Quality *for all*

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Quality Improvement Plan

Working document

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Our journey so far …

Sir Bruce Keogh, NHS Medical Director, undertook a review of the quality of the care and treatment being provided by those hospital trusts in England which had been persistent outliers on mortality statistics; Sherwood Forest Hospitals NHS Foundation Trust was one of these Trusts.

The initial Rapid Response Review (Keogh Review) took place in June 2013, and resulted in a report and risk summit which identified 13 urgent action and 10 high and medium actions. The Trust was placed in special measures. In December 2013, an assurance review was undertaken by the Keogh team. The Trust was measured as being 'fully assured' in 6 actions and 'partially assured' in 17 actions. No areas were recorded as 'not assured'. The actions identified from this Assurance Review in December 2013 were consolidated with actions from the parallel Care Quality Commission (CQC) inspection and the PwC report in respect of quality governance.

In April 2014 the Trust underwent a subsequent CQC inspection to assess the Trust's progress in relation to exiting special measures. This inspection recommended that the Trust should remain in special measures. The Trust developed an action plan to address the issues raised; the residing Keogh actions were amalgamated into this action plan.

Upon appointment of a new Improvement Director, Gillian Hooper, the Trust developed a comprehensive Quality Improvement Plan (QIP), which pulls together all the issues and concerns that could impact upon our ability to deliver quality care (excluding finance).

The following is an update of the actions included within the Quality Improvement Plan:

1. Recruitment and retention of a credible and competent Board of Directors equipped with the skills to deliver the strategic priorities of the Trust.

The Board Development and Review Programme has been established. The diagnostic has been completed and the board received feedback from Foresight on 4 December, 2014. Planning meetings for the next phase of work scheduled occurred on the 21 January 2015. This work will incorporate Kings Fund Partnership.

We have commenced our coaching programme and we are now receiving individual coaching. Our second team coaching has taken place for 2 February 2015, which included personality type indicators. Chair and Non-Executive Directors appraisals have been completed and the Chair's objectives have been agreed at Council of Governors. Chief Executive Officer's appraisal has been completed.

In December 2014 the Chief Executive recruited a substantive Chief Financial Officer who has accepted the post, and is planned to commence at the Trust on the 23 March 2015. The newly appointed Chief Financial Officer, Mr Paul Robinson, participated in the team coaching on the 2 February 2015.

Following the departure of our Director of Operations an interim Director of Operations is in post from 5 January 2015. We have commissioned the Leadership Academy to work with us to recruit to the Chief Operating Officer's post, and have taken a briefing from the Trust and they are developing a timeline for recruitment.

We are working with Odgers to recruit a new Non-Executive Director, and the interviews are likely to be the end of March 2015, potential candidates have been identified, and the Remuneration and Nomination Committee with Governors has been arranged for the 23 March 2015.

We have appointed a Turnaround Director, Mr Terry Watson, and we are in the process offinalising appointments to the Delivery and Programme Directors.

The Interim Director for Newark Hospital has completed the management review of the hospital, and a workforce consultation is now underway.

We are planning additional theatre lists at Newark Hospital to increase utilisation of empty theatre slots, along with the development of services not currently available, for example, a business case for the delivery of a DEXA service. We are embarking on a 'Choose Newark Hospital' campaign to increase awareness of the services offered, educate patients and General Practitioners about what services that are available to increase the market share in Newark.

2. Our culture is focussed on delivering 'Quality for All' and staff feel valued and empowered to do an excellent job and proud to work for our Trust.

We have rolled out the new recruitment documentation, and the recruitment and selection training programme has been revised to reflect the Quality for All values. We have completed the team conversation exercises and these have been shared across the Trust.

We have agreed the Capability policy and toolkit and this will be rolled out with training across the Trust, in conjunction with the Appraisal Policy reflecting the Quality for All values.

Values team conversations have taken place with many of our teams across the Trust. To date 67 team actions plans have been developed. On-going plans for Quality for All conversations are being initiated.

Following the curtailment of our original procurement exercise for Staff & Patient FFT, the Patient Experience Manager is taking forward interim arrangements with the Trust's current provider iWGC. The contract with iWGC for the Patient FFT expires in January 2016.

We haveconsidered two options for Staff FFT in Quarter 4, and we have pursued the In-house survey using Survey Monkey, which will be reported by 31 March 2015.

Our assessment of the benefits of a Listening into Action approach has been undertaken.

We have made a decision to undertake a cultural assessment as part of the King's Fund. This has been tested by other organisations and will be implemented in Quarter 1 2015/16. Our Director of Nursing continues to participate in the Royal College of Nursing Cultural Alignment Group.

3. Implement our leadership strategy with appropriate focus at divisional and service lines to support our leaders to deliver the strategic objectives.

We have completed our senior HR Leaders Development Workshop on the 6th November 2014 to map existing strategies across to a leadership strategy and identify gaps. We have written in draft our Leadership Strategy and action plan, and this will be completed by the 31 March 2015.

Our revised medical leadership programme has been devised and will commence in February 2015. April Strategy attended the Medical Manager's meeting in January 2015.

