Sherwood Forest Hospitals NHS
NHS Foundation Trust

Plan Name	Improvement Plan
Executive Sponsor	Susan Bowler
Date	20/02/2015 08:35
Version	v10.0
Trust Board	Feb-15

Key:

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

Overall Timescales at Risk
- Action fully implemented
- No progress made or progress is not expected to be made due to barriers
- Progress being made towards completion of the action or overdue on completion date
- Action on track to complete in line with the completion date
- Action not due to commence
- Action / BRAG to be determined

Reference	Improvement source	Theme	Trustwide / Service Line	Ref	Milestone Description	Executive/Divisional Lead	Owner	Start date	Completion date	Outcome	Progress	Evidence	Rating
DOMAIN – WELL LED													
Well Led	Hospital Inspection & Keogh	Leadership	Trust wide	1	Recruitment and retention of a credible and competent Board of Directors equipped with the skills to deliver the strategic priorities of the Trust	Chairman & Chief Executive	Chairman & Chief Executive	01/09/2014	31/03/2015	A credible and competent board in place with the necessary skills to competently deliver the strategic priorities as outlined within the Strategic Plan	Board Review and Development Programme commissioned September 2014. Individual and team coaching commissioned for all Executive Team members September 2014. Appropriately experienced and competent interim Chief Financial Officer – post offered December 2014		A
		Board of Directors	Trust Wide	1.1	Commission and implement a Board of Directors Review and Development Programme	Chairman	Chairman	01/09//14	31/03/2015	Board assessment completed, capacity and capability gaps identified and action plans put in place to address.	Foresight Partners commissioned to undertake Well Lead Board Health Review and detailed Board Review and development programme. Observations and self-assessments have commenced. **26.01.15 update:** Review completed. **February 2015 update** - RAG rating reassessed - COMPLETED	Foresight proposal and evidence of board agreement.	C
		Board Development	Trust wide	1.2	Ensure effective personal development process is in place for all board members.	Chairman & Chief Executive	Chairman & Chief Executive	01/04/2014	31/03/2015	All board members have received an appraisal and personal development review and are clear of their priorities and development needs.	Chair and NED appraisal process agreed and implemented. Chief Executive and ED appraisal process agreed and implementation is on going. **27.01.15 update:** Chair and NED appraisals completed. Chair's objectives agreed at Council of Governors. CEO drafted objectives but not yet agreed.	Completed appraisal documentation. Reports to COF and Remuneration and Nominations Committee	G
		Executive Team	Trust wide	1.3	Commission and implement individual and team coaching for Executive Team Members.	Chief Executive	Chief Executive	19/09/2014	31/03/2015	Executive team recognises their individual strengths and weaknesses, plans are implemented to close identified gaps. Team demonstrates effective team working.	The OCM Commissioned to undertake both team and individual coaching. **January 2015** Individual coaching commenced. Team coaching session scheduled in December 2014 and 2 February 2015, this will include personality type indicators. **February 2015 update:** Two team coaching session uhndertaken, future dates planned, individual coaching ongoing.	Proposal from OCM and evidence of agreement.	G
		Executive Team	Trust wide	1.4.1	Appointment of a substantive Chief Financial Officer –	Chief Executive	Chief Executive	Jun-14	31/03/2015	Appropriately skilled and competent substantive CFO appointed	Substantive recruitment to the post remains a challenge. Re-assessment of process to be undertaken end October 2014, chief Executive and Executive Director of Human Resources. Appropriately skilled and competent interim CFO appointed – to remain in post until 30/04/15. One round of interviews for substantive appointment unsuccessful. Second round scheduled for 08/12/14. **09.12.14 Update** Preferred candidate identified following interview, intention to offer the post substantively by 12.12.14. **January 2015:** Post offered and accepted, awaiting start date - confirmed date 23.03.15 **02.02.15 -** Newly appointed CFO participated in the team coaching exercise.	Email between Executive Director of HR and appointed CFO	G
				1.4.2	Appointment of a substantive Chief Operating Officer:	Chief Executive	Chief Executive	Dec-14	31/03.2015	Appropriately skilled and competent substantive COO appointed	**05.02.15 update:**Interim Director of Operations has participated in the team developing sessions. Chief Operating Officer job description has been written in draft and to be agreed.	Job description Offer Letter	A

		Governors	Trust wide	1.5	Ensure current and the new public governors elected in October are inducted into the Trust through a robust induction process and by attending planned Governor training events. Clarifying the role and duties of governors and how this differs from the role of Non-Executive Directors	Director of Corporate Services	Deputy Director Corporate Services	01/03/2014	30/11/2014	A strong Council of Governors which represents the membership understands the Trust's business and has the knowledge and expertise to hold the Board of Directors to account. Robust and professional interaction between board members and Governors building strong relationships.	Governor elections underway – 4 vacant posts results of election 24th October. Governor Induction programme for new governors to commence 27th October. Governor training programme implemented 2 remaining sessions for 2014. 5th October – Estates and Facilities - to enhance the governors understanding of PFI, soft FM e.g. the role of Medirest across all hospital sites 5th November – Media/Comms & Volunteers/Fund raising – to ensure governors are aware of the role of the Comms team and how governors should respond to media enquiries an external speaker from the local press will also present. The lead for Volunteers and fund raising will Inform the Governors of the work of the volunteers, how these support the hospital and contribute to the fund raising activities. **November** Four new public governors successfully elected. Governors have received full induction programme and have met the chair and director of Corporate Services for briefing. The Governor development programme has been developed for 2015 with input from the lead Governor. This milestone has moved from Amber to Blue.	Governor elections, milestone plan, profiles for new governors. Governor Development Training programmes Part 1 & 2 Register of Governors attended	C
		Governors	Trust wide	1.6	Strengthen links between Quality Committee and Patient Safety and Experience Governor Committee. Through improved quality reporting, which highlights 'governor relevant' information, triangulates quality information and highlighting progress against regulatory requirements	Executive Director of Nursing	Head of Governance Support Unit	01/03/2014	29/09/2014	Fully informed governor committee which is able to provide robust scrutinised reports enabling the Council of Governors to hold the Trust Board to Account to Council of Governors	Chair of Governor Patient Safety and Experience committee is observer at Quality Committee	Quality Committee papers with evidence of chair. Agenda of Quality Committee.	C
		Newark	Newark	1.7	Establish, develop and implement plans to increase utilisation of current capacity and increase service offer to Newark and Sherwood patients place this second to last in this section	Director for Newark Hospital	Assistant of Director of Operations	01/07/2014	30/03/2015	Ensure all services at Newark are efficient and appropriately utilised to create a vibrant and thriving local hospital.	A Transformation Programme is in place and a programme of work is in place for delivery over the next 6 months. To support this, a communication strategy has been developed including a series of planned staff forums, along with presentations to other stakeholders on the plans for Newark. A listening event led by the Chief Executive is to be held in November 2014. Recent appointment of Jacqueline Totterdill as Director of Newark	Theatre schedules Activity Plans and outturn. Planned staff forum. Communication plan Presentations.	A
		IT	Trust wide	1.8	IT Hardware and functions fit for sustainable purpose	Executive Medical Director	Trust IT Lead	01/03/2014	On going	Systems accommodate and responsive to clinical requests / need	PC replacement programme over 3yrs to maintain all hardware below 7yrs with adequate memory Wi-Fi upgrade completed. Systems performance monitoring, along with an ICE results reporting review has produced greater IT system stability. Phased upgrade for these clinical systems in Q.4-14/15 FY. Urgent results protocol agreed with laboratories Phase 2 Medway PAS implementation focused on nursing and medical documentation. Bid to technology fund for E Prescribing; interview in September 2014. Awaiting outcome but if successful planned implementation in Mar 2015 **26.01.15 update:** E-prescibing waits treasury outcome. David Linacre met with Steve Foley to have guidelines for Medway PAS. David Linacre attended the Medical Managers (13.01.,15) to discuss PAS phase 2; PC rollout; Floor walking technicians; and NHIS meeting the Trust's requirements. **02.02.15 update:** desktop PC replacement project is slightly off target, with completion now expected in April. It is proposed to concentrate the available budget on updating and replacing laptops to complete the Windows 7 upgrade programme. Work has been undertaken to stabilise the ORION system, further work to upgrade the servers to improve performance and realience will be completed by the end of March.	Floor walking technicians in clinical areas to deal with live issues. Activity logged. Regular Wi-Fi system testing Monitored via reporting at BI and IT ctte. Protocol ratified via Division. Monitored via ICR Board. Monitored via BI and IT ctte.	A

											The Head of IT has attended a number of services meetings and several JDF meetings to receive feedback on issues and opportunities relating to IT at the Trust, and to answer questions/ provide a general update on plans and progress. Further meetings are being scheduled - and this increased engagement between IT and divisional teams will be a regular theme. Planning for phase 2 of the Medway PAS implementation of off-target due to work necessary to stabilise the core system implementation. It is expected that work on phase 2 will be largely a 2015/16 project, with the main focus being on improving and further developing the integration of PAS with other systems internally and externally and the implementation of portal technology, to safely and appropriately share electronic patient records more effectively between SFH, GP's and other organisations. Floor walking technicians are visiting clinical areas to deal with live issues. Regular Wi-Fi systems testing is programmed in, assisted by new infrastructure management and proactive issue reporting tools. Planning is underway for the Head of IT and NHIS technical representative to shadow ward rounds and gather information about IT opportunities and technology enhancement requirements.		
Well led	Hospital Inspection & Keogh	Values led Culture	Trust wide	2	Our culture is focused on delivering 'Quality for All' and staff feel valued and empowered to do an excellent job and proud to work for our trust.	Executive Director of Human Resources	Executive Director of Human Resources	01/07/2014	On going	Improved staff experience and improved patient experience and care.	Listening events have led to the development of our Quality for All Values and behaviours. Staff briefings for more than 1,200 staff completed. Workshop – Leading for Values completed. Team conversation exercise completed. Ongoing progress in @quality for All' by development.		G
		Values Led Culture	Trust wide	2.1	Procure and implement arrangements for Staff Family and Friends test and quarterly pulse surveys to enable the monitoring of improvements in staff engagement	Executive Director of Human Resources	Deputy Director of Human Resources	01/04/2014	30/11/2014 **Revised** 31./03/2015	A baseline of staff engagement completed which will inform actions going forward.	Procurement exercise initiated. **November** - Procurement exercise reinitiated as OJU limits exceeded in first round of tendering. Internal mechanisms being utilised to undertake surveys in house in the short term. **Update 16.12.14** System in place for final quarter robust procurement plan in place for next year. **7 January 2015:** Internal processes in place for staff Friends & Family Test Q4 **February 2015 update:** The Patient Experience Manager continues to pursue options for monitoring the FFT.	Staff FFT Survey outcomes.	A
		Values Led Culture	Trust wide	2.2	Revise HR processes to support values based recruitment, selection and retention	Executive Director of Human Resources	Deputy Director of Human Resources	01/01/2014	24/11/14 **Revised** 31/12/14 **Revised:** 31.01.15	Improved recruitment processes focusing on selecting individuals who demonstrate trust values as well as pre-requisite skills and experience.	Work completed with NHS Employers in order to review assessment material and training necessary for recruiting managers. **November** Recruitment and selection training programme updated to reflect Quality for All values and behaviours. Recruitment paperwork currently been updated will completed by December 2014. **Update 16.12.14** As in November paper work to be completed by end of December. **7 January 2015:** Revised RDS paperwork completed. Rollout in place. **15.01.15 -** RAG rating reassessed as GREEN on track	Work from NHS Employers. Recruitment & Selection agenda. New Recruitment documentation	G
		Values Led Culture	Trust wide	2.3	Positive performance management campaign driving improved performance and referring to quality for all values and behaviours	Executive Director of Human Resources	Executive Director of Human Resources	01/07/2014	30.10.14 **Revised** 31/12/14 **Revised:** 31.01.15	To ensure the Trust is living its values and behaviour is consistent	Capability Policy currently under review. Training and toolkit for implementation being developed. **November** Capability policy agreed by OD and Workforce Committee on 4.11.14, toolkit for managers in development. **Update 16.12.14** Tool kit to be agreed with staff side by 31/12/14 and published on intranet. **7 January 2015:** Policy and toolkit agreed. Rollout to be completed by 31 January 2015.	Agreed Capability Policy published dates for Training Programmes published. Workforce & OD Committee papers Toolkit.	G

		Values Led Culture	Trust wide	2.4	Quality for All Team based conversations take place across the Trust.	Executive Director of Human Resources	Executive Director of Human Resources	01/08/2014	31/11/14 Revised 31.12.14	To ensure that the values and behaviours are being embedded into Trust culture	Team cascade briefings have taken place. Team conversation documentation developed and available. Evidence of team conversations taking place. **November** Action Plans are being received evidencing team conversations are taking place. Enhanced communication campaign has been established with refreshed intranet site. **Update 16.12.14** Team Values conversations have taken place with many teams across the Trust. To date 67 team actions have been received – these will be shared across the Trust and further team actions will be secured by the end of December. **7 January 2015:** Team conversation exercise completed. To be shared across the Trust. **26.01.15 update:** Action completed. Further action plan being developed and monitored through the OD & Workforce Committee, to ensure 'Quality for All' is embedded into all we do.	Team action and defined outcomes. Team cascade evidence Evidence within the Trust on Team Values conversations.	C
		Values Led Culture	Trust wide	2.5	Explore the possibility of a buddy relationship with a 'Listening into Action' Trust to undertake an assessment and gap analysis of 'Quality for All' against Listening into Action outcomes	Executive Director of Human Resources	Executive Director of Human Resources	Jul-14	16/10/2014	Executive Team fully understands and has considered the benefits that Listening into Action can bring and have assessed this again the Quality for All approach.	Extensive conversations with Listening into Action lead at UHL. Benefits assessment currently being undertaken. **November** Assessment against Quality for All undertaken, the outcome of which was that Quality for All encompasses the majority of benefits of Listening into Action and that developing staff focus groups will ensure Quality for All that the scheme brings equitable benefits. **Update 15.12.14** Change RAG rating to **COMPLETED**	ETM action notes 15.09.14 Item 19	C
		Values Led Culture	Trust wide	2.6	Work with the National Advisory Group for Cultural Alignment to gain expert guidance and support in assessing and supporting our journey of cultural shift	Executive Director of Nursing	Executive Director of Nursing, Executive Director of Human Resources	30/06/2014	01//06/15	The Trust influences national learning and sharing on cultural shift, whilst utilising expert knowledge and tools to assess our own journey	The Trust was successful in its application to work with key organisations and individuals (National Advisory Group for Cultural Alignment, Kent & Medway NHS and Social Care Partnership and the Christie NHS Foundation Trust) to assess its cultural shift. **February 2015 update:** Decision has been made to undertake a cultural assessment as part of the Kings Fund. This is being tested in other organisations, and will be applied in Q1 2015/16.	National Advisory Group for Cultural Alignment Report. Application form.	G
		Values Led Culture	Trust wide	2.7	Undertake an assessment of our current organisational culture to explore how the findings can be reflected within our programmes for change (e.g. Quality for All, Transformation)	Executive Director of Human Resources/ Executive Director of Nursing	Executive Director of Nursing	01/10/2014	31/01/2015 **Revised:** 30.06.15	A Trust wide cultural assessment is undertaken in which to develop individual responses	The Trust is working with the National Advisory Group for Cultural Alignment to identify a tool to undertake a trust wide cultural assessment, which triangulates with other information the Trust has acquired over the last 3 months like 'In Our Shoes', Medical Engagement Survey and Staff F&F's. Currently in conversation with a number of universities and companies who assist with cultural assessment. Also exploring QUASER work with Foresight and the possibility of being a pilot site in Naomi Fulop's research to look at the readiness for quality improvement and the impact of interventions . **Update 15.1.15** - The Trust has agreed to utilise the King's Fund Cultural Assessment Tool **26.01.15 update:** This tool will be available in Q1 2015/16		G
Well Led	Hospital Inspection	Leadership	Trust wide	3	Implement our leadership strategy with appropriate focus at divisional and service lines to support our leaders to deliver the strategic objectives	Executive Director of Human Resources	Executive Director of Human Resources	Jun-14	31/03/2015	Divisional and service line structures in place with clarity of roles and responsibilities. Leaders with the capability to deliver the strategic priorities.	Leadership Strategy currently being developed (final draft by 31 January 2015). Workshop completed and action plan developed to improve organizational effectiveness. Leadership development programmes evaluated and recommissioned.		G

