Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors

Subject:	Advancing Quality Programme	**Date:** 06/06/19	
Prepared By:	Elaine Jeffers, Deputy Director of Governance & Quality Committee		
Approved By:	Dr Andy Haynes, Medical Director, Suzanne Banks, Chief Nurse		
Presented By:	Elaine Jeffers, Deputy Director of Governance & Quality Committee		
Purpose			
To provide an update on the Advancing Quality Programme to the Board of Directors		**Approval**	**x**
		Assurance	**x**
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x			**x**	**x**

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**

Risks/Issues	
Financial	There may be some financial cost associated with the delivery of programme actions – will be identified and seek approval as required
Patient Impact	Delivery of the programme will have a positive impact on the safety and quality of care delivered to patients
Staff Impact	Delivery of the programme will have a positive impact on the experience of staff to deliver high quality, safe care to patients
Services	Delivery of the programme may impact on service delivery and may necessitate service re-design and reconfiguration
Reputational	Delivery of the programme will significantly improve the internal and external reputation of the Trust

Committees/groups where this item has been presented before

None

Executive Summary

The purpose of this report is to provide the Board of Directors with an update on progress against the Quality Strategy, Campaigns one to five inclusive. The report highlights the position as at 31 March 2019 following approval of 5 actions at the May Quality Committee. Section three indicates the starting position for the 2019/20 programmes with section four providing an overview of Campaign Five – 'CQC Should Do' Action Plan.

Each action within the four campaigns has been reviewed with the Medical Director and Chief Nurse through the Advancing Quality Programme Oversight Group to acknowledge progress to date and agree further actions where required. The full Quality Strategy (QIP Document) (Campaigns 1-5) for 2019/20 is available within the Reading Room.

Board are asked to:

- Note the content of the Report
- Note the progress through 2018/19
- Note the starting position for the 2019/20 Advancing Quality programme

1. Update on progress (AQP)

1.1 Table One records the performance position against the five campaigns of the Advancing Quality Programme at the end of 2018/19. This takes account of the actions approved as embedded at the May Quality Committee.

Position at end of 2018/19

Campaign	Red	Amber	Green	Blue
	Action Needed	Action Agreed	On Track	Embedded
Campaign 1 - A Positive Patient Experience	0	4	2	0
Campaign 2 - Care is Safer	0	2	2	8
Campaign 3 - Care is Clinically Effective	0	4	4	5
Campaign 4 - We Stand Out	0	1	8	0
Campaign 5 - CQC Should Do Actions	0	6	10	21
Totals	**0**	**19**	**26**	**34**

Table One

1.2 The Advancing Quality Programme Oversight Board meets each month with evidence presented from action owners where further assurance of progress had been requested.

1.3 The meeting provides action owners with the opportunity to present robust evidence of achievement and sustainability.

1.4 There are zero outstanding red actions as of 31 March 2019.

2. Advancing Quality Programme 2019/20

2.1 As outlined in the 2018/21 Quality Strategy improvement trajectories for the majority of actions are to be achieved over a three-year period. The 2019/20 Advancing Quality Programme has taken this into account and as such table two provides the position of the programme at the start of 2019/20.

Position at start of 2019/20 (with new measures)

Campaign	Red	Amber	Green	Blue
	Action Needed	Action Agreed	On Track	Embedded
Campaign 1 - A Positive Patient Experience	4	2	0	0
Campaign 2 - Care is Safer	2	3	6	0
Campaign 3 - Care is Clinically Effective	4	4	4	0
Campaign 4 - We Stand Out	1	7	0	0
Campaign 5 - CQC Should Do Actions	0	5	14	0
Totals	**11**	**21**	**24**	**0**

Table Two

2.2 The current BRAG ratings within each of the Quality Strategy Campaigns have been re-based to reflect the improvement trajectory for year two and the change in success measure. It is expected these will progress and the BRAG rating for some will have been improved by the July Quality Committee.