We have undertaken a Medical Engagement Scale in July 2014 and this demonstrated that we had average levels of engagement but marked polarity by age (older Consultants less engaged) and variation between teams. A strategy was developed with an external consultant to foster clinical engagement. The Medical Engagement Scale responds slowly to change and it is not recommended to be repeated for at least 12 – 18 months. However, a new tool has been developed a 'mini- Medical Engagement Scale' for the purpose which can help with regular checks. This tool is currently being run and the Trust will be one of the first Trust's to undertake this in the United Kingdom.

We have enhanced our medical engagement and we have established medical engagement group with Non-Executive Directors, the Medical Director and Consultants to explore mentoring and buddying. We have developed a shadowing programme with Executive, medical staff and Consultant and this has commenced.

We are now delivering our third wave of the Trust's Leadership Programme which has 15 clinicians enrolled onto the 12 month programme. The Chief Executive Officer and the Medical Director have launched the event and have returned to the Programme on the 9 March 2015 to discuss strategic objectives.

We have established middle and senior manager's focus groups for March and April 2015 to sense check the training needs analysis and to explore leadership developments themes emerging from staff exit interviews. The OD and Workforce Committee will receive feedback in May 2015.

Our Head of Strategic Planning has arranged Service Line Planning meetings with key individuals from within the divisions, and we have developed a Clinical Reference Group for strategy being established to embed strategy development at a service line level. All our service lines have produced plans for 2015/16, and feedback has been received on information that would support better Service Line Management.

4. Ensure Trust Risk Management processes are robust including appropriate identification of risks, incidents, mitigations and learning at all levels in the organisation.

Since the CQC visited in April 2014, we have undertaken a large amount of work to improve our risk management systems and processes. In November 2014, we appointed a Risk Manager who has quickly strengthened our risk management work; by January 2015 we had completely rewritten our Risk Management policy, ratified it at Trust Board and have started to disseminate across the organisation, via various methods of communication to reach the largest number of staff. We have written a risk management and Datix Risk user guide, and this has been introduced. We have developed a new generic risk assessment tool, this has been implemented and feedback has been positive.

Since November 2014 we have undertaken a 'confirm and challenge' exercise of the significant risks and are performing the same exercise for the lower scoring risks. This approach is creating a significant movement in the risk register. We can report that there are currently 129 open risks; 21 risks have been closed and archived in the last six weeks, 23 risks have had their score reduced and 2 risks where their score has increased. We have in total comprehensively reviewed over 129 of the risks.

We have cleansed of the data to be transferred to the DatixWeb Risk Management. The risk register is evolving daily providing assurance that risks are being reviewed, archived and re-scored, actions and new risks added.

We established, in December 2014 the first Risk Management Committee which have set the agendas and annual work plan. The two largest divisions (Emergency Care & Medicine and Planned Care & Surgery) had a comprehensive review of their risk register at the February meeting, and Newark Hospital and Diagnostics & Rehabilitation had a comprehensive review of their risk registers at the third meeting. We have now developed risk reports and these are provided to the local Governance forums for discussion/ action where necessary. We are now engaged in regular, robust reporting of significant risks and the risk profile of the Trust is taking place at Trust Management Board, Risk Management Committee and Clinical Quality & Governance Committee on a monthly basis.

We have reviewed the risks on the risk register and mapped to the Five Principal Risks of the Trust, this will enable the Corporate Risk Register/ Board Assurance Framework to be better aligned.

We have added the three levels of risk management to the Trusts Training Needs Analysis. These commenced in January 2015, with 5 sessions per month currently scheduled. We have provided awareness sessions to ward leaders and business support units and these have taken place. The Risk Management Training has commenced and initial feedback is encouraging.

We have met with a number of risk owners on a 1:2:1 basis and more meetings have been scheduled. These are proving invaluable from a risk discussion and debate perspective.

We received the 360 Audit Feedback Report on the 9 February 2015, and this concluded that **'significant progress'** had been made to address areas of weakness identified within the original audit report. The audit team are not proposing undertaking any further follow ups in this area.

The platform for Datix has migrated on the 3 March 2015 in readiness for uploading of version 12.3 week commencing 9 March. The version 12.3 allows the automatic feedback functionality to be enabled and the Datix co-ordinator is currently considering the specific section to be agreed for feedback.

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.

We have implemented the Patient Experience module of Datix and the reporting functionality and dashboards are being agreed.

We have established a task and finish organisational learning group which meets weekly and from this meeting a 'good ideas' tracker has been developed. We have developed a learning template that is being used in all the Divisional Clinical Governance meetings. We are implementing Organisational Learning as a standing item on group/committee agendas and this has been added to Clinical Quality & Governance Committee the demonstration of learning and connections between complaints, incidents and feedback.

We have established Learning Boards in all clinical areas, and in some non-clinical areas too.

Our three clinical divisions and Newark Hospital produced their first ever divisional quarterly learning report which was presented to the Clinical Quality and Governance Committee in March 2015. The content of these will be used to produce a themed learning report, and these are a good platform from which to now start to triangulate the learning for future reports.

Nurses and Midwives have attended the Nursing & Midwifery Time Out Days in which practice is shared and shaped around the Trust's new values of CARE. Over 300 have attended these days, which are planned until December 2015. The 'Proud' campaign is to commence in March 2015.