		Leadership	Trust wide	3.1	Medical Engagement Programme Developed and Implemented.	Executive Medical Director	Executive Medical Director	Jun-14	On going	Medical staff effectively involved in Trust activities and live by Trust Quality for All values	MES survey completed In Your Shores event held Engagement Event completed with Juniors and Consultants Programme designed with external consultants. **Updates 09.12.14** Rolling programme for MD to attend team meetings. MD to attend divisional meetings. Programme of weekly informal suppers with Consultants commenced in November. Medical Engagement Group formed with NED's, MD and consultants to explore mentoring and buddying. All newly appointed consultants meet MD at 12 weeks. Informal suppers for new consultants to meet colleagues. All new consultants to have a mentor within their own service. Monthly meeting for HoS, MD, ND and OD starting in 2015. Quarterly clinical forum for all consultants with Exec team in 2015. All Board members to spend time with a consultant in 2015. Consultant induction course, HoS training course and leadership courses in discussion with TED. **26.01.15 update:** Medical leadership Programme commences 20.02.15. April Strategy attending Medical Manager's meeting 27.01.15 for half day time out. **February 2015 update:** Service Line management is being taken forward through annual planning process for 2015/16 supported by the Head of Strategic Planning. Leadership and management training needs analysis has been completed in January 2015.	Email confirming Medical Engagement Strategy- copy of Strategy Medical Engagement Group with NED – papers Diary evidence of MD meeting new Consultants Diary evidence of HoS, MD meeting monthly Diary evidence of all Board members spending time with consultants Dates for quarterly clinical forums First three Medical Matters Bulletins MES survey results In Your Shoes event dates Engagement event dates Registers of all events Diary evidence of MD attending team meetings and divisional meeting Consultant induction course	A
		Leadership	Trust wide	3.2	Leadership Strategy and action plan developed and implemented	Executive Director of Human Resources	Executive Director of Human Resources	01/09/2014	30/11/14 **Revised** 31/12/14 **Revised** 28/02/2015	Strategy developed and implemented and leadership and management development programmes aligned to the strategy.	Leadership Strategy in draft form. Conversation with Kings Fund on 04.11.14 (KF and AH) to discuss Collective Leadership Programme. **November** Senior HR Leaders development workshop has been completed (6/11) to map existing strategies into a Leadership Strategy and identify gaps. Draft strategy currently being developed. **Update 16.12.14** Senior HR Leaders Development Workshop was completed on 6th November 2014 to map existing strategies across to a leadership strategy and identify gaps, strategy is in draft form. Revised completion date for draft strategy is 31st December 2014. **7 January 2015:** Draft strategy written. Completed and consulted by 28 February 2015.	Published Leadership Strategy Collective Leadership Programme	A
		Leadership	Trust wide	3.3	Undertake capability review of middle managers and implement required improvement actions	Executive Director of Human Resources	Deputy Director – Training and Development	01/08/2014	28/02/2015 - TNA completed Focus Group 31/03/2015	Leadership and management training needs analysis completed that assess the leadership and management training capabilities and skills of managers to then inform the required development programmes that we need to put in place.	Training needs analysis process developed and completed. Focus groups with service and middle managers established to ensure a better understanding of issues faced by manager. To enable action plan to be developed.	Training Needs Analysis	C
											26.01.15 update:Focus group to take place to understand what it feels like to be a middle manager and what issues they are faced with. **February 2015:** Middle and senior managers focus groups have been established for March and April 2015 to sense check the training needs analysis and to explore leadership development themes emerging from staff exit interviews. Feedback to the OD & Workforce Committee will be given in April / May 2015.	Evidence of focus groups	G
		Leadership	Trust wide	3.4	Provide clinical leadership development opportunities	Executive Director of Human Resources	Deputy Director – Training and Development	01/04/2014	31/03/2015 **Revised 15.01.15**	Band 6/7 clinical leadership programme/RCN clinical leadership programmes are in place. Clinical leaders have the necessary skills to competently perform their roles.	12 deputy ward sisters have completed a Band 6 Clinical leader's programme. 2nd cohort of band 7 Ward Sisters are currently undertaking the RCN leadership programme in collaboration with NUH. Continue to provide leadership opportunities for clinical managers. **15.01.15 -** RAG rating reassessed as BLUE completed	Programme details published Agenda and register of attendees RCN leadership timetable and attendees	C
		Medical Leadership	Trust wide	3.5	Provide medical leadership and management development opportunities	Executive Director of Human Resources	Deputy Director – Training & Development	01/04/2014	31/03/2015	Revised and dynamic medical leadership programme in place. Medical clinical leaders have the necessary skills to competently perform their roles.	Medical Leadership Programme has been refreshed from input from the Medical and Clinical Directors. Meeting with the provider in November to finalise approach and content Programme is due to commence February 2015. **26.01.15 update:** On track to commence in February 2015. **February 2015 update:** Executive, medical staff and Consultant shadowing programme has commenced. 12 medical leaders attended the Private Board.	Draft refreshed programme outline	G
		Medical leadership	Trust wide	3.6	Identify Roles and Responsibilities for Heads of Service	Executive Medical Director	Executive Medical Director	01/04/2014	31/10/2014 **Revised:** 28.02.15	Clarity of expected outcomes delivered by the role, identification of support required and performance management to create consistency.	Draft Job Description for all HOS and this was taken to medical managers following the meeting requested HOS for the training requirements as part of medical engagement work. **26.01.15 update:** Draft Job Descriptions will be with the Medical Director on Friday 30.01.15 **February 2015 update:** Currently with the Medical Director for comments, to be discussed at the Medical Manager's meeting next week.	Email confirming – Identify roles and responsibilities for Head of Service, copy of job description, meeting notes and HoS training requirements.	C

		Leadership	Trust wide	3.7	Fully implement and embed service line management in the Trust	Director of Strategic Planning and Commercial Development	Director of Strategic Planning and Commercial Development	01/10/2014	01/10/2016 **Revised:** 31.03.15	Clinical leadership strengthened through equipping the service line leadership teams with the skills and tools to determine and deliver the future for their own services.	SLM maturity assessment completed and report with key recommendations to be concluded by end October 14. Engagement within the Trust has reaffirmed commitment to principles of good SLM. **26.01.15 update:** Service line management taken forward through annual planning process for 2015/16, supported by Head of Strategic Planning.	SLM maturity paper – TMB Action plan	G
		Medical leadership	Medicine	3.8	Recruit a substantive Clinical Director for Emergency Care & Medicine	Chief Executive	Director of Operations	01/10/2014	30/03/2015	A substantive Clinical Director in place	Current Clinical Director is due to leave the Trust January 2015. A replacement is currently being advertised. **November** interviews for the appointment of a new clinical director are scheduled for completion on 28.11. 2014. **Update 09.12.14** New appointment made with the new candidate receiving a 2 week handover with the outgoing post holder.	Advert Formal offer being drawn up Offer letter.	C
Well Led	Hospital Inspection and Keogh	Risk Management	Trust wide	4	Ensure Trust Risk Management processes are robust including appropriate identification of risks, incidents, mitigation and learning at all levels in the organisation	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow & Patient Safety Manager	01/07/2014	28/02/2015	Risk registers and BAF adequately reflect current risks. DatixWeb implemented to increase the opportunity for improved information and opportunities for giving feedback and sharing of trends and themes to services and individuals. Evidence of Divisions learning and improvement from incidents through Clinical Governance Committee and Quality Committee	Risk Manager appointed. Review of divisional risk registers undertaken. Corporate risk register currently being revised to ensure risks are reported and scored appropriately and reflect the BAF. BAF currently being redesigned – To be presented at November '14 Trust Board. DatixWeb implemented and new level of information being obtained – being reported to Quality Committee and Clinical Governance & Quality Committee.		G
		Risk Management	GSU	4.1	Appointment of a Risk Manager to support the organisations management of clinical risks and make improvements in the way the Trust learns and share lessons across the divisions, service lines, departments and organisational boundaries.	Executive Director of Nursing	Head of Governance	01/05/2014	31/12/2014	Successful recruitment of a Risk Manager	Initial recruitment failed to appoint a suitable candidate. Interim in post for three months. Advertised post July. Risk Manager appointed – due to commence Mid November. Working x2 days a week to help establish systems and processes for learning. In process of confirming that risks currently on Datix Risk Module (Rich Client) and within the interim RM's excel spread-sheet are live/current and appropriately scored. (This exercise has commenced via the Clinical Governance Co-ordinator network in conjunction with the directorate management teams) **Update 01.12.14** Action **COMPLETED.**	Job description Offer Letter	C
		Risk Management	GSU	4.2	Appointment of Clinical Governance Co-ordinators within the GSU with a responsibility within the JD to support effective risk management and learning.	Executive Director of Nursing	Head of Governance	01/05/2014	31/12/2014	Successful recruitment of Divisional Clinical Governance Co-ordinators. Monthly reporting of Risk Register Activity in divisions.	All divisions have an appointed Clinical Governance Co-ordinator (all appointed in July – August 2014) Template for reporting monthly on risk register activity drafted and first risk reports to form part of divisional governance packs in November 2014. Divisional CGC's currently reviewing risks on risk register to ensure risks are appropriately described, controls recorded and for each risk any additional actions to mitigate/minimise the risk. CGC's are "handlers" on Datix for risks to help and support the risk leads in division. The role out of DatixWeb will give speciality leads access to their risks-to improve management at service level. **Update 01.12.14** Action **COMPLETED**	Names of Clinical Governance Co-ordinators. Templates for reporting risks. Clinical Governance meetings from each divisions to demonstrate risk is discussed.	C
		Risk Management	Trust wide	4.3	Approve revised Risk Management Policy at November Board of Directors meeting.	Executive Director of Nursing	Head of Governance	01/07/2014	30/11/2014	Approved Risk Management Policy with detailed understanding of the Risk Management Process contained therein.	Currently being fully consulted on to include TMB, CQ&GC, QC, Divisional and Specialty Governance Groups. Amend the draft Risk Management Policy to: - fully reflect the NPSA grading matrix throughout - Expand on the 4 levels of risk management/escalation (ownership) - Remove the procedural elements including the Datix User Guide **November** Approved at TMB, CQ&GC and Quality Committee. On agenda for BOD. Approved in principle by BOD – amendments to include establishment of Risk Committee.	Risk Management policy. Papers from TMB, CQ&G Committee, Quality Committee where is was approved. ToR and agenda for Risk Committee. 2015 dates for Risk Committee.	C

		Risk Management	Trust wide	4.4	Create a supporting Risk Management Procedure which will also serve as a training hand-out to include: - The SFH approach to identifying, assessing and managing risk - User friendly screenshots of DatixWeb Risk module & how to upload and subsequently manage risks (including action plans and archiving obsolete risks)	Executive Director of Nursing	Head of Governance	01/10/2014	01/12/2014	Approved Risk Management Procedure which will also serve as a training hand-out	Currently sitting as an appendix to the revised draft risk management policy, however agreed to have stand alone. Timescales dependent upon appropriate changes being made to DatixWeb as screenshots will be used for the procedure. **November** Draft circulated for comment to Clinical Governance Co-ordinators and HoG by the Risk Manager. This will be given out at training. Timescale will be met. This has been reassessed as green. **Update 16.12.14** Action **COMPLETED**	Risk User Guide – needs version control, author, approval process adding.	C
		Risk Management	Trust wide	4.5	Introduce a Risk Assessment form* which can be used to capture clinical & non-clinical risks. This form will be contained within the Risk Management Procedure.(* currently the only form is one used by the H&S Department).	Executive Director of Nursing	Head of Governance	01/10/2014	30/11/2014	Consistency in recording risks using unified assessment.	Draft to be circulated for comment and consultation w/c 10 October. **November** SFH Risk Assessment Form created to support the content of the Risk Management Policy: • Generic (Clinical & Non-clinical) • Standard 5 x 5 matrix • 4 T's included • Action Planning element • At-a-glance Tier Level ownership & monitoring requirement Action **COMPLETED** **Update 16.12.14** Action **COMPLETED**	SFH Risk Assessment Forms	C
		Risk Management	Trust wide	4.6	Launch the Risk Management approach (Policy & Procedure) - To form part of the GSU Communication Plan - A Risk Management TNA will be agreed & implemented offering different levels of training to different groups of staff - Specific DatixWeb Risk module training including running of reports and use of Dashboards will be delivered to areas with supporting reference material.	Executive Director of Nursing	Head of Governance	01/12/2014	21/01/15 & on going	Staff competent in the identification, assessment and management of risk according to their sphere of responsibility	Events, courses, awareness sessions and various media activity which will be continual – plans already being made for initial launch. **Update 16.12.14** The three levels of RM training have been added to the Trusts TNA and commence in January (there will be two Level 1 sessions pcm, two Level 2 pcm and 1 Level 3 pcm). Reassessed as RAG rated GREEN **February 2015 update:** The Risk Management policy has been published and communicated to a wide audience. A new generic risk assessment tool has been introduced and the feedback is positive. The Risk Management training has commenced and initial feedback is encouraging. A Risk Management and Datix Risk User Guide has been introduced.	Notes of QI meeting Launch details of Risk Management approach. GSU Comms plan. Risk Management training plan, dates and registers.	G
		Risk Management	Trust wide	4.7	Ensure DatixWeb reflects the content and approach set out within the Policy & Procedure (including links with incidents, claims and complaints). Transfer agreed risks onto DatixWeb version	Executive Director of Nursing	Head of Governance	01/08/2014	15/12/2014 **Revised** 31/01/2015	Risk module of Datix Web will have improved functionality, particularly in terms of reporting risks and source of risk, aligning risks to strategic objectives and CQC outcomes, risk status, response to risk e.g. 4T's (treat, tolerate, transfer or terminate), ownership of risk and escalation of risk.	Risk Management Module of Datix Web is being piloted at Newark and of specialty areas within ECM. A number of amendments are necessary and some work to align the old version of Datix (Rich Client) with DatixWeb. (NB: the timescale assigned reflect the fact that the Datix Administrator is attending the DCP course late October and the quality check of incidents on the incident module of Datix takes up a significant amount of the D.A. role). **November** Meeting with Datix administrator 14/11/14 and progress being made with Datixweb. **Update 16.12.14** The majority of the changes have been made to DatixWeb Risk it is expected to be early January it will have the fields required. The Risk Manager needs to test it fully before proper launch. As soon as that happens and everything works OK the Risk Manager will use the ICT training suite to undertake 2 x Datix risk sessions per month (from February) and from April 1 x dashboard session pcm **15.01.15 -** RAG rating reassessed as GREEN on track **February 2015 update:** The DatixWeb reflects the policy and risks are available on Datix. The RAG rating has been reassessed as BLUE - complete	Link to Datix homepage where information to this nature has been communicated across the Trust. Datix Web Risk Project plan. Results from Newark and EC&M pilot.	B
		Risk Management	Trust wide	4.8	Ensure there is a robust incident and reporting system is in place (DatixWeb) and that lessons learnt from investigations are shared with staff to improve quality and safety.	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow, Patient Safety Manager	01/07/2014	28/02/2015	Divisional and corporate risk registers reviewed to ensure they capture risks with appropriate mitigation and escalation. Evidence of Divisions learning and improvement from incidents through Clinical Governance Committee and Quality Committee.	DatixWeb rolled out across the Trust. Training completed. Staff being supported to improve quality of responses – 'other' category removed. Evidence of feedback to reporter is mandatory feedback in Datixweb. New style report being produced for Quality Committee and Clinical Governance Committee which includes themes and learning. **Update 16.12.14** Band 2 allocated from GSU to work with Datix co-ordinator to ensure cleansing of data and that lessons learnt are completed. **February 2015 update:**Regular, robust reporting of significant risks and the risk profiles fo the trust is taking place at TMB, RMC and CQ&GC on a monthly basis.	Lessons Learnt data. New style report example Evidence of where lessons learnt are discussed.	G

		Risk Management	Trustwide	4.9	Establish a Risk Committee reporting to TMB.	Executive Director of Nursing	Executive Director of Nursing	01/12/2014	31/03/2015	Risk Committee in place.	Committee structure defined. A decision to include a Risk Committee within the reporting structures made w/c 20/10/14. New risk management due to commence 03/11/14. Role will be to support the establishment of this committee. **November/December** Terms of Reference drafted for new Risk Committee. First meeting planned for December to agree ToR, membership yearly planner. Meetings planned for monthly. In early 2015 the Datix Risk Dashboard will be in a position to be either projected live at the meeting with dashboard reports prior to the meeting as papers. The ensuing discussion will satisfy the "monitoring performance" aspect of the Risk Committee. This milestone has been reassessed as Amber. **January 2015** - Two committees have been held. Terms of Reference agreed. Report sent to TMB completed. RAG rating reassessed as BLUE completed	Draft Risk Management Committee ToRs Nov 2014. Datix Risk Dashboard Committee dates. Minutes from meeting.	C
Well Led	Hospital Inspection	Learning	Trust wide	5	Ensure that staff receive appropriate and timely feedback from incidents and complaints and that actions taken and lessons learnt are shared across the divisions to improve quality and safety	Executive Director of Nursing/ Executive Medical Director	Head of Governance Support Unit, Patient Safety Fellow, Patient Safety Manager	01/07/2014	31/12/2014	Staff feel they are receiving appropriate and timely feedback. Improved quality and safety as a consequence of sharing and learning	DatixWeb in place across the whole Trust. This version increases the opportunity for incident reporters to receive feedback whilst also improving the depth and sensitivity of information to aid learning. Quality Summit shared best practice from Maternity, Critical Care and C&YP. Examples of 'what works well' from individual service lines discussed. Development of Medical Matters, use of iCare2 and safety bulletins. Strengthened SI process to support sharing and learning being implemented across the Trust. Learning from incidents and complaints strategy being developed.		A
		Complaints learning	Trust wide	5.2	Implementation of the Patient Experience module (Datix) to improve recording of complaints and learning opportunities.	Executive Director of Nursing	Executive Director of Nursing	01/09/2014	30/11/14 **Revised** 31/01/15	Improved recording of complaints subject and sub subject and lesson learnt to be completed.	Week commencing the 6th October agreed field for the patient experience module of Datix. Training of the patient experience team to start the 17th October with a view to go live the 10th November. **Update 16.12.14** From PE prospective, we need to agree fields and the process to go live fully, similar to the online incident reporting to ensure the full benefits of Datix Web are utilised and it can be used as a single system to avoid the current duplication and have an accurate audit trail. Meeting arranged for 17.12.14 to agree timeframes. Rationale for revised changes in how Patient Experience model will be utilised and realized. Change in management of Patient experience team. Revised timescale of 31 January 2015 tbc. **February 2015 update:** Patient Experience team are implementing the Patient Experience module (Datix),.	Patient Experience Dept Structure. Screen shot of patient experience module Evidence of training.	G
		Complaints learning	Trust wide	5.3	Introduce a complaint response action plan tracker (for every upheld or partially upheld complaint there will be a SMART action plan which will be monitored until last action complete). Themes will be collated monthly and form the basis for replicating learning across the Trust.	Executive Director of Nursing	Patient Experience Manager	01/10/2014	31/12/2014	Robust action plan tracker with evidence of escalation when actions exceeded timescales for completion. Auditable tracker of actions completed enabling improved evidence of lessons learnt.	Action tracker implemented. **15.01.15 -** RAG rating reassessed as BLUE completed	Action tracker.	C
		Learning through investigation	Trust wide	5.4	Deliver in house 1-2 day RCA training workshops.	Executive Director of Nursing	Head of Governance Support Unit	01/08/2014	31/01/15 and on going	To improve the quality of the investigation to enable clear identification of root cause and lesson learnt.	RCA training day for Governance Coordinators, Practice Development team and Matrons was undertaken during August. This was evaluated very positively with agreement to roll out monthly training for 2015 onwards. From January 2015 a programme of training will be rolled out across the Trust. To include RCA training report writing and being open policy. **15.01.15 -** RAG rating reassessed as GREEN on track **February 2015 update:** RCA training commenced on the 16 February 2015, and currently all available places are full.	Evidence of RCA training/ register. Being Open policy.	G
		Sharing and learning	Trust wide	5.5	Review Divisional Governance Performance Information to ensure it is in a format which facilitates sharing and learning for Divisional Governance Meetings.	Executive Director of Nursing	Head of Governance Support Unit	01/09/2014	31/12/2014	Divisional Governance Information is reviewed to ensure it provides robust, timely information for ; risks to be clearly identified, opportunities for best practice to be discussed and themes and trends to be shared with service lines and individuals.	Meeting held 23/09/14 and agreed divisional pack core content. Meeting notes available upon request. Core agenda agreed. Specialty governance packs being reviewed with core agenda to be finalised in line with divisional agenda. TORs being reviewed w/c 6/10/14. The Trust has purchased Datix dashboards and the GSU will work with Ward and Dept leads to create dashboards relevant to their service. Plan to facilitate this by the end of December 2014. **February 2015 update:** Standardised format is being used at all the Clinical Governance meetings this is being driven by the Clinical Governance co-ordinators.	ToR, Action notes 23.09.14. Governance Programme of Work Divisional Governance Meeting Data.	G

