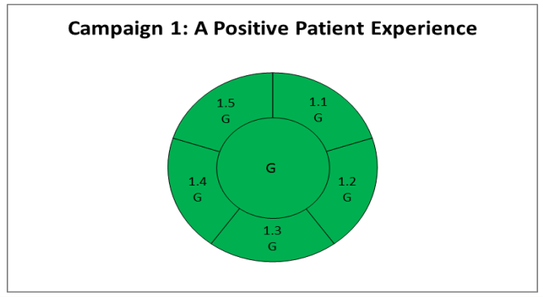


Campaign 1: A Positive Patient Experience

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:	22/11/2018
		Version	v11.18.0
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'		

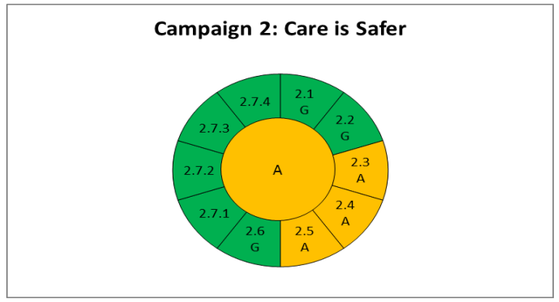


Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Embedded
1.1	**Focus on explaining care in an understandable way**	Maintain at least 90% or more patient's satisfied their care was explained in an understandable way	Kim Kirk	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%	Kim Kirk is working towards a way to pull all sources of patient expereince data together with an overarching action plan for pateint experience. 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. For 2018/19 the plan is to achieve 90% satisfaction score aggregated from all patient experience feedback. A more focussed approach will be evident for 2019/20 when outcomes from all surveys are received.	**G**	*Inpatient Survey *National Cancer Patient Experience Survey and action plan *National Maternity survey and action plan *National ED Survey and action plan *National Outpatient Survey and Action Plan *Local Cancer Patient Survey *Cancer Patient and Carer Group *Cancer Information and Support POD *Cancer Recovery Package Project		
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.	As above	**G**	As above		
1.3	**Educate and train staff to adopt the principle of co-design in care planning**	Number of staff trained, by Division 5% increase in staff reporting that they are involved in improvements from current baseline in NHS Staff Survey	Ceri Feltbower	30 March 2019	Staff capacity to support training, with other QI and Safety commitments	Number of staff trained, by Division – OD will have this data from Moodle – monthly reporting from October onwards – monthly to AQPOG 5% increase in staff reporting that they are involved in improvements from current baseline in NHS Staff Survey – annual reporting to AQPOG	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	

Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Embedded
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	Patient and Public representative attended the October PSQG meeting. Training Programme to be developed to support the post Further consideration to be given as to how to include hard to reach communities. To link with the work currently underway with the homeless community.	**G**	Minutes of the PSQG meeting PSQG Report to Quality Committee		
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	3 members of the Trust attended the launch of Cohort 10 of the National 'Always Event' Programme. The Trust is using the '#Hellomynameis' campaign as the 'Always Event'. This is alos linked to positive patient identification Pilot currently underway in the Intensive Critical Care Unit to determine 'what is important to me' from the patient, carer and staff perspective. Workshop being held in early Nocvember to discuss outcome of initial questionnaire and agree necessary actions The Trust is participating in the regulr teleconference with NHS England re event progress.	**G**	Output of initial questionnaire #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	Working with Cancer Services to understand how patient diaries are used there with a view to piloting in other areas.	**G**			

Campaign 2: Care is Safer

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



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

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%	100% compliance refelcts the theatres recorded on bluespier and is not necessarily indicative of all theatres. Plan to work towards having all theatres recorded on bluespier to give a better overall picture of performance.	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	Stop moments still to be defined. Weekly Planning and Development Group in place for Surgery which is attended by a senior member of the Theatres team.	A	Datix reports		
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	Current perfomance sits above the target of 3.2% with no mitigating plans in place.	A	Maternity Dashboard	Divisional Performance meetings Patient Safety and Quality Group	

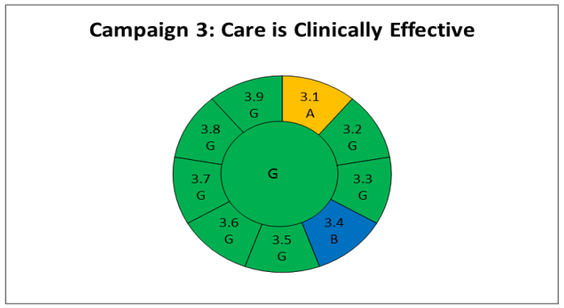
Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
2.6	**Delivering harm-free care**	≥95%	Yvonne Simpson	31 March 2019			Harm Free Care continues to be monitored and remains above 95% for July 2018. The Perfect 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)	
		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	

Campaign 3: Care is Clinically Effective

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

Sherwood Forest Hospitals NHS Foundation Trust

Campaign Leads	Andy Haynes Suzanne Banks Simon Barton	Date:	22/11/2018
		Version	v11.18.0
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		