We have held the first monthly Patient Safety briefing on 'positive patient identification', with 25 minute sessions including a 10 minute presentation, looking at incidents within our Trust. Our second Patient Safety briefing was held on record keeping in March 2015. We have had two nursing Grand Rounds on the deteriorating patient and falls, with a third planned for the end of March 2015 on medications. We have implemented intranet 'pop up' messages with key statements which include patient safety alerts.

We have developed a two day lead investigator Root Cause Analysis training which 14 staff attended the full two day course on the 16 and 17 February 2015. Two of the attendees were medical staff and the remainder were nursing staff, predominantly from Emergency Care & Medicine. Our feedback was excellent with all participants scoring the days as '5' for presentation, content, relevance and opportunity to participate. We ran our next course on the 16 and 17 March 2015, and this fully booked with 15 staff due to attend. All the placed for the remainder of 2015 have been booked.

All our divisions now hold their divisional governance meetings in the fourth week of the month. The meetings were moved earlier in the month to provide more time for leads to produce the relevant data for the divisional governance packs. The data packs do contain the required level of data to facilitate discussion of the priorities, the risks, for best practice to be discussed and for themes and trends to be shared with service lines.

6. Build safe and effective staffing levels with escalation processes to meet unpredicted demand.

Following the Keogh Review in June 2013, we committed to invest in nursing. There was an immediate response with an increase in overnight staffing on all inpatient areas. Respective Divisional Matrons have reviewed their nursing establishments in conjunction with our Executive Director of Nursing in order to seek consensus regarding skill mix and registered nurse to bed ratio. The Divisional Matrons are currently in the process of transacting these plans and recruiting to vacancies via a variety of routes in addition to standard recruitment practice; namely appointment of newly qualified staff, international recruitment and return to practice initiatives. We are providing individual preceptor support and development packs for internal recruitments who have not been part of our preceptor programme.

We have established a 60:40 Registered Nurse: Healthcare Assistant skill mix in Planned Care & Surgery moving towards 70:30 RN: HCA. Mansfield Community Hospital has also increased its Registered Nurse complement. We have increased night nursing in Emergency Department by one Registered Nurse and ward leadership in EAU has been strengthened with the employment of a second Ward Charge Nurse. We have proposed the staffing for 2015/16 and this has been agreed by the senior nurses and submitted for financial costing. Additional winter capacity remains open at the time of this report.

We have established that Emergency Care & Medicine will move to 60:40 (RN: HCA) ratio, with specialty wards already on 60:40 and moving towards 70:30. We have developed a marketing strategy for recruitment of Registered Nurses and this will be commenced through open days and external journal adverts. We have already recruited 50 international nurses and we are establishing a long term approach towards international recruitment.

We have responded to the Emergency Department NICE staffing guidance, and we have undertaken a gap analysis against the recommendations, this has informed the budget setting process. We discuss the medical and nursing gaps and skill mix in Emergency Department and Emergency Assessment Unit (and any other areas) at every bed meeting which is three times a day, seven days a week.

We have reported the current information monthly on UNIFY and NHS Choices, and this demonstrates that the Trust achieves 100% or greater for Registered Nurses and Healthcare Assistants day and night average fill rate, overall. The Healthcare Assistant has an increase in the average fill rate, and this demonstrates the utilisation of Healthcare Assistants to support the additional enhanced care needs required to some patients in 1:1 care.

We are undertaking a snapshot audit on the acuity and dependencies on Sconce Ward at Newark Hospital and Ward 11 to understand the potential acuity and dependency changes.

We have utilised the Safer Nursing Care Tool (SNCT) in January which will inform the Divisional Matrons of the next six months. There continues to be a large need for 1:1 enhanced support still required.

We have successfully recruited to the Acute Physicians posts and all six Acute Physicians are now in post, this is the highest number the Trust has recruited. The Acute Physicians are offering additional support to the Emergency Department to see General Practitioner referrals and medical admissions. We have interviewed for the 8th Emergency Department Consultant and appointed a long term locum Consultant. We are trying to attract Consultants to the 'hard to fill' vacancies by offering recruitment and retention premium payments.

We review the Emergency Department Escalation Plan at each bed meeting and at the weekly Capacity and Flow meeting, along with staffing issues (nursing and medical) for the Emergency Department.

We have an additional medical ward open for the winter pressure, plans to reduce beds in correlation with improvements in emergency flow are in place, and work has begun to reduce the number of patients who stay in hospital for 14 days or more. The division has seconded one of the Matrons to lead this project and it is anticipated that by reducing the number of patients over 14 days by 30% will lead to the closure of three medical wards.

We have added additional resources into End of Life team (Band 7 nurse), Falls team (Band 7 nurse) and an additional junior doctor to the Hospital at Night team following the Hospital at Night review.

The recruitment of an Interventional Consultant Radiologist with Nottingham University Hospitals is underway and this appointment will provide the Trust with 5 day interventional service in Radiology. Interviews for the Interventional Radiologist are schedule to create a service hosted by Nottingham University Hospitals. East Midlands Radiology (EMRAD) project has been created to implement a common digital imaging system across the seven Trusts and this will facilitate reporting across the region.