		Sharing and learning	Trust wide	5.6	Quality Summit to bring clinical leaders together to establish mechanisms for improving sharing and learning - incorporating successes in Maternity, Critical Care and C&YP (Good Outcome in last hospital inspection visit).	Executive Director of Nursing/ Executive Medical Director	Assistant Director of Nursing for Quality,	01/08/2014	27/09/2014	Quality Summit presented. Maternity, Critical Care and C&YP all presented at the summit. Learning and sharing opportunities collated.	Quality Summit identified individual, service line and Trust Wide learning opportunities – to be included within Learning from Incidents strategy.	Agenda and notes from quality summit. Learning from Incidents strategy.	C
		Sharing and learning	Trust wide	5.7	Task and finish group established to formulate a Trust Wide Strategy for improving sharing and learning of themes and trends and individual learning points which mitigate risks and improve outcomes.	Executive Director of Nursing	Patient Safety Manager	01/10/2014	30/11/14 **Revised** 31/01/2015	Sharing and learning strategy developed with evidence of individual learning.	Project initiation plan presented to Patient Safety Improvement Group and being shared at Clinical Quality and Governance Committee on 15 October 2014. Bite size feedback reviewed at Newcastle. **Update 16.12.14** Task group continue weekly. The Patient Safety Lead has been meeting with many leads of departments / harms etc. and still have other scheduled this week to update on work and ask them to identify what messages that they can produce on say monthly/bi monthly/quarterly basis some already have that can adapt. Objective being have a library of learning that can be used for learning boards condensed version s for screensavers etc. Ward leaders forum on 9.12.14 looked at what they do now which will be collated into a visual. One development that came out of this was to have nurse and AHP gran round. It was agreed at the meeting on 15/12/14 that his will be held twice a month and will commence with the first on in January. Will be able to have a message within SMART that is being worked up now. iCare2 shared learning event planned for 17th March. Consistent format for patient safety newsletter completed and shared 15/12/14 with divisions. **15.01.15 -** RAG rating reassessed as GREEN completed **February 2015 update:** iCare learning event is planned for March 2015 and is being driven by the Patient Safety Lead. Organisational leaning weekly meetings have developed a 'good idea' tracker. Organisational learning is a standing item on groups/ committee agendas.	Clinical Quality & Governance Committee minutes and reports. Patient Safety Improvement Group notes. Ward Leader forum agenda/ minutes – 9 December 2014. iCare2 shared learning event 17 March 2015.	G
		Sharing and learning	Trust wide	5.8	Sharing and learning report for Quality Committee to be produced quarterly – this will include triangulated learning from themes and trends identified in incidents, complaints, claims and inquest. In addition to include Parliamentary and Health service Ombudsman PMHSO feedback.	Executive Director of Nursing	Head of Governance Support Unit	01/01/2015	31/01/2015 **Revised** 31/01/2015	Triangulated lessons learnt reports.	Meeting held 23/09/14 and agreed divisional pack core content. Meeting notes available upon request. Quarterly template report drafted and is work on progress. **January 2015** - A Clinical Effectiveness & NICE learning report was presented to the Quality Committee - full report to March Committee **February 2015 update:** Demonstration of learning and connections between complaints, incidents and feedback are discussed in Clinical Quality & Governance Committee. Learning templates are being utilised in Divisional Governance meetings. Learning report will be a standing agenda item on Clinical Quality & Governance Committe from March 2015.	Patient Safety Bulletin. Divisional pacts Sharing & Learning report = example	A
		Sharing and learning	Trust wide	5.9	Implement a series of Trust Wide Nursing and Midwifery time out days to ensure every nurse and midwife complete learning workshops around the 6C's and the CARE values.	Executive Director of Nursing	Head of Professional Practice	31/10/2014	31/03/15 and on going (will take 12 month to complete)	A series of workshops are delivered which delivers clear messages regarding consistency in practice, whilst also conveying a ' pride to be a nurse' message	Workshops planned for next 12 months. First workshop to commence on 31/10/14 and then 2/52 for next 12 months (allowing a break during winter pressures). **15.01.15 -** RAG rating reassessed as BLUE completed	Study day/workshop agenda , notes and evaluation forms. Register attendees.	C
		Sharing and Learning	Trust wide	5.10.	Introduce an Innovation Hub to share the learning of the transformation work with patients, staff and visitors.	Executive Medical Director	Transformation Director	01/08/2014	11/11/2014 **Revised:** 31.03.15	Visibility of transformation agenda to patients, staff and visitors.	Innovation Hub established on Trust HQ Corridor. Showcase hubs planned in Comms Strategy to implement as soon as possible. **November** Improving Organisational Learning Task Group commenced - multidisciplinary membership. **Update 09.12.14** Plans agreed with PFI partners to create a hub in the main foyer by February 2015. **26.01.15 update:** Theatres and Radiology Innovation Hub in place, Innovation Hub on the Executive Corridor.	Photo of door/ office. Transformation Communication Strategy. Improving Organisation Learning Task Group – minutes from meeting.	A

		Sharing and Learning	Trust wide	5.11	Explore the option of implementing learning boards for every clinical area.	Executive Director of Nursing	Patient Safety Manager	16/01/2014	31/12/2014	Learning boards for every clinical area are in place.	The mock CQC learning event and Quality Summit have identified this as a need. **November** The Patient Safety Manager is taking the lead on developing a Sharing and Learning strategy for the Trust. A weekly task and finish group supported by the Director of Nursing is meeting to pull together and pilot ideas. The wards are piloting a learning template. A trust wide learning board has been designed and is being debated at the task group-this will be ready for wider consultation and development by 7th December. Screen savers with key messages and 'message of the week' will commence by December 7th. This milestone has been reassessed as Amber. **January 2015 -** Leaning Boards now in the clinical environments RAG rating reassessed as GREEN on track. **February 2015 update:** All ward areas have learning boards, and some non-clinical areas, with some amendments. RAG rating reassessed as BLUE - completed	Notes from Task & Finish Group. Learning template. Screen saver – message of the week.	C
DOMAIN - SAFE													
Safe	Hospital Inspection & Keogh	Staffing	Trust wide	6	Build safe and effective staffing levels with escalation processes to meet unpredicted demand.	Executive Director of Nursing/ Executive Medical Director	Executive Director of Nursing, Executive Medical Director	01/01/2014	01/04/2015	Staffing levels reflect the needs of patients and are sufficiently flexible to support variability in demand.	Acuity review completed for all inpatient wards. Nurse staffing numbers and skill mix collated and reviewed daily. Staffing information is uploaded onto UNIFY and Trust Board receive monthly reports which relates staffing shortfalls to incidents. Recruitment campaign in situ, with overseas recruitment established. Successful recruitment of Consultant Posts over past 6 months. Proactive recruitment of newly qualified nurses and increased numbers of HCA's on the nurse bank.		A
		Nurse Establishment & Skill Mix	Trust wide	6.1	Implement nurse staffing investment strategy (3 year plan - commenced 01.04.14) to increase the number of nurses and change the skill mix to 70:30 (RN:HCA) in line with professional and evidence recommendations.	Executive Director of Nursing	Executive Director of Nursing	01/04/2014	31/06/16	For inpatient wards RN Nurse: Patient ratios do not exceed 1:8, ward sisters have a supervisory role and the skill mix does not fall below 65:35. Nursing care outcomes improve with the increase of RN complement.	Trust Board has agreed to £4 million investment in Nursing (January '14). Additional Registered Nurse in place on all inpatient wards since July '13. All nursing staffing information collated into one spreadsheet (includes investment, actual, planned, and vacancies.). Director of Nursing and Director of Operations have met with all ward sisters to communicate current establishments and expectations for 2014/15. **January 2015 -** Surgery now at 60:40. Mansfield Community Hospital has increased its registered nurse complement, EAU ward leadership has been strengthened. ED staffing has increased on nights. RAG rating reassessed as GREEN - on track **February 2015 update:** Staffing proposal for 2015/16 has been agreed by senior nurses and submitted to finance for costing.	Safe Staffing levels Sept 14. Implementation plan for nursing investment.	G
		Medical Consultants	Trust wide	6.2	Develop a robust Workforce plan for medical consultants from the current workforce strategy.	Executive Medical Director	Executive Medical Director	31/10/2015	31/03/2015	Substantive clinical expertise available for all medical specialties.	This is within the OD & Workforce strategy.	Workforce & OD Strategy	A
		Medical and Nursing Staffing	Trust wide	6.3	Ensure there are sufficient numbers of qualified, skilled staff at all times in our wards and departments.	Executive Director of Nursing/ Executive Medical Director	Executive Director of Nursing, Executive Medical Director	01/01/2014	01/04/2015	Staffing levels reflect the needs of patients and are sufficiently flexible to support variability in demand.	Acuity review completed for all inpatient wards. Nurse staffing numbers and skill mix collated and reviewed daily. Staffing information is uploaded onto UNIFY and Trust Board receive monthly reports which relates staffing shortfalls to incidents. Overall the Trust nurse and medical staffing levels reflect demand apart from ED, EAU and some medical wards. Recruitment campaign in situ, with overseas recruitment established and a number of overseas nurses working at SFH. Successful appointment of Medical Cardiology Consultants , ED Middle Grades and newly qualified nurses for EAU. **Update 09.12.14** Additional Acute Physician appointed November 2014 with 3 more starting in Jan/Feb 2015. Review of junior doctor distribution across wards by DME underway. **26.01.15 update:** Urgent meeting last week re: H@N. Additional junitor doctor on at night to support H@N. Surgical juniors are part of the H@N team and do tasks as allocated. Further work to be undertaken to review the Night Team Leader role and further recrutiment. **February 2015 update:** All wards exceeded the UNIFY standard of 85% average fill rate. 4 out of the 31 wards at SFH did not meet the internal standard, and it was acknowledged that all 4 wards were undergoing a staffing reconfiguration. Additional junior doctor has been added to the Hospital @ Night team with immediate effect. Additional resources has been added to the Falls team and End of Life team.	Acuity audits Daily staffing reports TB monthly reports Evidence of international recruitment Evidence of medical appointments Review of junior doctors distribution	A
		Nurse Staffing	Trust wide	6.3.1	Undertake staff and skill mix reviews 6 monthly which is subject to Board Oversight.	Executive Director of Nursing	Deputy Director of Nursing	01/04/2014	Every 6 months	Trust Board receive monthly and 6 monthly staffing position (UNIFY return, 6 month acuity assessment and ward rota's) as recommended within NICE guidance.	Ward by ward staffing position reported monthly to the Trust Board since 01/04/14. Full establishment review with acuity assessment received by Trust Board with 6 month update planned 30/11/14. Acuity assessments undertaken July 14. All inpatient ward establishments reviewed and communicated to ward sisters during October 14. **15.01.15 -** RAG rating reassessed as BLUE completed	Safe Staffing levels Oct 14 TB Report	B

		Staffing	ED	6.4	Ensure there are sufficiently available Medical and Nursing staff to provide safe, timely care in the Emergency Department.	EC & M Divisional Clinical Director	ED Head of Service, ED, Matron	01/04/2014	31/03/2015	Staff levels and skill mix reflect the activity, and acuity needs of the patients. Patents are assessed and treated within a timely model of care.	ED nursing has been benchmarked with other similar sized Trusts and changes are required to increase midnight to 6am cover. The divisional team are developing a paper if this requires additional investment. **February 2015 update:** SFH has responded to the ED NICE staffing guidance, undertaken a gap analysis against the reocmmendations. This has informed the budget setting process. ED medical and nursing staffing / skill mix are discussed at all bed meetings (3 x daily and 7 days a week).	Benchmarking on ED staffing	A
		Staffing	ED	6.4.1	Review ED workforce model to match demand profiles.	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/04/2014	30/11/2014	Clinician capacity reflects demand and attendance modelling, with the 4 hour access target consistently achieved .	The agreed medical workforce strategy for ED has been refreshed to reflect the current market. Consultation has taken place with relevant staff to make rota changes to increase senior decision maker presence in the evening and at weekends. The department has been successful in international recruitment and middle grade posts are in the process of being filled (awaiting commencement). **Update 09.12.14** 2 additional ED middle grades in post and 2 more scheduled for Jan/Feb **February 2015 update:** as per 6.4	Medical Workforce Strategy for ED	G
			ED	6.4.2	Review ED night nurse staffing. Benchmark numbers and skill mix with organisations that have similar demand profiles.	EC & M Divisional Matron	ED Matron	20/07/2014	31/10/2014	To provide a comparison of staffing levels within other ED Departments of similar profile and assist making future informed decisions.	Benchmark against 4 other ED completed. Recruitment to commence to increase RN overnight by 1 per shift. Additional Band 6 shift leaders now in post. **Update 01.12.14** Action **COMPLETED**	Workforce review ED Benchmark report ED rota – additional staffing	C
			ED	6.4.3	Monitor ED escalation plan daily and review issues weekly at Capacity and Flow meeting.	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/03/2014	24.10.14. commence weekly capacity meeting	To ensure that resources are deployed effectively to manage surges in demand.	Escalation reviewed as part of the 10am capacity meeting and review of issues identified are raised directly with the Service Director and Divisional management team. The establishment of a formal capacity meeting from 24 October. **November** Weekly capacity and flow meetings commenced 24/10/14. This milestone has been reassessed as green. **February 2015 update:** Escalation monitor by gold on-call at all the bed meetings, and escalation for discussion at the Capacity and Flow meeting.	Notes from Capacity & Flow meeting. Diary evidence of meeting ED Escalation plan	G
			Emergency Care & Medicine	6.4.4	The Trust has had difficulty with recruiting and sustaining high calibre front door clinical decision making and therefore alternative models for recruitment are required.	Director of Operations	ED Head of Service	01.07.14	29/09/2014. first phase although this work is continuing	To recruit high calibre medical staff to deliver high quality safe care. Reduce admissions from improved decision making from substantive staff.	The Trust has had significant success from international recruitment, acute physician posts and ED middle grade posts are in the process of being filled with candidates starting to commence. **January 2015 -** 6 Acute Physicans in place by March 2015. **February 2015 update:** Final 2 Acute Physicians to be in post by March 2015, this is the most successful recruitment of Acute Physicians the Trust has experienced.	Report – Exec Team Middle Grad Doctors V3. Evidence of posts filled.	G
		Nurse Staffing	EAU	6.5	Ensure there are sufficient qualified nurses to provide safe care in the Emergency Admissions Unit.	EC & M Divisional Matron	ED Matron	01/06/2014	31/12/2014	All shifts are safely staffed, but where staffing levels do not meet demand, bed numbers are reduced to provide safe care.	All vacant RN posts recruited to. Agreed staffing ratio of 1:6 RN to patient maintained in the day and 1:8 at night. Agency/bank and temporary staff used to maintain agreed levels **January 2015 -** recruitment of 7 x Band 5 and 3 x Band 3 planned **February 2015 update:** Recruitment of the Band 5 is planned for the last week in February 2015.	Daily staffing tool used to review and evidence staffing Levels. Daily bed state identifies bed occupancy. Safer staffing care tool.	G
		Nurse Staffing	EAU	6.5.1	Recruitment of a second Band 7 Sister/Charge Nurse to the Emergency Admissions Unit.	EC & M Divisional Matron	ED Matron	01/07/2014	31/10/2014	To provide additional senior support and leadership to the Emergency Admissions Unit. To lead on governance within the department.	Experienced EAU Charge Nurse recruited with vast experience of EAU working and governance.	Monthly establishment produced via finance. Monthly ESR data produced by HR	C
		Nurse Staffing	Medicine	6.6	Ensure there are sufficient numbers of qualified, skilled and experienced nursing staff at all times within the Medical Wards.	Executive Director of Nursing	EC & M Divisional Matron	01/06/2014	31/03/2015	All the medical wards are staffed with substantive staff to meet the acuity and dependency needs of the patients.	Utilisation of bank/agency temporary staffing to maintain agreed levels of nursing. Recruitment manager in post. Lead PDN for recruitment / retention employed. Additional Preceptorship Nurse in post. Rolling RGN recruitment in place. International recruitment programme underway. Executive Team currently discussing a bed reduction plan which would enable teams to be merged to reduce the use of bank/agency nursing staff. **November** x3 daily staffing template indicates that shift numbers for medicine are being met. UNIFY return for October indicates no areas in Medicine are below 100% fill rates, with many wards exceeding 110% fill rates for HCA. A large use of 1-1 support and no adverse variance on the ward assurance matrix indicates safe environments. Successful recruitment of overseas nurses with the majority now within the establishment numbers. 2 months of preceptorship (6 month programme) for newly qualified nurses completed with increased preceptor support. Further information in relation to nurse staffing has been included within the Trust Board 6 Month Nurse Staffing paper. This milestone has been reassessed as Amber. **February 2015 update:** All medical wards met the UNIFY standard of 85% average fill rate, and the Trust's internal target. There remains a large need for 1:1 enhanced support across the Trust. Additional winter capaccity remains open. 50 international nurses has been recurited to the Trust, and we are looking to develop a long term recruitment plan for further international recruitment. EC&M are developing a marketing strategy for recruitment of registered nurses with open days and external journal adverts.	Utilisation of bank/agency temporary staffing to maintain agreed levels of nursing. Recruitment manager in post. Lead PDN for recruitment / retention. Additional preceptorship Nurse in post. Rolling RGN recruitment in place. International recruitment programme. UNIFY staffing information.	A