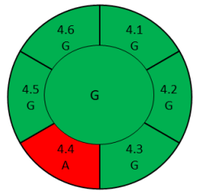
Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
3.1	**Reducing overall length of stay**	Top 25% of trusts for lowest length of stay To achieve top 25% based on Sept 2017 - Feb 2018 data our length of stay needs 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	A meeting has been arrangef or November to agree the Plans for the Fraily Unit between Mediceine and Urgent and Emergency Care. Long stay Wednesday's are up and running, reviewing the patients with a length of stay over 21 days and challenging the reasons for not discharging these patients and working with external partners to solve any problems with transfers to other care settings.	**A**	Patient Flow Improvement Plan - Length of Stay AQP National LoS Comparison Data Model Hospital NHSI Long Stays Dashboard SOF	Patient Flow Group FIP Working Group	
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	**G**	LD Datix data	Safeguarding Group Patient Safety and Quality Group	
		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)		**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%.	EoL/Fast Track flow has been developed by the task and finish group. Once approved this will be circulated to clinical staff. The new national EoL process has been inplemented from Ocotber 2018.	**G**	Mortality Annual Summary report Mortality Data - Dr Foster HSMR EOL Quarterly Highlight Report to PSQG End of Life Annual Report to Quality Committee	End of Life Group Patient Safety and Quality Group Quality committee Board of Directors	
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 Steering Group Deteriorating Patient Group Quality Committee Board of Directors	19/09/2018
		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. Dr Foster reports for the Mortality Surveillance group being re-defined. New Action for Mortality ot be worked up.	**B**		Mortaity Sterring Group Deteriorating Patient Group Quality Committee Board of Directors	19/09/2018

Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
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 presented to the Quality Committee in September 2018.	G	Inpatient Survey Discharge Lounge FFT Section 42 incidents Serious Incidents reported to Steiss involving discharge		
		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.		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)	G	Clinical Audit & Effectiveness Minutes Tracker Quarterly Report to PSQG	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. September 2018 audit Complete	G	14 hour review data	Board of Directors	
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%	Internal Audit have been asked to look at a number of older CAS alerts to ensure we have good assurances from historical alerts. PSQG to approve which alerts will be audited in Ocotber.	G		Patient Safety and Quality Group	

Campaign 4: We Stand Out

Campaign Leads	Julie Bacon Peter Wozencroft Andy Haynes Simon Barton	Date:	22/11/2018
		Version	v11.18.0
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		

Campaign 4: We Stand Out



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

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
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: Q2 18/19 - 77% (1180 responses) 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%	Q2 Staff FFT results published. Q3 national staff survey currently live. An increase in responses has been seen each quarter since Q4 with a steady result of 77%.	**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: Q2 18/19 - 88% (1180 responses) 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%	Q2 Staff FFT results published. Q3 national staff survey currently live. An increase in responses has been seen each quarter since Q4 with a steady result of 88%.	**G**	Staff Survey		
4.2	**Open and learning culture**	Top 25% of Trusts for levels of incident and near miss reporting	Yvonne Simpson Becky Stone	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 has now commenced in post. NRLS do not benchmark incident reporting as top 25 percentile. Evidence sourced from the CQC Insight Tool (October 2018) measuring against the England average	**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.	**G**			

Ref.	Key Outcome	Measure of Success 18-19	Action Owner	By When	Risk	Current performance	Progress	RAG	Evidence	Ongoing Monitoring	Date embedded
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.	A Pharmacy dashboard has been developed to report to PSQG. However, data on high risk medication errors is not yet collected and will be difficult to collect until E-prescribing is implemented. E-prescribing is not anticipated to be in place for 12 months.	**R**	Dashboard under development	PSQG	
4.5	**Create an integrated system-wide patient pathway for long term conditions such as:**										
4.5.1	**Heart Failure**	Pathways for Heart Failture are 'process mapped' to isolate potential crisis points and act on the analysis	Mel Bulgin	30 March 2019				**G**			
4.5.2	**Diabetes**	Establish baseline admission rates for Diabetes	Devaka Fernandez/ Paul Haridng	31 March 2019			Meeting with Dr Devaka Fernando 07/08/18 Elaine Jeffers working with Paul Harding and Dr Fernando on the diabetes data.	**G**			
		Pathways for Diabetes are 'process mapped' to isolate potential crisis points and act on the analysis	Devaka Fernandez/ Paul Haridng	31 March 2019				**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.	**G**			

	Campaign 1	Campaign 2	Campaign 3	Campaign 4	Campaign 5
1	1.1	2.1	3.1	4.1	5.01
1	1.2	2.2	3.2	4.2	5.02
1	1.3	2.3	3.3	4.3	5.03
1	1.4	2.4	3.4	4.4	5.04
1	1.5	2.5	3.5	4.5	5.05
1		2.6	3.6	4.6	5.06
1		2.71	3.7		5.07
1		2.72	3.8		5.08
1		2.73	3.9		5.09
1		2.74			5.1
					5.11
					5.12
					5.13
					5.14
					5.15
					5.16
					5.17
					5.18
					5.19
					5.2
					5.21
					5.22
					5.23
					5.24
					5.25
					5.26
					5.27
					5.28
					5.29
					5.3
					5.31
					5.32
					5.33
					5.34
					5.35
					5.36
					5.37

Key

R	Action Needed
A	Action Agreed
G	On Track
B	Embedded

Key

R	Action Needed
A	Action Agreed
G	On Track
B	Embedded