We will from April be searching for a Radiologist locum Consultant with on-call arrangements to support Diagnostics & Rehabilitation following the retirement of a Consultant Radiologist.

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.

We have updated the Medical Device Management Policy and the policy has been approved. This policy has been communicated across the trust via various methods in order to reach the widest audience. We have utilised the Learning Boards to display posters promoting choosing the right equipment, 'Choose Right: Using Right: Keeping Right'.

We have introduced a standardised electronic medical device reporting systems. This ensures there are no discrepancies between reporting arrangements. The roll out of this system has been through the distribution of posters, through the staff bulletin and onto the Learning Boards in all the clinical areas. iCare2 communications have been issued to support this new reporting method.

Our Medical Equipment Maintenance Department (MEMD) have prioritised the servicing of the Trust's equipment, and by March 2015 they have serviced 100% defibrillators, 100% neo-natal incubators and resuscitaires, 92% of infusion devices and 92% of pressure relieving air mattresses. This demonstrates that there has been a prioritisation of essential emergency equipment undertaken. We have serviced 67% of hospital beds across the three sites of the Trust, and we have implemented a phased plan for completing the servicing.

We are in the process of ordering from Beaver Healthcare (the company who has been awarded the tender) six of resuscitation trolleys (with a further 75 trolleys being ordered, as per the procurement process) so that staff can become familiar with the trolleys and for training purposes. We have established weekly implementation meetings to support the roll out programme of the resuscitation trolleys.

8. Improve the systems and processes for the storage and administration of all medicines. Reduce the incidence of medicine omissions.

We have an operational group, chaired by our Director of Nursing, which meets weekly to drive the improvements required for medicine safety. We have tried many initiatives have been implemented including; informative posters, use of red aprons and a red apron campaign, which is now mandatory across the Trust, new Trust Wide prescription chart, new e-learning opportunities in relation to medicine safety which has been successfully used in other local Trusts, and the introduction of 2 nurse check at the bedside.

Our Executive Director of Nursing and our Medical Director will be advising that all nursing and medical staff are to carry out the Virtual College e-learning package on Missed and Dealyed doses of Medicines and Safe Use of Insulin.

We have developed a medicines error policy to standardise the management of staff who make medication errors, this is being presented at JSPF week commencing 16 February 2015 for final ratification, and is now in use in the clinical environment.

We have trialled in the Emergency Department the 'red cards' to highlight when patients require medications, however this has not been successful and we are working with the Emergency Department to find an alternative.

The Pharmacists are working with the Ward Leaders and the nursing teams to provide safe administration and storage of medicines. Our mandatory training workbooks will include a section on storage and safety of medicines from April 2015.

The Pharmacists and nurses are undertaking twice monthly missed/omitted drug audits, which are being reported back to the Divisional Matrons. Our missed and delayed drug audit in February demonstrated that there were only 2.5% of drugs missed or delayed. We have refined the audit to identify which parts of the system are causing medicine omissions - to enable focused action. Emergency Department are introducing 'named nursing' which is expected to provide greater responsibility for medicine management.

We have participated in the Medicines Safety Thermometer and although the sample size was small (46 Trusts) we have results better than the national average.

We are auditing medication storage and this has been undertaken across the Trust, which is being used to improve storage and understanding on the wards. Our medication safety and storage audit did not

demonstrate good compliance and this will be discussed within the divisional governance forums. We are trialling the pharmacy secure boxes, with a plan to implement across the Trust by the end of March 2015.

We are training nursing staff to work towards Patient Group Directives and ward based discharges, which will be an on-going training exercise as staff are recruited to the wards, this training is being undertaken by the Pharmacists.

The Practice Development Matrons have focussed on medication safety and this has demonstrated a reduction in medication errors and missed/omitted doses. We have included eLearning module for insulin safety into the preceptor programme. We are reviewing a learning tool for improving medicine's safety, used successfully by a local Trust.

9. Ensure patient records are appropriately maintained in line with Trust policy and legislative requirements.

The WHO surgical checklist was established as an area of good practice which had not been embedded within the organisation. Following the Keogh Review in 2013, Theatres have embraced the WHO surgical checklist, and it is now championed by a Trauma & Orthopaedic Consultant. The Trust is currently one of the better performers within the East Midlands, and the audits continue to demonstrate high levels of compliance. The compliance for February 2015 was 88% (stage 1) and 67% completed (stage 2) which is a slight improvement from the previous month.

The Practice Development Matrons have a dedicated focus week on 'Record Keeping', in February 2015. There is on-going delivery of weekly record keeping training sessions for nursing staff and bespoke sessions for those requiring additional support e.g. overseas nurses. A new record keeping session is now included within the nursing induction to ensure all new staff are captured upon entering the Trust. We are currently trailing the development and delivery of a specific record keeping training session for HCA staff.

We have developed a new monthly documentation audit which reflects qualitative elements to the nursing record keeping. We are providing regular teaching and awareness sessions on record keeping. We support all new registered and international nurses to the Trust with 1:1 support sessions from a Practice Development Matron, in order to set the standard and expectation of the Trust for record keeping and documentation. We have produced a 'Record keeping guidance' for the nursing staff at Sherwood Forest Hospital, to support their practice.