		Nurse Staffing	Medicine	6.6.1	Review acuity and dependency in all medical wards to identify the workforce mix required.	Executive Director of Nursing	Matron, Medical Specialties	01/07/2014	31/10/2014	Acuity and dependency review completed. Staffing requirements reviewed and the staffing model for each ward assessed to reflect the outputs of SNCT professional view and Telford modelling.	SNCT on all medical wards completed during July 14. 50:50 and 60:40 establishment and skill mix numbers for individual wards set and communicated individually to all ward sisters. During October, numbers will be reviewed in light of SNCT results but minimal changes anticipated. **February 2015 update:** Safer Nursing Care Tool assessed in January 2015, which will inform the next six months staffing.	SNCT paper and results. October Trust Board paper.	C
		Nurse Staffing	Medicine	6.6.2	Proactive overseas recruitment of Band 5 Nurses to help fill current vacancies.	Deputy Director of Human Resources	EC & M and PC & S Divisional Matrons	01/04/2014	30/03/2015	To supplement rolling recruitment programme with international workforce to meet required increased demand in RGN.	24 Overseas RGN's in post. Practice Development Nurse appointed to lead on international recruitment and provide orientation support. Further overseas recruitment planned for Ireland and Greece in Oct/Nov. **January 2015 -** 50 international nurses in post. RAG rating reassessed as BLUE - completed	Monthly establishments produced. Monthly tracker produced for overseas recruitment. International recruitment.	C
		Nurse Staffing	Medicine	6.6.3	To reduce bed capacity as part of QUIPP and the cost improvement programme explore the possibility of merging two poorly established medical wards to improve the skill mix and numbers on other Trust Wards (redeployment of staff).	Director of Operations/ Executive Director of Nursing	Divisional Matrons	01/10/2014	29/11/14 **Revised:** 24/12/14 **Revised:** 28.02.15	Bed reduction programme supports the staffing pressures within the remaining Trust wards through the redeployment of permanent staff into other vacancies.	This proposal is being discussed as part of the Trust plan to meet the current priorities. **Update 1.12.14** Ward 21 will be empty 24.12.14. Wards 14 and 21 will be amalgamated in Surgical Admissions ward. **Update 16.12.14** Ward 21 to be merged with Ward 14 by 24th Dec 2014. Staff have been given placement choices across the Trust. **January 2015 -** Ward 21 was opened to facilitate an increase in Medical admissions during late December and January 2015. RAG rating reassessed as AMBER **30.01.15 updates:** DTOCs 'pull' team requested as part of the 'perfect week' roll out, to commence week commencing 9 February 2015. 14 days LoS stay and over distributed to all wards to unblock and make visible long waiting patients. Increased use of the discharge lounge. **February 2015 updates:** Winter bed capacity remains open . Disccharge Lounge utilisation was 218 patients in January - 12.45% of the Trust's discharges used the Discharge Lounge.	CIP Paper Staffing plans for Ward 21 staff. Communications information on ward closure.	A
		Medical Staffing	Medicine	6.7	Ensure there are sufficient numbers of Medical Staff to safely care for patients in the medical wards.	EC & M Divisional Clinical Director	EC & M, Divisional General Manager	01/05/2014	30/11/2014	To provide timely, responsive and high quality medical care, 7 days per week.	All areas have been reviewed and the medical model of rehabilitation and delayed transfer of care areas amended to ensure medical resources are deployed according to needs. This will reduce number of locums required.	Medical teams and current vacancies.	A
			Trust wide	6.7.1	To implement alternative, attractive strategies to recruit into 'hard to fill Medical posts.	Director of Operations	Director of Operations	1.7.14.	29.9.14. continuing	To ensure the Trust is providing attractive packages to recruit and retain staff.	The Trust recognised that in the current climate, alternative recruitment strategies are required. A recruitment and retention package for middle grade doctors in hard to fill specialties has been implemented to improve recruitment and retention. To date there has been improved success particularly in ED and Acute medicine. **Update 1.12.14** A Plan has been developed for each specialty as appropriate.	Recruitment and retention packages for middle grades.	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8	Ensure there are sufficient numbers of Radiologists to meet clinical demands with escalation processes if reporting times are breached.	Director of Operations	D & R, Divisional General Manager	01/04/2014	30/03/2015	Staffing levels meet clinical need. Diagnostic waiting times and reporting targets are met.	The Trust has developed a detailed Consultant Radiologist strategy which is currently being implemented. First year of the strategy is currently on track. **Update 09.12.14** Phase 2 of the external consultancy work starts 08.12.14 and will produce a clear operating and management framework, with a service improvement portfolio, quick wins and continued leadership development. On going partnership in EMRAD Board to develop common technology platform and new models of working across Nottinghamshire including joint consultant appointments. **February 2015 updates:** Interviews for Interventional Radiologist schedule to create a service hosted from NUH project board for the EMRAD created to implement a common digital imaging system across seven trustl This will facilitate reporting across the region.	Radiology Strategy Evidence of Consultancy work and plan Recruitment plan for Radiologist Evidence of joint appointment	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.1	To provide a safe radiology service which meets current demands whilst transforming to meet the 24/7 requirements.	Director of Operations	D & R , Divisional General Manager	01/04/2014	30/03/2015	To have a sustainable radiology workforce that meets the needs of current demands, but is also able to respond to the 24/7.	The Trust has an excellent track record of recruiting and retaining radiographers however this is becoming more challenging and with the national shortage of Consultant Radiologists, has commissioned an external consultancy with expert radiology expertise to work with the Radiology team to develop and implement transformational changes to ensure a sustainable service. .The Phase 1 review will conclude in October and an action plan implemented in Q3 and Q4 in Phase 2.	Initial report from external consultancy will report at the beginning of November as planned.	G
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.2	Review radiology staffing levels to identify any potential gaps in service provision.	Director of Operations	D & R , Divisional General Manager	01/07/2014	31/10/2014	Clinical capacity sufficient to meet demands and diagnostic waiting times.	Francis team working with the clinical team to review radiology provision to identify efficiencies and transformational change. Locum Radiologist secured to cover vacancies. **Update 01.12.14** Stage 2 Frances due to commence. Adverts placed for recruitment of substantive Radiologists.	Frances team outcomes Radiology rota. Advert for post and HR paperwork.	G

		Radiology Staffing	Diagnostics & Rehabilitation	6.8.3	Ensure radiology reporting KPI's are met.	Director of Operations	D & R , Divisional General Manager	01/07/2013	31/07/2013	Reporting times met KPI's.	Outsourcing utilised to support reporting times. Radiographer reporting extended. Robust reporting issues escalation process implemented.	Radiology reporting reports. Escalation process. Radiographer extended reporting roles KPIs	C
		Radiology Staffing	Diagnostics & Rehabilitation	6.8.4	Recruitment of Radiologists.	Director of Operations	D & R , Divisional General Manager	01/07/2014	31/03/2015	Clinical capacity reflects demands.	Joint appointment with Nottingham for Interventional Radiologists out to recruitment. Work being undertaken with Nottingham to improve Paediatric Radiology. International recruitment tried but not successful. Plan to reattempt recruitment with revitalised advert. **November** Radiology has progressed with phase one. Meetings with other Trusts are on going. This milestone has moved from red to amber. **Update 09.12.14 (AH)** Nottingham have recruited Interventional Radiologists and the provision of an interventional service to SFH is under discussion. **February 2015 updates:** Interviews for interventional Radiologist are scheduled.	Recruitment of Radiologists. Evidence of 5 day interventional Radiologist.	A
		Staffing	Trust wide	6.9	Offer flexible working arrangement for both substantive and temporary staff.	Executive Director of Human Resources	Executive Director of Human Resources	01/06/2014	31/03/2015	A flexible workforce with the capabilities necessary to achieve successful outcomes in an ever changing environment.	Contract and working arrangements being reviewed to meet both the needs of individuals and the Trust. **26.01.15 updated:** Reviewed activities and continues to be on track	Flexible working policy.	G
		Staffing	Trust wide	6.9.1	Establish an effective temporary staffing function (in house bank) and ensure effective rostering/deployment of clinical staff.	Executive Director of Human Resources	Deputy Director of Human Resources	01/04/2014	31/10/2014	Temporary staffing requirements are met by appropriate competent individuals at a cost effective price. Increased numbers of staff registered on the trust bank, improved process for booking and monitoring bank staff, reduction in variable pay spend.	Options appraisal currently being developed. Standard Operating Procedure currently development for all bank processes. Review of current rostering systems completed. **Update 01.12.14** New Rostering systems approved by TMB 24.11.14. SOP's completed and rolled out. **26.01.15 update:** Workforce efficiency tool has an established project plan to support roll out. In house bank arrangements being developed to support Registered Nurse and Admin & Clerical termporary requirements **February 2015 updates:** The Allocate rostering system is on track, and are currently on site offering training to the Bank Office team.	Options appraisals SOP Bank Report Rostering system tender and procurement	G
Safe	Hospital Inspection	Equipment Management	Trust wide	7	Ensuring equipment maintenance programmes are fully compliant and operate systems to identify, assess and manage risks relating to the health, welfare and safety of service users and others.	Director of Operations	Medical Physics Manager	02/06/2014	01/12/2014	Staff are aware and following the Trust equipment maintenance programme, The medical device management policy has been strengthened, staff are using standardised reporting systems and a system of escalation for missing items is established.	Policy been approved. Comms team and MEMD will re-launch the policy to highlight key areas of change.		G
		Equipment Management	Trust wide	7.1	Revise the Medical Device Management Policy to strengthen learning from medical device incidents and processes around medical device maintenance Programme to publicise new medical device management policy and train staff in new policy arrangements.	Director of Operations	Medical Physics Manager	02/06/2014	25/10/14 **Revised** 05/01/15	Medical device policy revised, redistributed and communicated.	Policy been approved and comms team and MEMD will re-launch the policy to highlight key areas of change. **Update 01.12.14** Comms Strategy Developed. Launch Date revised to Jan 2015. **Update 15.12.14** Completion date revised to 5.01.15. RAG rating reassessed as AMBER. **January 2015 -** policy ratified and being communicated. RAG rating reassessed as GREEN - on track **February 2015 update:** Launched through the Communication Department on the 10 February 2015. The policy was also presented to the Ward Leader's forum and it was received favourably.	MEMD Comms Plan 2014-15 Revised 10.12.14 CQ&GC minutes where MD policy approved. Medical Device Policy.	G

		Equipment Management	Trust wide	7.2	Introduce a standardised medical device reporting system.	Director of Operations	Medical Physics Manager	02/06/2014	30/11/2014	Standardised medical device reporting system introduced to ensure there is no discrepancy between reporting arrangements.	Standardised system established. All wards using a log book supported by guidance. MEMD team is monitoring compliance. MEMD are currently testing an electronic reporting system for fault reporting as part of an upgrade to the medical device information system. This will be more robust than log books as all wards can see status of equipment at any time. Final testing of system underway and improvements to be made by software developers Friday 10th October. Pilot wards to test during late October/Early Nov. **Update 01.12.14** Piloting in Audiology and Ward 23. Next roll out will be in ED – w/c 06.12.14. Link to reporting system will be issued to all users in the new year as a rolling programme of roll out. Ensuring MEMD are not overwhelmed by reports. **January 2015 update:** Hospital roll-out of this system with communications in January 2015. To update the QI meeting weekly throughout January to monitor delivery. **February 2015 update:** posters are on the learning boards, update from Medical Physics manager at the end of February 2015.	Evidence of compliance - report Evidence of electronic trial on Ward 23 Feedback report.	G
		Equipment Management	Trust wide	7.3	Introduce a new escalation process for missing maintenance items. Part of the escalation process will be to agree corrective action plans with the Matrons for missing maintenance items.	Director of Operations	Medical Physics Manager	01/10/2014	30/11/2014	Escalation process introduced with clearly defined actions plans for missing maintenance items to ensure all equipment is appropriately maintained. Evidence of staff using medical device management policy.	Datasets currently being analysed following introduction of upgraded medical device information system and will be distributed to Heads of Nursing for comment by end October. Update 01.12.14 The analysis will be complete by end of Dec 14 and distributed to Heads of Nursing for comment. Service lines will be informed of missed maintenance items. **January 2015 update:** 12.01.15 - Learning Boards to be utilised to display the posters for choosing the right equipment - 'Choosing right; Using right' Keeping right'. 19.01.15 - Trustwide amnesty to take place in January 2015 to identify outstanding equipment for maintenance. **February 2015 update:** posters on the learning boards 'choosing right: using right' keeping right'.	Copy of the Medical Device information system analysis Evidence from Risk Registers.	G
		Resuscitation Equipment	Trust wide	7.4	Ensure fully working resuscitation equipment is available in all clinical areas and is checked daily.	Executive Director of Nursing	EC & M and PC & S, Divisional Matrons	01/05/2014	31/12/2014	Clear standards and procedures for checking daily of rhesus equipment.	Programme in place to replace resus boxes and trolleys to enhance checking procedures. Out of hours visit (23rd September checked rhesus trolleys with very few gaps). Mock CQC visit 16th October demonstrated very few gaps, with majority of wards achieving 100% **February 2015 updates:** Procurement tender completed, and awarded to successful company. Resuscitation Officer has discuss the new trolleys and the new way of working at the Ward Leader's forum. Weekly implementation meeitngs have been established, with a project plan to be completed by the end of August 2015. Six trolleys have been supplied by the succesful supplier and a further 75 trolleys to follow, these will be used to familiarise staff with the equipment, and for training purposes.	Mock CQC Report. Metrics Resus checking.	C
Safe	Hospital Inspection	Medicines Management	Trust wide	8	Improve the systems and processes for the storage and administration of all medicines. Reduce the incidence of medicine omissions.	Executive Medical Director	Chief Pharmacist	01/07/2014	30/03/2015	Drugs are managed in line with Trust policy and legislative and omitted medications are appropriately managed. Patients receive all prescribed medications.	Task group chaired by DoN meeting weekly. Ward Medicine Champions identified. Ward 51 trialling a new swipe card access for bedside lockers, to improve security. Drug trolleys ordered for outstanding medical wards.	Agenda minutes and action log for Medicines Task and Finish Group. Medicines Optimisation Strategy. Medicines Policy Communication. Champions list of names	A
		Safe and legal supply/administration of medicines	Trust wide	8.1	Patient Group Directions (PGDs) – An updated process in line with NICE guidelines to be implemented across the Trust to ensure we are following best practice.	Executive Director of Nursing	Chief Pharmacist	01/06/2014	31/12/2014 **Revised: 31/03/2015**	All Nurses to carry out PGD competency pack for PGD's specific to their area.	PGD policy to be signed off by the Trust Medicine Safety Policy Group. Ophthalmology clinic are trialling the new competency training paperwork which is based on the NICE competency framework. Draft competency pack has been circulated around the Medicine Task & Finish Group(MTFG) members for comment. **Update 01.12.14** New policy implemented and training commenced this will be completed in the new year. **January 2015 update:** 12.01.15 - PGD and ward based discharges training taking place. **02.02.15 update:** Training continuing, new NICE guideline policy in place.	Meeting minutes and action log. Signed off competency packs - Ophthalmology Trust Medical safety policy Group - minutes	G
		Safe and legal supply/administration of medicines	Trust wide	8.2	Nurses to complete competency around pre-pack medications.	Executive Director of Nursing	Chief Pharmacist	01/09/2014	On going for all nurses affected	The Medicine Champion will ensure all staff have completed their pre-pack competency before carrying out this role.	Policy being updated. Maternity have produced a draft competency framework which will be adapted to be used Trust Wide. Tom Bell producing a short training presentation which will be shown to the Medicine Champions to cascade training. **02.02.15 -** Training maintained.	Training presentation. Competency Framework. Signed off competency packs.	G