2.3 This is an expected position but it is likely evidence of achievement will be less challenging through year two.

2.4 Additional actions and measures of success are currently being agreed for a number of actions where additional improvements have been identified.

2.5 CQC Action BRAG ratings have not been altered as the measures of success have not changed. Table three presents the 2018/19 achievement of CQC Actions with table four representing the position of the outstanding actions.

Actions removed as completed in 2018/19

18/19 Ref.	Objective
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.
5.07	The provider should reduce the ligature risk of the two call bells in the UCC by replacing them with a suitable alternative.
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.
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.
5.14	The provider should ensure staff have training in relation to FGM.
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.
5.19	The provider should ensure all risks on the risk register are reviewed and given their next review date.
5.23	The provider should ensure gaps in the junior doctors' rota are appropriately covered to provide a sustainable junior doctors' service to women.
5.24	The provider should ensure there is a dedicated theatre list for women undergoing a planned caesarean section.
5.29	The provider should consider reviewing the storage facilities to ensure there is sufficient storage available to meet the needs of the service.
5.30	The provider should ensure staffs receive training and information on FGM.
5.31	The provider should ensure access to patients requiring MRI scans is improved.
5.32	The provider should ensure the risk register consistently reflect risks that were managed through local and divisional governance processes.
5.34	The provider should ensure that document control is reviewed, and updated documents should be readily available to staff.
5.35	The provider should consider how to make the waiting areas throughout the department more patient centred.
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.
5.37	The provider should ensure staff have the support and resources they need to continue developing audit and patient outcomes work.

Table Three

Actions remaining, due to be completed in 2019/20

18/19 Ref.	19/20 Ref.	Objective	RAG
5.01	1920.5.01	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	**G**
5.02*	1920.5.02	The provider should ensure staff assess patients for any underlying or previous mental health issues when presenting at the department for a physical illness.	**G**
5.03	1920.5.03	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.	**A**
5.05	1920.5.04	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.	**Grey**
5.06*	1920.5.05	The provider should ensure staff do not use family members of patients instead of the telephone interpreting service. This is not considered good practice.	**G**
5.08	1920.5.06	The provider should consider producing local safety standards for invasive procedures as recommended by NHS England.	**G**
5.10	1920.5.07	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.	**G**
5.11	1920.5.08	The provider should consider including questions about religious and cultural beliefs in patient documentation.	**G**
5.12	1920.5.09	The provider should take action to improve the response times for mental health patients requiring an assessment by specialist mental health staff.	**G**
5.15*	1920.5.10	The provider should ensure staff have practical fire safety training sessions.	**G**
5.16	1920.5.11	The provider should ensure the consistent use of the 'This is Me' document.	**G**
5.18	1920.5.12	The provider should consider improving the ward environments to make them more suitable for patients living with dementia.	**G**
5.20	1920.5.13	The provider 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.	**A**
5.21	1920.5.14	The provider should ensure the mental capacity assessment paperwork reflects the requirements of the mental capacity act legislation.	**A**
5.22	1920.5.15	The provider should ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.	**G**
5.25	1920.5.16	The provider should ensure cleaning schedules are readily available in all areas to ensure consistency of standards.	**G**
5.26	1920.5.17	The provider should commence temperature checks in the rooms where medicines are stored.	**A**
5.27	1920.5.18	The provider should have a policy to provide guidance regarding the transition of children into adult outpatient services.	**A**
5.28	1920.5.19	The provider should ensure cleaning schedules are readily available in all areas to ensure consistency of standards.	**G**
5.33	1920.5.20	The provider should ensure that patients from wards are brought to the radiology department with their notes.	**G**

* Action was agreed Blue at quality Committee on 15 May 2019

Table Four.

2.6 It should be noted that for all green actions the evidence being gathered is to demonstrate sustainability of achievement over a period of time prior to approval as embedded by Quality Committee rather than actions still requiring completion.

2.7 The amber actions are expected to move to green and in some cases directly to a ‘blue form’ (embedded) by the July Quality Committee.