We have undertaken monthly Consent audits, which in February 2015 demonstrated that 54.3% of the consent form was fully completed, 95.1% had legible writing and 79% had confirmation of consent completed.

We have implemented of Care & Comfort Rounds on all wards at Sherwood Forest Hospitals, this has been audited and the results are being reviewed. We have implemented Accountability Handovers this has been audited and 96.8% of the patients audited had accountability handover sheets present in their nursing documentation. This is will be re-audited within the next month.

We are monitoring the number of missed case notes in Outpatient and this is being monitored across the divisional teams, however this is demonstrating good practice with only 0.21% of case notes missing week commencing March 2015. We are also monitoring the number of clinics cancelled at short notice, and this has significantly improved and is being managed by a cross divisional team.

10.0 Ensure the processes for the recognition of deteriorating patients are robust and appropriately acted upon.

We have rolled VitalPac out across Kings Mill Hospital and there will be an upgrade due prior to April 2015 and a planned upgraded roll-out to Newark and Mansfield Community Hospitals in January and February 2015. We are training for staff at Newark and Mansfield Community Hospitals has been planned with support from the VitalPac trainers.

The implementation of VitalPac has improved the escalation rates of deteriorating patients, as in January 82%, were escalated appropriately and timely.

The issues identified are:

- Poor WiFi at Newark Hospital which has caused some delays;
- Deliverability by the Learning Clinic to supply the system in a timely manner;
- The Fluid Balance module has been trialled and the clinical team at the Learning Clinic are not currently satisfied with the usability and therefore have withdrawn this module, and are hoping to trial again in April at Sherwood Forest Hospitals.

We have undertaken a Fluid Balance internal audit which has demonstrated that we have further work to do, albeit 80% compliance.

We are extensively testing of the new version of VitalPac performance over the last month to monitor patient safety when launching the new upgrade. We are preparing for an upgrade version of VitalPac by providing education to Kings Mill users and this will take place during February 2015.

We have issued medical staff Personal Identification Numbers (PIN) in order that they can view pathology and radiology results on their iPads.

The Learning Clinic have highlighted that Sherwood Forest Hospitals were within the Top 3 on compliance measures out of all the VitalPac sites (Trusts) – 23 in total.

Our HSMR mortality variation for November 2014 (most current) demonstrates that the weekday and weekend mortality figures are similar; however our mortality numbers remain high. Therefore, our Medical Director has instigated a review of all deaths in July 2014, all sepsis deaths in Q2 and Q3, and a review of deaths mid-December 2014 to mid-January 2015, to review rise in mortality. Our Medical Director has also instigated a review of our coding practices in respect of switching to HES data and the new Medway PAS system.

10.5 Infection Prevention & Control (Key Action 18 – Quality Improvement Plan)

We remain over our trajectory for the C-diff target of 37 cases. The Nurse Consultant for Infection Prevention and Control is working in partnership with the local CCGs and a Task & Finish group has been established to review C-diff.

We are actively involved in the writing of a new community anti-microbial prescribing policy, with our Consultant Microbiologist and our Nurse Consultant. We have reviewed our anti-microbial prescribing and the community team are to review their practice too. We have undertaken a peer review of anti-microbial prescribing and the review suggests that our practice is good.

We are improving the Root Cause Analysis documentation in order to record clinical input which will include medical presentation. This will strengthen the 48 hour rapid review reporting.

We are reviewing with the Nurse Consultant for Infection Prevention & Control and the Medical Director the Terms of Reference for the Infection Prevention & Control Committee to strengthen clinical involvement and engagement in the meeting. We have changed the dates of our HCAI and IPPC meetings to allow clinical representation, and there are now no clashes with other sub-committees.

Our Infection Prevention & Control Team now attends Emergency Care & Medicine and Diagnostics and Rehabilitation's clinical governance meeting. Infection Prevention & Control are now standing agenda items on Emergency Care & Medicine and Diagnostics & Rehabilitation divisions' clinical governance meetings.

We are ordering 14 hand hygiene stations which will be placed in areas such as the main reception, outpatients, the lift lobbies, outside Costa and the Voluntary Coffee Bar and in the Emergency Department. This will be launched through a communication plan which will include a twitter account - #handhygiene.

11.Ensure safe, appropriate and timely flow of patients from admission to discharge, with the support of good bed management and discharge processes. Achieving sustaining all three 18ww pathways.

We opened the discharge lounge in October 2014, utilising space within Clinic 9. This area is to support SFH in maintaining patient flow for emergency admissions, and ensure that there is good flow throughout the day. We have utilised the Discharge Lounge consistently well, and this will be monitored as one of the Key Performance Indicators for this section, in February 245 patients were discharged through the Discharge Lounge which was an increase on the previous month by 27 patients.

We need to improve the flow of emergency pathway with timely access to relevant services and discharges, therefore the RAG rating remains RED, as there remains significant bottlenecks within the patient flow system, which is reflected in the monthly four hour trolley wait (95%) not being achieved. We as a Trust have recast the Emergency Flow plan for internal issues which is a sub-set of the overall Emergency Flow plan for the Health Economy. This has been signed off by the Mid Nottinghamshire system resilience group. A revised trajectory has been submitted, the Health Economy is to advise on the operational standards.