		Medicines Storage	Trust wide	8.3	Treatment room doors and all medicines cupboards including patient's own drug lockers to be kept locked when not being accessed.	Executive Medical Director	Chief Pharmacist	Re-focus 01/10/12	31/12/2014	All medicines stored securely at all times not allowing unauthorised access.	Issue has been highlighted previously, but has remained an on going concern. Audits taking place on wards and departments to assess medicines security. Nursing metrics audited monthly re medicines storage. Outcome guardian visits being undertaken. **Update 01.12.14** Outcome of Medicine Safety audit will be published in 2 weeks. **Update 09.12.14** 2 spot checks in ED by Pharmacy and both times the drugs were secure. **02.02.15 update:** Audit completed in January - awaiting results **February 2015 update:** Trailling new pharmacy medicine secure box, with a plan to implement across the Trust by the end of March 2015.	IPR September Quality and Safety V2 Nursing metrics – medicines storage Medicine safety audit Spot check audits January audit	A
		Medicines Storage & Missed & delayed doses	ED & EAU	8.4	Optimise administration process and minimize security risks by use of technological solutions.	Executive Medical Director	Chief Pharmacist	01/02/2014	31/03/2015	High turnover/high risk areas to utilise electronic medication cabinets.	ED and EAU to have electronic secure storage and dispensing cabinets installed by the end of 2014/15. **02.02.15 update:** On track to implement.	Business case, meeting notes. Photos Procurement details email from SM	G
		Medicines storage	Trust wide	8.5	All areas to have secure bedside lockers in working order.	Director of Strategy and Commercial Development	Chief Pharmacist	06/08/2014	On going constant maintenance	All patients medication will be stored securely at their bedside.	A list of the areas being formulated re issues with bedside lockers. Ward 51 trialling a new swipe card access bedside lockers, awaiting feedback. Additional keys to be organized forward areas that have insufficient for each nursing team. **15.01.15 -** RAG rating reassessed as GREEN - on track **02.02.15 update:** Still some outstanding bedsie lockers, plan in place.	Audit Outcome guardian and metrics	G
		Missed & delayed doses	Trust wide	8.6	Posters designed to help promote good medicines administration and reduce missed doses to be displayed around the Trust on Medicines Management. One poster aimed at patients/visitors, one at nurses and one at doctors.	Executive Medical Director	Chief Pharmacist	01/03/2014	10/11/2014	A highlighted focus on medicines management across the Trust.	3 Posters have been designed and changes made at the MTFG. Costing's have been established for posters. **Update 01.12.14** Posters were distributed 19th November and are on display.	Posters in place across wards , clinics and medical and nursing areas.	C
		Missed & delayed doses	Trust wide	8.7	Medicine Champions to be implemented across the Trust.	Executive Director of Nursing	Katie Smalley, Practice Development Matron	06/08/2014	31/11/14 **Revised: 01/12/2014**	Highlighted focus on Medicine Management driven by Medicine Champions.	Medicine Champions identified within all areas, predominately band 6 or senior band 5 nurse. A Standard Operating procedure is currently in draft, to be signed off at the MTFG. **Update 01.12.14** This action is **COMPLETED.**	Email confirm Strategy ready to be launched. Names of Champions Pharmacy cover in day case and maternity. Milestone plan for Pharmacy cover in day case and maternity.	C
		Missed & delayed doses	Trust wide	8.8	Trust Medicines Safety E-learning pack to be developed and introduced Communication campaign across the organisation promoting Medicines Management.	Executive Medical Director	Debbie Dean, Training and Education Katie Smalley, Practice Development Matron	01/10/2014	31/03/2015	Staff to complete e-learning medicine safety pack to highlight the focus of Medicines Management across the Trust.	E-learning package being developed by Training and Development for consultation once completed. **February 2015 updates:** e-learning package for insulin available for staff to access in the ward environment.	Staff Bulletins – w/e 15/08/14 Optimisation Strategy. Evidence of packages and consultation. Register of staff completed.	G

		Missed & delayed doses	Trust wide	8.9	To reduce the amount of missed and delayed doses.	Executive Medical Director	Chief Pharmacist	01/02/2014	On going	For incidents around missed and delayed doses to be reduced across the Trust.	Pharmacy carrying out monthly audits, consideration being given of whether audits should be undertaken on a weekly basis. RAG rating reassessed as GREEN on track Medicine rounds to be given high profile within the organization comparable to 'mealtimes matter'. Trust standards to be agreed for drug administration to include the wearing of red tabards. Order code to be circulated. New Drug administration trollies ordered to prevent interruptions to drug rounds. New medicines chart has been agreed at Drugs &therapeutics to include missed doses section. To be sent to print, drug chart to be implemented. 10/11/2014. Implementation of the accountability handover project, this will highlight delayed and missed doses. Practice development matrons and medicine champions in all area to promote good practice. Introduce use of Medicines Safety thermometer to measure and highlight areas of good practice or concern. Introduction of red cards in ED and EAU to highlight STAT doses of medication to prevent missed doses. **January 2015 update:** 12.01.15 - PDMs had a focus week in December on medicine safety including missed and delayed medications. Divisional Matrons to produce an action plan to inform the QI meeting on how they are going to close the gap on missed doses. Medicine Safety	iCare 2 notice – New Trust general drug chart. IPR September 2014 Quality & Safety. Evidence of missed dose audits. Evidence of red tabloids. Evidence of trollies on wards are ordered. Audit of accountability handover. PDM's in all areas – medicine focus report Medicine Safety thermometer. Red cards in ED & EAU for stat doses.	G
											thermometer will be on the wards by the end of January 2015. Missed dose audit will continue fortnightly. **02.02.15 update**: ED to review 'red card' system or alternative. Missed and delayed audits did demonstrate an improvement, Divisional Matrons to develop action plan and report back to Quality improvement meeting end of February		
		Missed & delayed doses	Trust wide	8.10.	Ward leaders to check prescription charts on their leadership rounds – check for missed doses, documentation, legibility of prescriptions.	Executive Director of Nursing	Chief Pharmacist	22/10/2014	3/11/14 **Update 15.12.14** ONGOING	Reduce missed and delayed doses, improve prescription legibility.	Nurses to pick up discrepancies and issues. Highlight legibility issues with prescribers. **Update 01.12.14** Included in nursing metrics. Agenda item for ward leaders development day 09.12.14. **Update 15.12.14** Completion date revised to on-going. RAG rating reassess as AMBER.	IPR Sept 2014 Quality & Safety. Leadership rounds. Nursing metrics. Audit of missed doses. Agenda from Ward Leader development day.	A
		Missed & delayed doses	Trust wide	8.11	Controlled drugs ordering stationery to be kept locked away unless in use. Not left on ward stations.	Executive Director of Nursing	Chief Pharmacist	15/09/2014	01/12/2014	Ensure security of CDs and reduce missed doses due to lack of stock being ordered.	Trial of cone shaped notice for porter staff to alert that there is a CD order that needs transportation. **Update 01.12.14** Task and finish group in 2 weeks will provide update of roll out of Cone notice for porters. Medicine Safety audit (outcome in 2 weeks) will provide evidence. **02.02.15 update:** Continues to demonstrate improved practice.	Incident reports. Results of trail for CD ordering. Evidence of Task & Finish Group. Medicine Safety Audit - results.	G
		Missed & delayed doses	Trust wide	8.12	Individual ward performance regarding missed medicines doses to be displayed on ward performance areas.	Executive Director of Nursing	Chief Pharmacist	15/10/2014	15/12/2014 **Revised: 31/03/2015**	Share wards performance with patients, carers and other staff helping to drive improvement.	Discussed at task and finish group 15/10/14. Information re Drug administration to be displayed on learning boards. **Update 01.12.14** New Ward Communication boards which include performance regarding missed medicines doses will be rolled out at the beginning of December 2014. **January 2015** - reassessed and RAG rated GREEN **02.02.15 update:** This is being shown as datix incidents which are 'critical doses' - continue to monitor	Meeting notes White Boards Evidence of New Ward Comms boards.	G
		Missed & delayed doses	Trust wide	8.13	Develop and communicate list of responsibilities for staff groups in relation to missed and delayed doses.	Executive Medical Director	Chief Pharmacist	06/08/2014	31/12/2014 **Revised: 28/02/2015**	All staff understand their role within ensuring medicines are given. Reduced missed doses.	To be initiated. To be included at staff induction and within Medicines Policy. Includes Nursing and Medical staff. **Update 01.12.14** Not yet included in staff induction. Policy will be revised in 6 months.	Medicines policy Induction programme	G
		Missed & delayed doses	Trust wide	8.14	Communicate with prescribers the requirement to ensure that doses not required are clearly marked with an X or score line to prevent the appearance of a missed dose. (The new chart also has prescribed time to help prevent this).	Executive Medical Director	Chief Pharmacist	15/10/2014	01/12/2014 **Revised: 28/02/2015**	Improvement in prescribing, reduced "false" missed doses.	Included on the posters. Work to be undertaken for communication. New Drug chart at printers. To be included in medicines policy as part of prescribing requirements. E-prescribing will prevent this problem. **Update 01.12.14** New Drug chart will be back from printers within 2 weeks. **02.02.15 update:** Jo Richardson to address Medicine's safety and missed doses at the February's Grand Round	Audit Incidents Drug chart Communications plan e-Prescribing roll out plan iCare2 for medical staff – evidence from Jo Richardson	G

		Missed & delayed doses	Trust wide	8.15	Produce a flow chart that describes actions to be taken should a medicine not be able to be given.	Executive Medical Director	Chief Pharmacist	15/10/2014	15/12/2014 **Revised: 31/03/2015**	Helps ensure that missed doses are appropriately dealt with e.g prescription review, source the medicine.	Flow chart in draft. **Update 01.12.14** Will be included on agenda of ward leaders development day 9th December 2014. **02.02.15 update:** Flow Chart with the Deputy chief pharmacist	Meeting notes Flow chart once completed	G
		Missed & delayed doses	Trust wide	8.16	Ensure nurses are administering in-line with NMC guidance and know what medicines being administered are for, side-effects, correct dose etc.	Executive Director of Nursing	Divisional matrons/practice development matrons	01/06/2014	31/12/2014	Nurses understand what a medicine is for, the correct dose, side-effects and administer appropriately understanding whether the medicine is a critical medicine. The likelihood of incorrect administration and missed administrations is reduced.	Pilot work on ward 23 with training specific to drugs in use on ward. Needs to be expanded.	Training packs Evidence from attendance/completion of packs	A
		Missed & delayed doses	Trust wide	8.17	Empower nurses and other staff to challenge illegible handwriting – it is not acceptable to administer from a prescription if that prescription is not clear. The Trust Medicines Policy standard is that the medicine should be written clearly in BLOCK CAPITALS.	Executive Director of Nursing	Divisional matrons/practice development matrons/Chief pharmacist	15/10/2014	30/11/2014	All prescriptions are clear and patients receive the intended medicine on time.	Standards are listed in medicines policy. Specific empowerment campaign to be initiated. **Update 01.12.14** Included on posters. Documentation audit will provide evidence. **January 2015 -** Evidence of omissions due to poor handwriting **15.01.15 -** RAG rating reassessed GREEN on track	Medicines Policy Communication Documentation Audi	G
		Missed & delayed doses	Trust wide	8.18	Implement e-prescribing	Executive Medical Director	Chief Pharmacist	2010	2016	Provide electronic tool for highlighting missed doses and hence reduce frequency.	E-prescribing on ward 14 since Feb 2012. Ongoing work related to procurement of system in progress. **26.01.15 update:** Eprescribing awaits treasury outcome.	E- Prescribing system Meeting notes Roll out plan	A
		Missed & delayed doses	Trust wide	8.19	To produce and implement a Policy for Managing Staff Involved In Medicines Errors/Incidents.	Executive Director of Nursing	Martin Bullock, EC & M Divisional Matron	Feb-14	31/12/2014	The Trust will have a standardised system in place when a member of staff carries out a medication error.	The Policy is currently in the later stages of draft. The policy will include an algorithm for ward leaders and other clinical supervisors/managers to follow when a staff member carries out a medication error. Nursing staff currently undertake a medication pack adapted by PDM Katie Smalley depending on the type of error that has occurred. **Update 01.12.14** Currently going through committee process for consultation and approval. Must ensure is approved by Staff side and subsequently OD & Workforce. SM to send KL the policy. Policy to be agenda item on Ward Leaders Development Day 09.12.14 **February 2015 updates:** Policy going to JSPF next week for final ratification.	Meeting notes The policy Potential disciplinary hearing records Agenda from Ward \Leaders Development Day 9 December 2014	G
		Missed & delayed doses	Trust wide	8.20.	Implement regular audit of missed and delayed doses of medicines	Executive Medical Director	Chief Pharmacist and Divisional matrons	Oct-13	31/12/2014	For incidents around missed and delayed doses to be reduced across the Trust	Pharmacy carrying out monthly audits, there is to be a larger push and audits are to become fortnightly with nurses undertaking every 2 weeks. **Update 01.12.14** Action **COMPLETED**	Audit results	C
Safe	Hospital inspection	Documentation and Records	Trust wide	9	Ensure patient records are appropriately maintained in line with Trust policy and legislative requirements	Executive Director of Nursing/ Executive Medical Director	Divisional Teams.	01/07/2014	31/12/2014	Confidential patient documentation available to all relevant professionals to support consistency of treatment and interventions to maximise health outcomes	Trust policy for Standards for nursing record keeping has been reviewed setting out the expectations of the organisation. Developed a 'how to' guide for record keeping and frameworks which will help individuals to improve their record keeping. These will be printed and launched by 31/10/14. Developing a new documentation audit tool which is sensitive to the qualitative aspects of record keeping. Currently developing a proposal for a consistent approach to nursing document storage. Care & Comfort champions for each ward identified and focus group dates set. Use of accountability handover process to be audited as part of documentation audit. Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director commenced. Compliance in WHO checklist improved.	iCare2 Clinical Record Keeping – Policy updated	A
		Medical Admissions Documentation	Trust wide	9.1	Rationalise admission documentation (to improve data quality and standardise)	Executive Medical Director	ECM Divisional Director and ED Head of Service	01/09/2014	30/11/2014	Ensure admissions booklet is completed by ED and Acute Medicine in a consistent manner.	Review of structure and content of existing booklet to create areas for ED and Acute Medicine by EC&M. Revision of comorbidities page. Plan for completion by end of November. **05.12.14 Update** Progress monitored via Medical Managers Forum. Implementation monitored via Documentation audits **26.01.15 update:** Emergency Care documentation completed and will be audited.	Progress monitored via Medical Managers Forum notes. Implementation monitored via Documentation audits	A

		All nursing and medical records	Trust wide	9.2	Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director	Executive Medical Director/ Executive Director of Nursing	Patient Safety Fellow, Patient Safety Lead	11/08/2014	31/12/2014	Clinical teams own monthly safety round	Currently safety team review 1 ward per week. Weekly documentation ward rounds with Safety Team, Medical Director and Nurse Director commenced. **Update 01.12.14** Completed	Emailing confirming meetings take place along with copy of notes for meetings to date. Nursing Documentation Audit report 05.08.14 Notes from meeting.	C
		WHO Checklist	Theatres	9.3	Embed WHO checklist - especially the briefing before and after surgery. Team briefings before and after surgery mandatory from 1 July 2014.	Executive Medical Director	PC & S Divisional Clinical Director &/ Sharon Baxter	01/05/2014	01/01/2015 **Review:** **31/03/2015**	100% compliance by Dec 2014. Eliminate surgical never events.	Compliance dramatically improved in latest August audit to 70%. Compliance in who checklist improved. **Update 09.12.14** Marked improvement in step 1 (brief) and step 5 (debrief) in Safer Surgery; step 1 compliance 1% Apr14, 54% Sep 14 and 89% Oct 14, step 5 1% Apr 14, 31% Sep 14 and 75% Oct 14. **Update 15.12.14.** RAG rating reassessed as GREEN - as the Trust is currently achieving good standards of compliance, being monitored through the Quality Improvement Meeting. **February 2015 updates:** continues to be monitored monthly.	Ongoing audit Need evidence of monthly audit - WHO checklist	G
	HEEM visit	Consent and WHO checklist	T&O	9.3	Consent practices within T& O include appropriate markings and completion of WHO checklist.	Executive Medical Director	Divisional Clinical Director PC&S	01/11/2014	31/12/2014	Consent procedures are compliant.	Divisional meeting with Consultants. Meeting with CEO /MD and Consultants scheduled. **November** WHO audit progressing well. Good engagement with process and need to improve. This milestone has moved from red to amber. **Update 09.12.14** Weekly report to MD and monthly meeting between Division, team and Exec. **Update 15.01.15:** RAG rating reassessed as GREEN - as the Trust is currently achieving good standards of compliance, being monitored through the Quality Improvement Meeting. T&O Consultant is champion for WHO Surgical Checklist **February 2015 update:** Monthly consent audits in T&O are taking place.	Ongoing audit – T&O specific Evidence of Divisional meetings with consultants. Diary evidence of MD & CEO meeting T&O Consultants.	G
		WHO Checklist	Trust wide	9.4	To add the WHO checklist to the SFH intranet under Theatres sub-folder of the Clinical Policies and Guidelines intranet	Executive Medical Director	Clinical Policies and Guidelines Officer	30/09/2014	30/11/2014	Accessible checklist on the intranet	Sue Dale has liaised with Sharon Baxter to organise. **January 2015 -** WHO checklist is on the Trust's intranet **15.01.15 -** RAG rated reassessed BLUE - completed.	WHO Checklist on Intranet	C
		Consent Mental capacity assessment	Trust wide	9.5	Consent protocol updated, communicated and performance monitored. Appropriate completion of capacity assessment.	Executive Medical Director	Richard Hind, Chair Consent Ctte	30/07/2014	Ongoing	Remove variation in practice, adequately performance manage and investigate breaches	Consent policy updated and circulated to Service Directors. Datix reporting system updated. Consent training completion reviewed. Consent audit results circulated. Breach reporting system defined. Mental capacity assessment audited within documentation review.	Consent Ctte Ongoing Audit Consent policy Consent training plan/ timetable MCA audit	A
		Nursing Records	Trust wide	9.6	Develop standards for record keeping, in line with the NMC Record Keeping Guidance to ensure good record keeping is an integral part of nursing and midwifery practice.	Executive Director of Nursing	EC & M and PC & S; Divisional Matrons	06/06/2014	31/12/2014	The principles of good record keeping are well established and reflect the core values of individuality and partnership working.	Trust policy for Standards for record keeping has been reviewed setting out the expectations of the organisation. Developed a "how to guide" for recordkeeping and frameworks which will help individuals to improve their record keeping. These will be printed and launched by 31/10/14. Setting up workshops and roadshows to educate nurses and midwives about the revised policy and how they can improve their own record keeping. Ward Sisters to do targeted work with individuals who's recordkeeping requires improvement. **Update 01.12.14** Record Keeping Policy approve at CQ&GC November 2014. ICare 2 issued Friday 28.11.14. Booklet completed. PDM's training on policy. **Update 15.12.14** RAG rating reassessed as **COMPLETED**	The recordkeeping booklet. Improvement in the documentation audit results. Staff can verbalise what they have changed within their practice. Records & Record keeping policy. How to guide for record keeping. Evidence of launch. Evidence of workshops/ roadshows. Registers of attendees. Evidence from Ward leaders development day.	C

		Nursing Records	Trust wide	9.7	Develop a new documentation audit tool which is sensitive to the qualitative aspects of record keeping.	Executive Director of Nursing	Clinical Audit Officer, Alison Davidson, PDM	01/09/2014	01/12/2014	An improved documentation audit is utilised to audit nursing records, which acts as one tool to support improvement .	Tool developed and piloted for ratification at the next practice development forum. Aim is to be using the tool by 1st Nov 2014. Sisters to encourage all staff groups to undertake the audit. Registered nurses to undertake a self-audit of their documentation as part of the appraisal process. Create a SOP for the process including actions following the results of the audit. **Update 01.12.14** Audit tool developed but no yet utilised. **Update 15.12.14** RAG rating reassessed as COMPLETED	Audit tool and (results needed). Evidence of approval at Practice Development Forum. Evidence of self appraisal SOPs	C
		Nursing Records	Trust wide	9.8	To promote communication and sharing of information develop a standardised approach to nursing documentation storage, which is utilised in all inpatient areas.	Executive Director of Nursing	EC & M and PC & S Divisional Matrons supported by Denise Clay, PDM	15/10/2014	30/11/2014	A standardised approach to the storage of nursing documentation is evident across the Trust.	Identified and acknowledged risk of all patient documentation being at patient bedside. Cheryl Beardsley to articulate the risk to be entered on the trust risk register. New location for patient documentation to be communicated via divisional teams. Denise Clay with ward sisters from ECM & PCS to mock up folders to present at divisional sisters meetings. When agreed, to be rolled out by 31st Oct. **Update 01.12.14** Action Completed	Extract from Trust Risk Register Evidence of meeting 31 October 2014 Photo of new storage (documentation) Audit results to monitor standardization of documentation storage.	C
		Nursing Records	Trust wide	9.9	To help teams organise their workload and support improvement, ensure Care & Comfort rounding is consistently in place across the Trust.	Executive Director of Nursing	EC & M and PC & S Divisional Matrons supported by Kerry Smith, PDM	01/11/2013	30/11/2014	Care and Comfort embedded within the organisation	All ward areas have new C& C boards except 11&12 (due for delivery w/c 13/10/14. C& C champions for each ward identified and focus group dates sets. Website updated. **November** All ward areas have boards. Nil orally magnets delivered to all wards by K Smith. Explanation given to staff member/Nurse in charge to cascade to other staff. Notification sent out to all Ward Leaders to nominate champions. Focus groups taken place. Explanation poster to be developed for display alongside C&C board (aimed at patients &/or relatives.) Presentation to be prepared for Ward Leader meeting 20/1/15. **Update 15.12.14** No further updates **January 2015** - Education programme commenced. Audit to be undertaken in February. **February 2015 updates:** Care & Comfort audits to take place end of February 2015.	Observed practice List of Care & Comfort Champions Evidence of website updated Evidence/audit of C&C boards on all wards Evidence of C&C rounds Focus group notes Posters aimed at patients / families Presentation from Ward Leaderships meeting 20 January 2015	G
		Nursing Records	Trust wide	9.1	Strengthen accountability handover to promote individual accountability for the care of patients by the peer review and challenge of Registered Nurses looking after those patients	Executive Director of Nursing	EC & M and PC & S Divisional Matrons supported by Ultan Allen, PDM	30/03/2014	30/11/2014	Accountability sheets at the point of handover is signed to confirm all documentation and charts have been fully completed	Teaching aids and resources produced. Champions identified and supporting implementation into their area. PDM's supporting wards at handover times to identify best practice and support individuals. Challenges due to ward size & shift times at MCH & Newark being discussed at divisions. Adapting tool to work at other handover of care time's e.g. EAU to Ward, ED to EAU, theatre to ward. Use of accountability handover process to be audited as part of documentation audit. develop a consistent approach to printed handover sheets. **November** Teaching aids and resources produced. Champions identified within their individual areas who support implementation into their area. PDM's supporting wards at to identify best practice and support individuals, but continued challenge required by ward area leaders. Ward areas to embed best practice and focus on accountability process as opposed to the 'traditional handover'. Workforce change in progress at MCH & Newark occurring at divisional level. Challenges exist with regard to on-going consultation with ED to produce a usable, effective tool that will ensure optimal patient safety without impacting on patient flow. Close working with Theatres to ensure accountability component within every aspect of patient journey.' **Update 15.12.14** No further updates **January 2015** - Audit undertaken 23 January to be fedback to Quality Improvement Meeting on 2 February 2015. Traffic light standard developed to help ownership. Intense discussions with ED to establish handover sheet. February 2015 update: Accountability audit has been undertaken, 96.8% patients had a current accountability handover sheet, and 54.4% accountability handover sheets had two signatures in place. This will be re-audited regularly.	Accountability handover process and Escalation Care tool. Audit of Accountability handover.	G

DOMAIN - EFFECTIVE													
Effective	Hospital Inspection & Keogh	Recognition of the deteriorating patient	Trust wide	10	Ensure the processes for the recognition of deteriorating patients are robust and appropriately acted upon	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	Jun-13	31/01/2015	Staff are confident in the identification and management of patients whose condition is deteriorating. Patients are recognized and treated in a timely appropriate and safe manner.	Vital Pac rolled out across 23 inpatient wards. 1,500 staff have received training and are using the system. Serious Incidents in relation to failure to rescue reduced. Number of calls to Critical Care Outreach Team have increased since Vital Pac implementation, demonstrating earlier identification of deteriorating patients.	Flash Report	A
		Recognition of the deteriorating patient	Trust wide	10.1	Implement fluid management and nutritional screening modules to support recognition of the deteriorating patient and hydration needs (phase 2)	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/2014	31/01/2015	Patient records are consistently and accurately recorded ensuring hydration needs are met, communicated clearly and widely. Deteriorating patients proactively highlighted	Testing the modules in January 2015. **January 2015 update:** 12.01.15 - Testing the modules this month. Fluid balance will be available in to test in Q1 (2015/16). By March 2015 there will be an upgrade to the system, which will include Nutritional Screening. PDMs will have a focus week in February 2015 on the 'deteriorating patient'. Fluid balance focus week took place in December 2014. **February 2015 update:** New Fluid Balance audit being undertaken in February 2015.	Vital Pac Board minutes	A
		Recognition of the deteriorating patient	Trust wide	10.2	Consolidation and optimisation of the early benefits of Vital PAC (phase 1) through learning clinics, working with Critical Care Outreach Team, Practice development and clinical leads	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/2014	31/01/2015	Staff use all current "live" aspects of the Vital PAC system to a consistently high standard ensuring accurate record keeping and monitoring of acutely ill patients	**Update 09.12.14** Vital Pac Learning Clinic held 2.12.14. We consistently benchmark one of the highest performers in the completion of observations and accuracy of NEWS scores. A Vital Pac report format for ward level information will be implemented in Jan 15. Roll out of phase 1 to all sites scheduled for early 2015. **January 2015 update:** 12.01.15 - MCH and Newark Hospitals to have roll-out in January and February 2015. **February 2015 update:** Preparation of an updated version of VitalPac to educate Kings Mill users to take place in February. VitalPac project team produce weekly ward performance reports.	Notes from the leaning clinic event – 2 December 2014 Implementation plan for reports – January 2015. Implementation plan for 2015 rollout.	A
		Escalation of the deteriorating patient	Trust wide	10.3	Implement Vital PAC for Doctors (phase 2) including personal portable devices for staff and automatic escalation of deteriorating patients. Clinical charts and investigation results available in responders' hands to help instigation of treatment.	Executive Medical Director	Lisa Milligan/ Morgan Thanigasalam	01/06/2014	31/01/2015	Doctors and critical care outreach will be aware of deteriorating patients immediately based on clinical observations. More timely intervention leading to reduced mortality and morbidity.	Planned for December launch but currently delayed by Learning Clinic national issues. **Update 09.12.14** Expected to start implementation of alerting in early 2015.	Implementation plan	A
		Weekend mortality	Trust wide	10.4	Eliminate variation in weekday and weekend mortality	Executive Medical Director	Divisional Clinical Directors	30.10.13	Ongoing	Eliminate and sustain the difference in HSMR between weekdays and weekends	Currently weekend and weekday mortality are within the same range statistically	Monitored via Trust Mortality Group, Divisional bed to Board report will incorporate this. Reported to Board Quarterly.	A
		Infection Control	Trustwide	10.5.1	Implement a strengthened approach to infection, prevention and control through: · Establishing a county wide C Difficile task and finish group	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist	01/10/2014	31/12/2014 **Revised:** 19.01.15	Shared understanding and learning with community colleagues to understand and reduce the risk of colonization pre hospital admission. Medical engagement in RCA process.	Community wide task and finish group planned. **Update 09.12.14** Meeting with CCG to discuss Community C diff scheduled 19.12.14. Antibiotic Pharmacist met counterpart in community. New drug chart implemented with focus on antibiotic prescribing. Infection Control Mandatory Training for consultants over 90% Continuing deep clean programme with new fogging machine due on site next week. **January 2015 update:** 09.02.15 - meeting with Nurse Consultant to review actions, to attend the next Quality Improvement Meeting - 19.01.15 to assure the QI members. **26.01.15 update:** Patient Safety Colloborative reviewing progress in February 2015 following meeting with CCG. **February 2015 update:** Second meeting for the Joint CCG and SFH C-diff group is planned. Actions agreed at the meeting. External review of internal assurance measure to take place in February 2015 by Patient Safety Collaborative.	IPR September 2014 Quality & Safety. RCA Datix report, HCAI agenda & minutes. Evidence of county wide task & Finish Group – agenda/ ToR/ minutes. RCA evidence/ presentation. Job planning. Meeting notes from CCG meeting. New drug chart. Infection Control Mandatory training for Consultants. Deep Cleaning Programme. Examples of RCAs anonymised.	R

				10.5.2	Establishing and implementing clear escalation procedures to Medical Director & Nurse Director when breaches to IFC policy are repeatedly observed	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist	01/10/2014	31/12/2015	Medical engagement in RCA process	Expectation that either the relevant medical consultant or infection control lead should input to and attend RCA presentations. Review of infection control leads within job planning process and evidence at appraisal of attendance at relevant meetings. Good level of discussion in RCAs. **26.01.15 update:** RAC documentation needs to record clinical input which will include medical presentation. **February 2015 update:** Root Cause Analysis documentation is being reviewed in order to record the clinical input which will include medical presentation. This will strength the 48 hour rapid review reporting.		A
				10.5.3	Revisiting and strengthening membership of the IPCC to ensure clinical engagement	Executive Medical Director	Infection Control Nurse Consultant & Infection Control Microbiologist			Strengthen the membership of the IPCC to ensure clinical engagement	**26.01.15 update:** Nurse Consultant for IP&C reviewing ToR and membership **February 2015 update:** ToR and membership to be reviewed in order to increase clinical attendance.		A
Effective	Hospital Inspection	Access Targets	Urgent & Elective Care	11	Ensure safe, appropriate and timely flow of patients from admission to discharge, with the support of good bed management and discharge processes .Achieving and sustaining all 3 18 ww pathways	Director of Operations	Emergency flow Project lead	Dates	31.3.15.	95% sustained Reduced LoS Achieving & sustaining all 3 18 ww pathways.	Review of infection control leads within job planning process and evidence at appraisal of attendance at relevant meetings		R
		Patient Flow	Trust Wide	11.1	Improve the flow of emergency pathway with timely access to relevant services and discharge.	Director Of Operations	Emergency flow Project lead	01/04/2014	01/03/2015	95% sustained Reduced LoS Increased Pre-noon Discharge Rate	Perfect week held. Discharge team and social services co-located. Transfer to assess project in place. Board round training in plan to complete November 2014. Discharge lounge in place. **Update 16.12.14** ED Recovery plan in place with a 6 week trajectory to improve performance. Reassessed as RED because we are unable to achieve 95% performance.	Perfect Week report Transfer to Assess criteria Evidence/ audit Board Rounds Discharge Lounge utilisation Discharge Lounge policy ED recovery plan	R
		Patient flow	Trust wide	11.1.1	Improve discharge education and training of ward teams, ward leadership improvements	Director of Operations	Emergency flow Project lead	01/05/2014	30/12/2014	To reduce LOS (excluding 0-1 days) to 6 days	Work commenced in July with board round principles now in place on 20 wards across the Trust. Board round process written to ensure consistency & programme to embed this within ward culture. PID and status report for first stage engagement process with IDAT complete.	PID and status report for first stage. Engagement process with IDAT. Implementation of a new Jaundice pathway. Board Round process.	A
		Patient flow	Trust wide	11.1.2	Reviewed the working arrangements of the discharge team to ensure they are fit for purpose to support new ways of working for discharge	Director of Operations	Emergency flow Project lead	01/05/2014	01/12/2014	Supporting ward teams with patient discharges to reduce LOS to 6 days. Working as an integrated workforce with community and intermediate care teams to enable as many patients as possible to be rehabilitated in their own homes.	Discussions held between organisations to expedite these arrangements prior to winter 2014. IDAT structure reviewed and interviews for new roles at the end of October. 6 Day/week working in place from beginning of October. 7 Day/week working in place from December. **05.12.14 Update** CHP Clinical Assessor roles have now commenced to work in collaboration with IDAT to expedite discharge and improve patient experience.	PID and status report for first stage. Engagement process with IDAT. Implementation of a new Jaundice pathway. IDAT structure review and evidence of new roles appointed. Rota to demonstrate 7 day working. Evidence of Clinical assessors in place.	G
		Patient flow	Trust wide	11.1.3	Open a substantive discharge lounge	Director of Operations	Divisional Team EC&M	01/06/2014	27/10/2014	Discharge lounge open and fully staffed increase morning discharges by 50%. X number of patients leave ward beds by 10am	Substantive discharge lounge opened in clinic 9 at the beginning of October 2014.	Discharge lounge policy. Utilisation report.	C
		Patient flow	Trust wide	11.1.4	Better Together implementation – supporting the prism model of working and utilising community capacity	Director of Operations	Emergency flow Project lead	01/07/2014	27/12/2014	Reduced LOS to 6 days (excluding 0-1 days) >95% 4 hour access target consistently .Reduced no's of patients over 20 days in hospital	Teams now in place in EAU & Ward 52 and will commence work in Ward 35 week commencing 20 October. **November** Attendance of CHP colleagues within areas Urgent Care Working Group Papers and SRG Plan. **Update 12.12.14** Plan New Clinical Assessors in place from Dec 8. Full capacity PRISM model being developed staffing extended temporarily using agency.	LoS Flash Report for Improvement Plan. Evidence of teams on EAU, Ward 35, Ward 52. Urgent care working group papers. Clinical assessors.	A

		Patient flow	Trust wide	11.1.5	Better Together implementation – delivery of transfer to assess	Director of Operations	Emergency flow Project lead	01/07/2014	27/12/2014	Reduced LOS to 6 days (excluding 0-1 days) >95% 4 hour access target consistently. Reduced no's of patients over 20 days in hospital.	Teams now in place in EAU & Ward 52 and will commence work in Ward 35 week commencing 20 October. Working group has now mapped out both community and bed based transfer to assess schemes to facilitate implementation prior to winter. **November** Attendance of CHP colleagues within areas Urgent Care Working Group Papers and SRG Plan. **Update12.12.14** Plan transfer to assess service commenced Dec 8. Full service implementation by 27/12 on track.	LoS Flash Report for Improvement Plan. Evidence of working group, membership, agenda, notes. Criteria for Transfer to Assess.	G
		Patient flow	Trust wide	11.1.6	Using the directory of ambulatory care, Increase the number of conditions admitted to the Clinical Decisions Unit	Director of Operations	Emergency flow Project lead	01/02/2014	01/03/2015	>95% 4 hour access target consistently. Additional 5 ambulatory pathways in place. Reduced LOS Improved patient experience.	A new jaundice pathway has been introduced during Q1 and work is ongoing. Abnormal bloods, hypertension, physiotherapy and psychiatric pathways drafted and circulated for consultation	Implementation of a new Jaundice pathway. Plan for further pathways	G
		Patient flow	Trust wide	11.1.7	Undertake a full review of the bed model to provide improved planning.	Director of Operations	Emergency flow Project lead	06/06/2014	29/09/2014	Support areas to identify reduced LOS. Support pathways to Improve patient experience.	Bed Review Completed: two versions ide defying likely impact of schemes and support planning.	Bed Review Paper presented to the Executive Team	C
		Patient flow	Trust wide	11.1.8	Review, plan and deploy a medical daycase reducing dependency on inpatient capacity for elective (and in some case non-elective) procedures	Director of Operations	Emergency flow Project lead	06/06/2014	12/12/2014	Reduced LOS >95% 4 hour access target consistently. Improved patient experience.	Medical daycase options are now completed and trial implementation is taking place during October 2014. The unit will be based within Clinic 9 to ensure it is not impacted by any pressure. Recruitment of a Clinical lead for this area is critical. **Update 12.12.14** Recruitment of staff unsuccessful, and insufficient in first round from November. New staff model being piloted in early January. Reassessed as RED. **January 2015 update:** Department Leader in place; reviewing pathways.	Medical Daycase Model/SOP. Recruitment plan, advert, interview dates, appointments. Medical Day Case Unit policy. Medical Day Case Unit rota.	R
		Patient flow	Trust wide	11.1.9	Undertake a review of escalation processes and site management arrangement to ensure the organisation consistently responds during pressure and site management is optimal.	Director of Operations	EC & M Divisional Manager	01/07/2014	07/11/2014	>95% 4 hour access target consistently. Improved patient experience. Reduced admissions & readmissions. Less pressure felt across clinical services.	Escalation procedures reviewed and being operationally road tested. Full operational guide for on-call and site managers written and distributed. Monthly communication cells held with on-call and site managers to discuss and resolve issues and improve services. **Update 05.12.14** Escalation processes reviewed and implemented. Further enhancements to improve processes to support ED have been agreed by the capacity group and revisions to escalation will be piloted from w.c. 8.12.	Revised escalation process and SOP. Silver on-call framework. Capacity and Flow meeting notes.	A
		Out of hours	Trust wide	11.1.10	Review of Hospital At Night activity to identify resource gaps	Executive Medical Director	EC & M Divisional Clinical Director	01/06/2014	27/10/2014	Ensure cover is safe and distributed appropriately	Audit completed Aug 2014 to be presented at TMB. HEEM review in August presented at Medical Managers	Audit and Findings from Dr A-L Schokker. Report on H@N	C
		Patient Flow	Newark	11.1.11	Review Newark and Kings Mill Trauma protocol	Executive Medical Director	ED Head of Service	01/092014	07/11/2014	To ensure these reflect the skills and knowledge of the teams. Reviewed by ECM	Review in progress to be completed by the end of October. **Update 15.12.14** RAG rating reassessed as COMPLETED	Trauma Protocol. Newark MIU Major Trauma Pathway. Speciality Clinical Governance Monthly report for 19.09.14 and 17.10.14.	C
		Patient Flow	Trustwide	11.1.12	Review of the Medical Outlier Policy and embed the Medical Outlier Decision Tool into the clinical areas	Executive Director of Nursing	EC&M Divisional Matron		31/03/2015	To ensure patient safety	**February 2015 update:** Policy was ratified in January 2015, and audited for compliance. The audit demonstrated 19.% compliance, the Duty Nurse Managers are reinforcing this tool as a mechanism of patient safety in moving patients to outlying beds. This audit is planned to take place again at the end of February 2015.	Medical Outlier policy Medical Outlier audits	A
				11.2	Achieve and sustain all 3 18 ww pathways	Director of Operations	EC & M PC&S, DNR Divisional General Managers		31.3.15.	Achieving & sustaining all 3 18 ww pathways	18 weeks programme of work in place to sustain improvements in problematic pathways, T & O, ophthalmology & urology	Evidence of RTT achievement	A