We have increased our focus in improving streaming in the Emergency Department, and a focus on ensuring patients are appropriately and safely discharged with the assistance of the community teams. As a consequence there has been a slight improvement in performance in February 2015 when compared to January 2015. We are concentrating on ensuring that the time waiting to be seen in the Emergency Department does not exceed 60 minutes, and we are ensuring that there is always empty beds on the Emergency Assessment Unit, this will ensure that flow improves through the Emergency Department.

Our Emergency Care & Medicine division have seconded a Matron to improve the Emergency Flow for the Trust, and review the patients who are in hospital for 14 days and over. A reduction of 30% in the number of patients who are in hospital for 14 days and over, will enable the Trust to close medical wards.

The Hospital @ Night audit and review has now been completed, and the draft copy is to be discussed with the Medical Director. We have increased the resources into the Hospital at Night team by one additional doctor, with immediate effect.

The Medical Outlier Policy has now been ratified at the January's Clinical Quality & Governance Committee, and the compliance monitoring is agreed. The Outlier Decision Support Tool has been audited in January 2015, which was 19% compliant. This will be re-audited in March and the Duty Nurse Managers will be promoting this tool as a good practice for safe transfer of patients. The provisional results from the March 2015 audit is that there has been an improvement in the compliance with the outlier decision support tool

We are continuing to monitor the Refer To Treatment (RTT) 18 weeks monthly, and a Trust-wide achievement of 'admitted' 90.2% (target 90%) and 'non-admitted' 95.5% (target 95%) in Q3. Our RTT for January 2015 was 'admitted '86.4%' (target 90%); 'non-admitted' 91.5% (target 95%).

We are planning for phase 2 of PAS implementation of off-target due to work to 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 safety and appropriately share electronic patient records more effectively between the Trust, General Practitioners and other organisations.

12. Improve delivery of mandatory and targeted training for staff.

We have developed the Mandatory training e-learning workbooks and following a successful pilot in four areas will be launched by the 31st January 2015, giving staff 24/7 flexible access to complete their mandatory training requirements. This new system includes an app for staff that can be used on a mobile phone and tablet device, to access mandatory training information and to promote greater

engagement with the completion of mandatory training. This new system will begin to be rolled out in April 2015.

An evaluation report was presented to the OD & Workforce Committee in January 2015 on the impact that mandatory training has on patient care. This reporting mechanism will form part of the routine quality infrastructure of the Training Department and we will receive further feedback every six months.

The Medical staff mandatory training for C-diff and MRSA remains above 90% compliant.

We have provided staff with personalised letters which identifies their mandatory training requirements and compliance have been issued. We have noted that this has improved uptake of mandatory training course bookings.

Launch of supervisor self-service completed for January 2015 to enable Managers to have real time mandatory training information.

We have completed this section, and this will now be monitored three monthly with the action owners.

13. Strengthen the processes to enhance staff performance, ensuring the availability of skilled and competent staff.

We have developed detailed action plan as a result of the HEEM visit, which is on track with significant improvement noted on the re-visit. All actions are being progressed through the OD & Workforce Committee, with good progress. In February 2015 we had a further two HEEM visits where further issues were identified. We have developed and formulated an additional action plan to address the issues raised and the oversight for this will be with the OD & Workforce Committee.

As part of our first HEEM action plan we have worked to improve the relationship between the medical teams in the Emergency Department and Trauma & Orthopaedics. The Head of Service for Emergency Care and the Trauma & Orthopaedic team meet monthly to address issues and the Head of Service for Emergency Care attended the meetings around the development and implementation of the Trauma Assessment Unit.

We have revised and agreed the Appraisal Policy, which now reflects Quality for All Values and Behaviours. This is in the process of being rolled to managers and will be completed by 12 March 2015. This was communicated on the Staff Bulletin on 13 February 2015, and there are guidance notes available for staff and managers on the Trust's intranet site.

We have established Stress Management Focus Groups and these are taking place across the Trust regarding approaches to Stress Management in relation to staff. We have reported an interim update to the Health & Safety Committee on the 8 January 2015. The report was considered by the OD & Workforce Committee on 3 February 2015 and further work was requested to triangulate the results with the outcomes from the staff survey. We will develop an action plan to be presented to the OD & Workforce Committee in March 2015.

We have above 90% of our Medical staff appraisals completed and this will be monitored on the Quality Improvement Plan's Key Performance Indicators.

We have a ratified Clinical Supervision Guideline and the Clinical Supervision website is live. We have a data base of clinical supervisors and we have trained 12 clinical supervisors to date, we are working with individuals who have undergone training in other organisations, to establish a data base for the Trust with external Clinical Supervisors. We have added' train the trainer clinical supervisor education' to the Training Needs Analysis so we can become self-sufficient as an organisation.

14. Improve the effectiveness and responsiveness of services through the use of evidence based clinical pathways.

We have completed pathways for Cardiology, Respiratory, Gastroenterology, Endocrine, Neurology, Ear, Nose & Throat, Paediatrics and Obstetrics & Gynaecology, and these have been signed off and are on the Trust's intranet site.

Our clinical pathways are in a standard format with version control which is uploaded to a single point of access on the Trust's intranet. These pathways will provide optimised management for common presentation which is consistent. These pathways were developed from discussions with Heads of Service at the Medical Managers weekly forum. We have developed a communication plan to target junior doctors, heads of service and divisions over the next 9 weeks. We will review the uptake of the clinical pathways in May 2015.

We have agreed the new NICE guidelines policy and this is available on the Trust's intranet site. The implementation of relevant new NICE guidance will be traced at 12 weeks after publication and monitored via the Clinical Audit and Effectiveness Committee. We are in the process of arranging the 360 Assurance audit to be undertaken to review the NICE Guidance processes.

We are reviewing our Trauma & Orthopaedic, Ophthalmology and Urology services and transforming the service as part of the Elective Care Transformation Programme.

The Hip/Knee Schools and combined physiotherapy clinics for Orthopaedics will be implemented by March. The Nurse led cystoscopy clinic requires nurse training which will take six months to complete.

We have standardised how Newark Hospital Minor Injuries Unit and King's Mill Hospital's Emergency Department operating and ensured that a single pathway is followed and is the same on both sites.

15. Increase patient feedback by collating a higher level of Family and Friends responses.

We have recently met with the current provider following an unsuccessful procurement activity, in order to discuss ways in which we can increase the Friends & Family response rates in ED. We have continued increased support in order to increase the uptake of this test response (please refer to the Trust Board Patient Experience Report).

We are re-branding the FFT information, posters, barriers and electronic signage distributed throughout the Trust. We have agreed a communication strategy to re-launch FFT throughout the Trust. We have dedicated workers supporting both ward, Emergency Department, Outpatients and Day Case Unit to improve response rates.

We have commenced the Customer Service Excellence Training with 65 places for our ward hostesses and reception staff. Customer Service Excellence Training has been delivered to 9 Emergency Department staff to date.

We are going to pilot the implementation of an Android App for FFT in Emergency Department and Outpatients from February 2015, and it is anticipated that there will be an increase in the response rates.

We commenced our bereavement relative experience survey in October 2014, and the Lead for End of Life has produced the first quarterly report which is positive.

16. End of Life is responsive to the needs of our patients (and their carers), delivered by competent, knowledgeable staff who respect and meet individual preferences.

We have made some progress with End of Life following the visit of the Care Quality Commission. Since April 2014 we have:

- Developed an End of Life Strategy which is strongly linked to the six-steps within the National End of Life Care Pathway NEoLCP (2010); this was presented to the Trust Management Board in January 2015, with some amendments to be actioned.
- Developed a network of Ward Champions and Clinical Leaders within each speciality whom will facilitate the processes necessary for good quality care for EoLC patients and their families, and encourage a culture of compassionate care by staff caring for individuals approaching end of life.
- Produced guidelines and care plans to support patients in the Last Days of Life Care. This was launched at the beginning of September and was implemented by the end of December 2014.
- Ensured End of Life care education and training is either delivered or being developed in a number of ways: Implementation of the Last Days of Life Care guidelines and care plans, Multi-disciplinary Induction Programmes, End of Life Care module within Mandatory Training Workbook, End of Life Care study days and communication skills training for staff who are involved in difficult conversations on end of life care
- Commenced a bereavement survey to capture patient / carers experience during their last days/hours of life.

We have increased the resources to deliver this programme of work, and this has been provided by the Divisional Matron for Emergency Care & Medicine. The Lead Nurse with the additional resource reviewed the Discharge Policy and has updated the Fast Track/ Continuing Health Care and Rapid Discharge home to die section of the policy. We will continue to embed the Gold Standard Framework for Acute Hospitals to the wider inpatient areas, along with the Amber Care Bundles, with a further two wards being enrolled into the Programme in 2015. We are working to ensure that the Amber Care Bundle will have a phased roll out and be fully rolled out by April 2016.

We are currently updating the End of Life intranet site to reflect the new documentation, strategy and the team.

The Practice Development Matrons have a plan of work which focuses on key areas, one of which is End of Life. This consists of a self-assessment by the Ward Leaders and their teams, followed by a week with the Practice Development Matrons focussing on key areas to create improvements. The self-assessment for the End of Life demonstrated a positive understanding of the documentation and the principles of End of Life.

17. On-going concerns from different sources about our existing safeguarding arrangements

We are delivering Safeguarding training within mandatory training, as targeted specialist training to particular staff or areas and supplementary additional support. Mandatory training for adult safeguarding is at 92%; mental capacity training at 94%; learning disabilities is at 96% and Prevent awareness is at 80% in Q3. In addition, 75 of our staff have attended supplementary vulnerable adults study days this year and over 200 additional staff have been trained on consent, deprivation of liberty and mental capacity. Our Planned Care & Surgery division have asked us to provide additional level 3 Children Safeguarding training.

We have identified and trained clinical champions for Adult Safeguarding and established for all inpatient clinical areas with a resource pack to assist with local knowledge and expertise to raise awareness.