		Referral to Treatment Time	Trust wide	11.2.1	The Trust must achieve and sustain all 3, 18 week pathways by ensuring Capacity and demand analysis for all key specialties, especially those 8 specialties not currently meeting 18 ww access targets, robust PTL arrangements, full pathway review of failing specialties, adherence to the Trust Access Policy and different methods of improving and developing 18 weeks knowledge	Director of Operations	EC & M PC&S, DNR Divisional General Manager	01/05/2014	30/09/2014	>90% RTT – Admitted – achieve & sustain. >95% RTT – Non-admitted – achieve & sustain. > 92% incomplete pathways – achieve & sustain.	Capacity & demand analysed and more robust arrangement in place for enabling continual review using the IST capacity & demand tool. Substantive recruitment where activity is to sustain and insufficient capacity following improvement work. Clinicians currently supporting capacity gaps with additional sessions to meet demand. The weekly PTL meetings are now reviewing all patients to expedite their pathways & ensure issues are dealt with to enable 18 week achievement. This includes ensuring adherence to the Trust Access Policy. The Trust is on track for delivering all 3 pathways by the end of September. An e-learning package for 18 weeks is currently under review.	Capacity and demand summaries. Diary screenshot. Weekly RTT trajectory info taken to GM meetings. 18ww RTT eLearning package.	C
		Referral to treatment time	Trust wide	11.2.2	Complete reviews with National Intensive Support Team (IST) to improve the 18 week pathways, including a full review of cancer pathways	Director of Operations	Director or Operations	01/07/2014	02/06/2014	Full compliance with IST recommendations	The IST has now signed off the Trust with a small number of minor issues e.g. to return to review post implementation of the new PAS system to be completed	SFHT Intensive Support Team – Closure Report.	C
		Administration & Information System	Trust wide	11.3	Ensure that the clinical administrative model is fit for purpose and meeting relevant KPIs and that information systems support this model.	Director of Operations	Divisional General Managers	01/03/2014	02/02/2014	Typing turnaround <10 days. 80% of telephone calls to be answered within 1 minute. Supporting specialty achievement of RTT by tracking patient pathways. Improved accuracy of data on inpatient consultant allocation. Improved reporting and access to business intelligence. Reduced waste/time spent on notes/administration.	Full review of all specialties, including Newark has been completed by the Service Improvement team and all clinical teams were asked to participate in the review feedback. The recommendations are being actioned – to complete by November. Medical specialties working extremely well, surgical specialties still have capacity issues with sustaining KPIs but significant success in trauma & orthopaedics. Additional supervisory support in place for surgery to sustain and improve. Additional training is taking place to support clinical teams.	PPC Future state figures. PPC review by Service Improvement Team. Evidence of recommendations being achieved. Evidence of training.	G
		Patient information system	Trust wide	11.3.1	Optimise benefits of PAS implementation: Single system for tracking named consultant, and for case note tracking, and improved business reporting formats	Executive Medical Director	Executive Medical Director	01/05/2014	30/10/2014 **Revised:** 31.03.15	Consistent and accurate consultant attribution at entry to and transfer from EAU	Go Live 3.10.14 **26.01.15 update:**Additional resources identified, Medway PAS still not fully implemented . **February 2015 update:** see 1.7	PAS implementation plan. Update report	A
		Administration	Trust wide	11.3.3	The Trust is keen to ensure that all contacts from the Trust are timely and professional and when attending the Trust their appointment is not delayed and all relevant information is available.	Director of Operations	D & R Divisional Manager	01/05/2014	31/10/2014	95% of cases notes to be available for short notice (2ww) clinics. 98% of cases notes to be available for planned clinics. Improved patient experience of outpatient services	All clinic booking rules have been reviewed and amended with clinician involvement to limit delays in clinic. One-stop services have been introduced in vascular to reduce delay in clinic and in RTT pathways. Additional work is ongoing as part of the elective transformation programme to use alternative models of follow-up than traditional face to face to improve patient experience e.g. Further work is continuing with clinics who overbook to plan this more effectively. **Update 01.12.14** Cross Divisional Group reviews cancellations at short notice. Clinicians are contacted at the beginning of the week to ensure they are aware of and attending clinics as booked in order to reduce short notice cancellations.	Missing notes and clinic cancellations. Missing notes improvement meeting. Evidence of reviewed booking rules. Evidence of 1 stop clinics. Evidence of alternative follow-ups. Notes from divisional group meetings. Evidence of short notice cancellation clinics.	A
		Administration	Trust wide	11.3.4	Improve control of booking to provide sufficient time to enable notes availability, timely notification of appointments to patients with performance managed at divisional performance meetings	Director of Operations	Access, booking & choice manager	010/5/14	31/10/2014 **Revised** TBC	95% of case notes to be available for short notice (2ww) clinics. 98% of case notes to be available for planned clinics<DNA. Improved patient experience of outpatient services.	A full project team has been established and a process agreed with divisional teams for booking. The only exceptions will be 2ww where capacity has to be managed more flexibly. KPIs agreed and will form part of divisional performance from November. **Update 01.12.14** Cross Divisional meeting has developed KPI's – currently not being achieved. **Update 16.12.14** A Booking workstream has commenced led by Steve Jenkins. A project scope is in development.	Project team action plan – ToR, membership. Evidence as part of divisional performance meeting. Booking workstream. KPIs	G

Effective	Hospital Inspection	Training	Trust wide	12	Improve delivery of mandatory and targeted training for staff	Executive Director of Human Resources	Executive Director of HR	01/04/2014	31/03/2015	Staff receives relevant supervision, appraisal and development to enable them to perform effectively in their roles and support delivery of trust strategic priorities. Mandatory training targets are achieved.	OD & Workforce Committee receive reports on approaches of training into practice. Employee supervisor Self Service launched. Mandatory training e-learning workbooks launched.		G
		Training in Practice	Trust wide	12.1	Establish a task and finish group to identify appropriate metrics of how staff use their knowledge from training to improve the quality of patient care	Executive Director of Human Resources	Deputy Director of Training and Education	01/08/2014	27/10/2014 **Revised:** 06.01.15	Evidence of staff utilising their knowledge from training in the provision of high quality patient care	A task and finish group has been established and has met and agreed an approach to measure the impact of mandatory training on patient care. A new training audit will commence in November 2014 and will feedback into the Workforce and OD Committee on a 6 monthly basis . **26.01.15 updated:** Completed 06.01.15	Task & Finish Group membership – aims & objectives. Training audit.	C
		Appraisal	Trust wide	12.2	Provide accurate appraisal data to ensure performance management of compliance rates	Executive Director of Human Resources	Deputy Director of Human Resources	01/08/2014	31/12/2014 **Revised:** 06.01.15	Confidence that appraisal data is accurate.	Evaluation of current data to provide assurance of accuracy of data. **26.01.15 updated:** Completed 06.01.15. RAG rating reassessed		C
		Mandatory Training	Trust wide	12.3	Provide annual personalised mandatory training report for all employees outlining what their mandatory training requirements/ refresher periods are, what training information is on the OLM system and when their current training expires. Supporting individual compliance and remind staff to arrange attendance	Executive Director of Human Resources	Deputy Director of Training and Education	01/08/2014	30/11/2014 **Revised:** 26.01.15	Improved mandatory training compliance rates. Improved personal accountability for completion.	Additional resource has been engaged to complete this project and personalised training reports have begun to be sent to staff. **November** Personalised letters have begun to be sent out to all staff starting at the end of October. By the 30th November all staff will have received their personal mandatory training letter which should help to improve compliance with mandatory training. **Update 15.12.14** Reassessed as COMPLETED	Examples of individual reports	C
		Mandatory Training	Trust wide	12.4	Enhance electronic monitoring systems - Employee Self Service	Executive Director of Human Resources	Deputy Director of Training and Education	01/04/2014	29/12/2014 Revised 31/03/15	Improved real time mandatory training data, improved mandatory training completion.	Employee Self Service was launched in April 2014 to enable all staff to access their own staff training record and personal details, including mandatory training. Additional resources have been secured to develop supervisor self service to enable managers to access real time and instantaneous staff mandatory training information. This is planned for launch in January 2015. **26.01.15 update:**Reviewed and remains on track. Rolling out training on how to access Employee Self Service.		G
		Mandatory Training	Trust wide	12.5	Introduce mandatory training workbooks as e-learning - enabling - enabling improved access 24/7	Executive Director of Human Resources	Deputy Director of Training and Education	01/06/2014	31/12/2014 Revised 02/02/2015	Improved mandatory training compliance. East of access to mandatory training.	Mandatory training e-learning workbooks have been developed and will be piloted in 4 areas from 16/10/14 for one month. This will then be evaluated and launched trust wide. **7 January 2015** Workbooks launched by 31 January 2015 **15.01.15 -** RAG rating reassessed as GREEN - on track **02.02.15 update:** RAG rating reassessed - BLUE completed.	Report on trial	C
		Mandatory Training	Trust wide	12.6	Target medical training for fire lectures, C-diff and MRSA	Executive Medical Director	Divisional Clinical Directors	01/04/2015	30/11/2014	>90% compliance	Compliance rates were 30-40% in June, increased to over 70% in September after Medical Matters publicity and now the residual names are being targeted. **Update 09.12.14** Achieved for C diff and MRSA **15.01.15 -** RAG rating reasessed as GREEN - on track **26.01.15 -** Now chasing individual Consultants. At the end of December 2014 MRSA 94% and C-difff 91% compliance. **February 2015 update:** RAG rating reassessed - BLUE completed	Medical matters bulletin for target medical training for fire lectures, c-diff and MRSA by division sent to GP's. Training dates for Safeguarding & Mental Capacity/ Prevent.	C
Effective	Hospital Inspection	Individual Staff Performance	Trust wide	13	Strengthen the processes to enhance staff performance; ensuring the availability of skilled and competent staff	Executive Director of Human Resources	Executive Director of Human Resources	01/04/2014	31/03/2015	The appropriate numbers of skilled and competent staff are deployed across the Trust	NHS Medical Appraisal Policy implemented and distributed to all Medics. Eight Practice Development Matrons have commenced in post. New preceptor programme commenced Sept 2014. Work in progress on Stress management. Revised Appraisal policy agreed. Incremental progression protocol agreed.		G
		Medical Appraisal	Trust wide	13.1	Strengthen Medical Appraisal – to ensure appraisal processes are consistent and performed to a high standard	Executive Medical Director	Executive Medical Director	01/01/2014	02/06/2014	To ensure all medical staff are consistently and professionally appraised annually	Excellent medical appraisal rate (90%+) implemented the NHS England Medical Appraisal Policy and distributed to all medics. Written to all medics confirming their new appraisal date as we have spread appraisals out across the year (which has been welcomed). Reinvigorated the Appraiser Forum which has excellent attendance and this will enable delivery of the Framework for Quality Assurance **February 2015 update:** Medical Appraisals are consistently above 90%, currently in January 2015 at 98%.	Health and Safety Committee Minutes 09.10.14. HoS training, job descriptions. Evidence of medical appraisal. Letter to Consultants. Appraisal Forum.	C

	HEEM	Medical trainees	ED & T&O	13.2	Improve working relationships between ED and T & O	Executive Director of Human Resources/ Executive Medical Director	Divisional clinical director PC&S and Head of Service ED	20/10/2014	31/03/2015	Reported positive working relationships between ED staff and T&O trainees	HEEM feedback – action plan developed. Trauma Pathway review completed. **26.01.15 -** HEEM action plan agreed and submitted, regular meetings with T&O Consultants to monitor actions/delivery - next meeting planned 27.01.15. **February 2015 update:** HEEM action plan is being monitored through OD & Workforce Committee.	Monitored via LETB and GMC surveys at Workforce Ctte. Reviewed at Junior Doctor Forums. HEEM feedback & action plan. Trauma pathway review.	G
	HEEM	Medical trainees	Trustwide	13.3	Address safety concerns raised by HEEM visit	Executive Director of Human Resources/ Executive Medical Director	Deputy Director of Training & Education	20/10/2014	Next monitoring HEEM visit November 2015	HEEM monitoring lifted	Review of ICE results concerns by Patient Safety Fellow and NHIS to identify issues and training required. Review by cardiology Head of Service; consultant vacancies recruited. **Update 09.12.14** Action Plan in place. **26.01.15 update:** Delivery continues to be monitored. RAG rating reassessed to GREEN. **02.02.15 update:** Action plan monitored montly by OD & Workforce Committee, reamins on track to deliver at deadlines to meet HEEM timescale.	ICE results review. Cardiology review – Consultant vacancies. Action plan	G
		Appraisal	Trust wide	13.4	Review appraisal documentation to ensure fit for purpose and incorporates Quality for All Values	Executive Director of Human Resources	Deputy Director of Human Resources	Jul-14	24/11/2014 Revised 31/12/14 **Revised: 02/02/2015**	Appraisals are undertaken in a timely manner and reflect the values of the organisation. New appraisal documentation and policy, incremental pay progression policy support embedding our values.	Task and finish group established to complete process review. **November** Appraisal and Incremental pay policy reviewed to reflect quality for all, associated paperwork reviewed and managers toolkit under development. To be presented at Policy sub group JSPF 09/12/14. **January 2015 -** RAG rating reassessed as BLUE - completed.	Task & Finish group – notes. Appraisal & incremental pay policy. Minutes from JSPF 9 December 2014.	C
		Job Planning	Trust wide	13.5	Review Job Planning Toolkit to ensure it remains fit for purpose and supports delivery of contracted activity and 7 day services	Executive Medical Director/ Executive Director of Human Resources	Executive Medical Director/Executive Director of Human Resources	11/10/2014	31/03/2015	Job planning processes which support delivery of safe patient services in a cost efficient manner.	7 day services project has identified areas to be enhanced in relation to Job Plans. **Update 09.12.14** Dialogue with LNC re 2015-16 toolkit with business case for introduction of the Allocate e system in Mar 2015 for rostering, ;eave planning and job planning. **15.01.15 -** RAG rating reassessed as GREEN, on track **26.01.15 -** Project Manager to implement the Allocate system has been recruited. Meeting arranged for the 9 February 2015 to launch the project. **February 2015 update:** Allocate are on site training staff, project manager has been appointed who has previously worked with Allocate software.	Job Planning Toolkit. 7 Day service in job plans. Plan & implementation of Allocate esytem	G
		Practice Development	Trust wide	13.6	Implement a new structure of Practice Development Matrons to support staff in clinical practice to deliver excellence in practice	Executive Director of Nursing	Head of Practice Development	01/07/2014	01/09/2014	A full complement of Practice Development Matrons who support developments and excellence in practice	Eight practice development matrons have commenced in post. They are all allocated to a group of wards, whilst having individual responsibility for leading on documentation, medicine management, policy underpinning practice, development of a journal club, clinical supervision, improving preceptorship I international recruitment, education and training, falls, dementia care, evidence based practice and the RCN leadership programme.	Structure chart. Workload	C
		Preceptorship	Trust wide	13.7	Implement a new preceptor programme for RN's with increased support and focus on medicines management, access to electronic systems and discharge planning	Executive Director of Human Resources/ Executive Director of Nursing	Deputy Director – Training & Development,, Preceptor Support Nurse	30/09/2014	31/12/2014	A modern preceptor programme that supports the development and retention of newly qualified RN's.	New preceptor programme commenced Sept '14. Support sessions for preceptee are well attended. Task and finish group to develop new preceptor documentation established. Focus groups being established to provide peer support and gain intelligence for further development of the programme. Examining the feasibility of student nurses undertaking IV training pre reg to support preceptees on qualification. **15.01.15** - RAG rating reassessed as BLUE completed	Copy of preceptor programme. Task & Finish Group – notes. Focus group notes. Audits / evaluations	C
		Clinical supervision	Trust wide	13.8	Implement clinical supervision opportunities for nursing staff across the Trust	Executive Director of Nursing	Head of Practice Development	01/06/2014	31/12/2014	All nurses have the opportunity to access clinical supervision	Guidelines for Clinical Supervision to be agreed at October Practice Development Forum. Website created. Scoped current supervisors within the Trust. Training days for new supervisors on 16th and 22nd September. Making links with Chesterfield and NUH to create supervisors outside the organisation for senior staff. **Update 01.12.14** Presented at CQGC November 2014 and uploaded to intranet. **February 2015 update:** Clinical supervision website is operational. Clinical Supervision guidelines has been ratified. There are 12 identified clinical supervisors, and are working with other organisations to identify further opportunities.	Clinical Supervision guidelines. Training day agenda for supervisees. Evidence of external links for supervision externally. Clinical Quality & Governance Committee November 2014.	G

		Absence Management	Trust wide	13.9	Continue roll out of Stress Education Programme (for managers and staffs - in groups or individually) and effective signposting for managers and staff.	Executive Director of Human Resources	Rebecca Garner Senior OH Nurse	01/06/2014	30/03/2015	Improved management of stress related absence and improved awareness of symptoms of stress to allow early intervention.	Support provided on request with resilience training. **26.01.15 update:** Reviewed activities to reduce stress remains ongoing and monitored through the Health & Wellbeing Group **February 2015 updates:** Stress Management Focus Groups hae been taking place across the Trust regarding approaches to Stress Management in relation to staff. Interim updates were considered by the H&S Committee in January 2015, and a report was considered by OD & Workforce Committee in February, and further work was requested to triangulate the results with the outcomesfrom the staff survey. An action plan will then be developed and presented to the committee in March 2015.	Minutes from OD & Workforce Committee	G
		Absence Management	Trust wide	13.10.	Develop and implement mechanism for Individual Stress Risk Assessment - ensuring appropriate support plans are developed	Executive Director of Human Resources	Health & Safety Manager	01/08/2014	31/10/2014 **Revised:** 15.12.15	Stress risk management tool assists in the early identification and management of stress related absence.	Risk assessment tool developed and presented to health and safety committee on 9/10/14. **November** Stress Risk assessment form Approved for use at Health and Safety Committee on 9/10/14. **Update 15.12.14** Reassessed as COMPLETED	Individual Stress Risk Assessments. Sickness absence toolkit. Health & Safety Committee.	C
		Absence Management	Trust wide	13.11	Enhance management development opportunities to incorporate recognition of stress and development of support mechanisms	Executive Director of Human Resources	Deputy Director – Training & Development	01/06/2014	29/12/2014 **Revised:** 26.01.15	Manager competently identify stress related issues and respond accordingly	New increasing personal resilience and managing stress module embedded into Trust Leadership Programmes. Managing stress also incorporated into Managing Absence Training. **26.01.15 update:** Updated COMPLETED. RAG rating reassessed.	Trust Leadership Programme. Evidence from managing absence training.	C
Effective	Hospital Inspection	Clinical Pathways	Trust wide	14	Improve the effectiveness and responsiveness of services through the use of evidence based clinical pathways	Executive Medical Director	EC & M and PC & S Divisional Clinical Directors	01/05/2014	31/12/2014	Clearer guidance and improved pathways of care in line with evidence based guidance.	Pathway review of 3 surgical specialties underway. Elective transformation programme in place. EC&M reviewing Newark pathways and all 'external transfer protocols visible on the intranet.		A
		NICE Guidance	Trust wide	14.1	New process for NICE Guidance agreed	Executive Medical Director	Clinical policies lead	01/06/2014	27/10/2014	Approved NICE Policy and Process	Policy and process approved at CQ&GC in September and shared with Quality Committee at the September meeting.	NICE policy. New process will be evidenced through governance meetings. Clinical Quality & Governance Committee September 2014.	C
		Surgical Pathways	Planned Care & Surgery	14.2	Comprehensive review of pathways: T+O Urology Ophthalmology Pre Operative Assessment Review of DayCase and Surgical Assessment Unit processes.	Executive Medical Director	Divisional Team, Planned Care & Surgery	01/06/2014	Ongoing	Safe and efficient access	Agreed and in progress from June 2014 – includes access targets and patient pathway improvement (including recovery delays). Engagement events for T+O and Urology held in September. Reported via Elective Programme Board and Transformation Steering Group **26.01.15 update:** Elective Care Transformation team undertaking review of services **February 2015 update:** Completed pathways by Cardiology, Respiratory, Gastroenterology, Endocrinology, Neurology, ENT, Paediatrics, Obstetrics and Gynaecology are signed off and communication plans agreed.	Quick wins and clinical risk analysis. Attendees at Urology event. Engagement event T&O. Minutes from Transformation elective Programme Board.	G
		Newark MIU Pathways	Newark	14.3	Standardise Newark MIU pathways	Executive Medical Director	ED Head of Service	01/06/2014	27/11/2014	To ensure these are consistent with KMH pathways and reflect the skills and knowledge of the team. Reviewed by ECM	Reviewed by Emergency Care and Medicine. Meeting with GPs and CCG re future of Newark front door	MIU review Evidence of GP/CCG meeting at Newark Hospital	A
		Care Pathways	Trust wide	14.4	Standardise protocols for transfers 'out of Trust to tertiary care'	Executive Medical Director	EC & M and PC & S Divisional Clinical Directors	01/06/2014	27/11/2014 **Revised:** 15.03.15	Safe transfer and handover of sick patients for ongoing care	Pathways visible on intranet in clinical areas and communicated to relevant external agencies. Version control **26.01.15 update:** Pathways are currently being reviewed and standardised. Plans to upload the pathways by mid March 2015.		A
				14.5.1	Standardise an action plan for each investigation to be shared with divisions and completed with the Safeguarding Board	Executive Medical Director	Executive Medical Director	16/02/2015	TBC	To ensure a consistent approach to safeguarding across the Trust	**16.02.15 update:** action added to the Quality Improvement Plan		A
				14.5.2	Standardise reporting format to the Safeguarding Board to track activity overtime	Executive Medical Director	Executive Medical Director	16/02/2015	TBC	To ensure a consistent approach to safeguarding across the Trust	**16.02.15 update:** action added to the Quality Improvement Plan		A
				14.5.3	Review of the current Safeguarding service at Sherwood Forest Hospitals NHS FT	Executive Medical Director	Executive Medical Director	16/02/2015	TBC	To ensure a consistent approach to safeguarding across the Trust	**16.02.15 update:** action added to the Quality Improvement Plan		A
Caring	Hospital Inspection	Family & Friends (F&F)	Trust wide	15	Increase patient feedback by collating a higher level of Family and Friends responses.	Executive Director of Nursing	Deputy Director of Nursing	01/06./4	31/10/2014	To increase the overall response rate for F & F to 50%	Currently the Trust uses a paper system for obtaining responses to F& F's. Failure to provide additional provision for patients to record their views is limiting our ability to increase our response rates. The Trust is currently tendering for an external provider to provide a provision for: · NHS Staff F & F plus quarterly pulse surveys · NHS Patient F & F plus quarterly pulse surveys · Doctor revalidation feedback · Registered Nurse revalidation feedback		A

		Family & Friends (F&F)	Trust wide	15.1	Secure a system which meets NHS England FFT requirements , provides user friendly survey methods whilst providing a real time reporting system which drills down to individual wards and departments	Executive Director of Nursing	Deputy Director of Nursing	01/06/2014	31/10/2014 **Revised** 31/03/2015	Achieve the internally set response rate of 50%	Currently in the final stages of tendering for a provider to facilitate FFT (staff and patient). The cost is currently far greater than planned. **November** Procurement exercise reinitiated as OJU limits exceeded in first round of tendering. The Trust is implementing its own promotion material to increase its response rate. At the end of October 2014, the response rate was 40%- being the best recorded rate since F&F commenced. Further work is required in Maternity and ED. Use of tools like IPads and stands are being explored. This milestone is reassessed as Amber. **Update 16.12.14** From an organisational perspective we have been unable to secure a provider to facilitate FFT across the trust. Following a meeting with the current provider we have clarified that the current contract for provision of FFT will expire January 16. We are therefore working with the current provider in the interim to increase our response rates across all areas. **February 2015 update:** Continue to work with current providers whilst considering the options currently available. Rebranding of all the FFT infromation, posters, banners and electronic signage distributed throughout the Trust. Implementation of the pilot of the Android App for FTT in ED and OPD from February 2015.		A
			Emergency Department	15.2	Implement ED focused F&F action plan	Executive Director of Nursing	Deputy Director of Nursing	01/07/2014	30/09/2014 **Revised** 01/03/2015	Improve ED response rates	Meeting convened with Department Leader and Matrons to discuss and increase overall response rates. CQUIN workers deployed to ED to support and improve response rates. We have recently met with the current provider in order to discuss ways in which we can increase our FFT response rate in ED. We have requested some technical advice form the provider regarding the installation and compatibility of an app in order to secure responses electronically either via an IPAD or Android tablet. We have in addition redeployed our CQUIN workers to ED in order to support an increased uptake of FFT and have via our comms team produced a series of posters and banners to promote patient feedback. As part of the overall communication strategy we are liaising with the local press and social media to increase overall awareness and uptake of FFT. **February 2015 update:** Dedicated workers supporting ED to improve response rates. Customer Service Excellence Training has been delivered to 9 ED staff.	Action plan	G
		End of Life	Trust wide	15.3	Develop a prospective survey to capture the bereaved relative's experience	Executive Director of Nursing	Head of Chaplaincy, End of Life, Nurse Specialist	01/12/2014	31/10/14 and ongoing	Bereaved relatives feedback is used to assess the progress and delivery of the end of life strategy	Survey commenced 13/10/14 **05.12.14 Update** The survey has been underway since 13th October. The Bereavement Centre are obtaining the relatives consent to participate and questionnaires are being sent out 8 weeks post bereavement. It is anticipated that a quarterly report will be generated to identify areas for improvement.	Survey	C
DOMAIN - RESPONSIVE													
Responsive	Hospital Inspection	End of Life	Trust wide	16	End of Life Care is responsive to the needs of our patients (and their carers), delivered by competent, knowledgeable staff who respect and meet individual preferences.	Executive Director of Nursing	Mark Robert, Consultant, , Lead Nurse for End of Life & Cancer	01/07/2014	30/11/2015	Patients requiring end of life care receive a responsive service that is timely and personalised to their needs	End of Life strategy developed – currently being finalised for consultation. New guidelines and documentation implemented to replace the Liverpool Care pathway. A further 2 wards have commenced the AMBER care bundle, 2 more wards have registered on the Gold Standards Framework in Acute Hospitals Programme and the service specification for fast track / rapid discharge is being reviewed. **November update (received after TB)** End of Life strategy has been developed and is being taken to the Trust Board in December. New guidelines and documentation implemented to replace the Liverpool Care pathway. A further 2 wards to commence the AMBER care bundle in January 2015, 2 more wards have registered on the Gold Standards Framework in Acute Hospitals Programme and the service specification for fast track / rapid discharge is being reviewed.		A

		End of Life	Trust wide	16.1	Produce an end of life care strategy to support transforming end of life care.	Executive Director of Nursing	Mark Robert, Consultant, , Lead Nurse for End of Life & Cancer	01/07/2014	30/11/2014	Strategy agreed and implementation evidenced through an improved profile and understanding of end of life care	End of Life Strategy produced which is linked to the six-steps within the National End of life Care Pathway. It is in accordance with the National Transforming End of Life Care in Acute Hospitals Programme framework. Currently being reviewed by End of Life team to prepare for consultation. Nurse Expert (national) currently assessing strategy to ensure it dovetails national direction and thinking. **November update (received after TB)** End of Life Strategy produced which is linked to the six-steps within the National End of life Care Pathway. It is in accordance with the National Transforming End of Life Care in Acute Hospitals Programme framework. Plans are in place to take to Trust Management Board in December for ratification then it will be launched across the Trust. **February 2015 updates:** End of Life strategy was presented to TMB in January with some amendments. The End of Life website is being refreshed with the new End of Life Strategy, documentation.	End of Life Strategy. Evidence of the 6 steps to National EofL pathway. Trust Management Board – December 2014	G
		End of Life	Trust wide	16.2	Development and implementation of Last days of Life guidelines and care plans across the whole Trust. (This replaces the Liverpool Care Pathway documentation)	Executive Director of Nursing	Mark Robert, Consultant, Lead Nurse for End of Life & Cancer	15/07/2014	31/12/2014	The trust has implemented Last Days of Life Care guidelines and documentation across the Trust to enable staff to provide good end of life care	New guidelines and documentation developed. Launched at ward sisters and Grand Round. Being implemented across all wards with education, training and clinical support from Carolyn Bennett at the beginning of September. **November update (received after TB)** New guidelines and documentation developed and being used on the majority of wards. Launched at induction, ward sisters and ward staff meetings, Clinical Governance meetings, Medical Management meetings, Doctors lunch time meetings and Grand Round. Carolyn Bennett continues to support implementation across all wards by delivering face to face education, training and clinical support. **February 2015 updates:** The Lead Nurse for End of Life care is implementing this throughout the Trust, with the new additional resourse this will be at a faster pace.	Guidelines & documentation. Launch information. Implementation plan. Approval in Sept 14, evaluation in January 2015.	G
		End of Life	Trust wide	16.3	Implement a programme of multi-disciplinary training to increase the knowledge and skills of staff providing end of life care.	Divisional teams	Lead Nurse for End of Life & Cancer	15/08/2014	31/12/2014	There is trust wide, coordinated multi-disciplinary training in end of life.	Team currently teaching on multi professional induction, ward sisters events, junior doctor's forum, Grand Round and wards and departments through the launch of last days of life guidelines and new documentation. X1 End of Life study day offered to all staff every 3 months. Exploring the option to incorporate End of Life Care module within Mandatory Training Workbook. Ensure all end of life care training delivered is recorded on the Trust-wide database. **January 2015 update:** 12.01.15 - Advanced Communication skills for Consultants and Specialist nurses to be provided End of Life courses will take place for staff - 2 courses arranged. End of Life care is on the Induction programme for all new staff. Looking at junior doctors induction. **15.01.15 -** RAG rating reassessed as GREEN - evidence of training on all the Induction days **February 2015 updates:** Induction of all new starters includes End of Life care, the mandatory workbook now includes End of Life care.	MDT training plan. Evidence of EofL training in mandatory training. Agenda from Induction programme.	G
		End of Life	Trust wide	16.4	Implementation of End of Life Care key enablers e.g. AMBER care bundle; Gold Standards Framework in Acute Hospitals to enable staff to develop guidance for patients in their last days of life.	Executive Director of Nursing	Consultant, Lead Nurse for End of Life & Cancer	15/07/2013	30/11/2014	Phased implementation of Gold Standards Framework in Acute Hospitals Programme based on 2 Wards per year. Phased implementation of AMBER care bundle based on 4 Wards per year.	The Trust is currently in the second phase of implementation of the Gold Standards Framework in Acute Hospitals Programme (GSFAH). With a further 2 wards registering on the GSFAH Programme in July 14. The Trust is currently in the second phase of implementation of AMBER care bundle with a further 2 wards preparing to commence the AMBER care bundle in November '14. **November update (received after TB)** The Trust is currently in the second phase of implementation of the Gold Standards Framework in Acute Hospitals Programme (GSFAH). With 4 wards now implementing GSFAH into practice. The Trust is currently in the second phase of implementation of AMBER care bundle. unfortunately the further 2 wards planning to commence the AMBER care bundle has been deferred to January 2015 due to the EOLC Team having difficulties in supporting the wards with training and education. **February 2015 updates:** Additional resource has been provided to the team by EC&M, and this will assist with the pace of delivery.	Implementation plan. Attendees from National event.	A
		End of Life	Trust wide	16.5	All formal arrangements are in place to ensure all patients nearing the end of life have access to an effective, safe and coordinated fast track/rapid discharge.	Director of Operations	EoL Lead Nurse	13/10/2014	30/04/2015	Fast Track/Rapid Discharge processes allow patients nearing the end of their life to have access to an effective, safe and coordinated fast track/discharge. Audits will demonstrate how many patients were discharged to their preferred place of care, or the time it took to discharge patients .	Reviewing the current service specification to ensure all formal arrangements are in place. Exploring the possibility of designated Palliative Care beds at SFH for those patients who choose to die in hospital, to ensure they are cared for in a less acute environment. Audit programme in place for measuring Preferred Place of Care, anticipatory medication on discharge, time to fast track/rapid discharge, care of the dying patient and advance care planning. **January 2015 update:** 12.01.15 - 2 policies on fast track to be written. IDAT team to support 1 day a week. **February 2015 update:** The Discharge Policy is currently under review to update the fast track/ continuing health care and rapid discharge home to die section of the policy.	Audit of preferred place of care	A

		End of Life	Trust wide	16.6	Allow Natural Death documentation is fully completed	Executive Medical Director	Divisional Clinical Directors	01/01/2014	Ongoing	Patient records are completed sensitively with clear, timely entries	An AND audit was conducted over Quarter 4 period. The results have been presented at the Grand Round 15 October 2014 and to each Divisional Governance Lead. Each Division has been asked to develop an action plan in response to the audit findings by 30 November 2014 to improve current compliance levels, particularly regarding improved communication. The AND audit findings will be tabled at the next Resuscitation Committee meeting to be held on the 6th November 2014. A working group is being convened to look at overlapping areas of concern within areas of specialism such as End of Life Care, patients with learning disabilities and those who lack capacity. **November update (received after TB)** The AND audit findings will be tabled at the next Resuscitation Committee meeting to be held on the 1st December 2014. A working group is planning to meet on the 16th December to look at overlapping areas of concern around AND within areas of specialism such as End of Life Care, patients with learning disabilities and those who lack capacity. **26.01.15 update:** Q3 AND audit - Consultant signature 80% compliance. Issues of information sharing with relatives, action plan for improving ED compliance to be developed. AND forms to be reviewed in February 2015.	AND Audit data Grand Round 15 October 2014 Divisional action plans Minutes from Rhesus Committee Notes from working group – 1 June 2014	G