Our Serious Incident investigation process has been reported by the Coroner to be exemplary in the East Midlands. We have aligned our safeguarding investigation process to this to ensure consistency, Duty of Candour, legal review, and an executive sign off process. This will be tracked on the divisional action plan and be monitored for organisational learning. We have shared with our colleagues in the local Clinical Commissioning Groups and the Care Quality Commission, our Serious Incident investigation process.

We are currently reviewing who can support our Trust to review our current safeguarding arrangements, and having reviewed many recommended options, the Royal College of Nursing have established a name and a line of enquiry to pursue.

March 2015

Key Performance Indicators:

Key Performance Indicators:	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
All Board posts are filled on substantive basis by competent individuals	Full Board	Full Board	Full Board	Full Board	Interim CFO	Interim CFO	Interim CFO	Interim CFO	Interim CFO	Interim CFO CFO apt	Interim CFO Interim DofOps	Interim CFO Interim DofOps
Staff FFT positive response rate improves from 52% to 62% by 30 June 2015				31.3%			35.8%			TBC		
Mandatory training compliance rates at 90% or more			78%		79%	79%	80%	81%	82%	83%	81%	82%
Staff appraisal completion rates for AfC staff at 98% or more		82%	84%	81%	83%	84%	82%	84%	83%	85%	87%	86%
All inpatient wards record >85% nurse staffing levels on UNIFY return			T – 100.8% UT – 109.7%	T – 104.9% UT – 111.6%	T – 105.7% UT – 111.8%	T – 103.2% UT – 107%	T – 102.2% UT – 109.3%	T – 100% UT – 110.2%	T – 101.1% UT – 110.0%	T – 101.1% UT – 110.3%	T – 105.5% UT – 109.3%	T – 102.5% UT – 110.2%
ED patient 4 hour wait – 95% target		93.4%	93.42%	95.96%	92.97%	**95.78%**	93.37%	91.26%	87.92%	84.46%	89.45%	90.45%
Infection Prevention & Control – number of C-diff – target 37 cases		**5**	**6**	**5**	**7**	**5**	**7**	3	7	9	3	6
Deteriorating patient escalation >95% compliance		78%	84%	**92%**	83%	73%	78%	**92%**	84%	**95%**	82%	TBC
Increase family & friends response rate to 50% overall (inpatient response)		32.8%	32.2%	31.3%	38.1%	34.3%	35.8%	40.5%	36.6%	36.6%	38%	TBC
RTT 18weeks – admitted 90% and non-admitted 95%		A - 90% NA – 94.5%	A – 91.1% NA – 94.1%	A – 92.1% NA – 94.7%	A – 90.2% NA – 92.6%	A – 89.4% NA – 91.8%	A - 91.6% NA – 95%	A – 91.3% NA – 95.7%	A – 90.2% NA – 95.5%	A – 90.2% NA – 94.3%	A – 86.4% NA – 91.5%	TBC
Medical Outlier Decision Support Tool compliance											19%	
Medical staff appraisal – 90% compliance		92%			93%			97%			98%	
Missing Notes in clinic											0.19%	0.21%
WHO surgical checklist compliance											87% (S1) 66% (S5)	88% (S1) 67% (S5)
Discharge Lounge utilisation number of patients											218	245
Medical Outlier Decision Support Tool audit (% compliance)											19.1%	
Accountability Handover audit – two signature handover											54.4%	

Abbreviations:

T = trained/registered nurse

UT = untrained/ healthcare assistant

A = admitted pathway

NA = non-admitted pathway

Feb-15

Assurance Dashboard

Whole Trust

<< dashboard

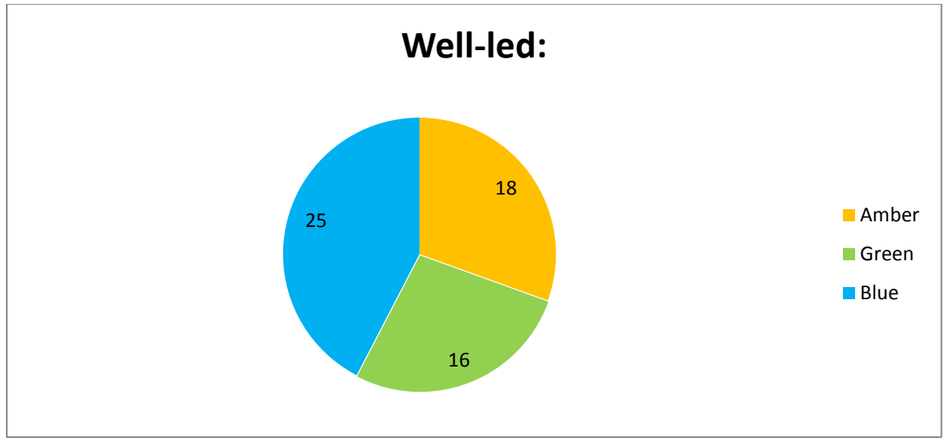
nd = No Data

	Medicines			Fluid Management	Deteriorating Patient		Infection Control	Safeguarding	Equipment	Capacity/Flow
	Storage	Omissions	Critical Meds	Fluid Balance	Observations on time	Escalation	8 hr VIPs	2 stage test & best interests	Resus Trolley Checks	Pre-Noon D/C
Data Source	NMetrics	MD audit	MD audit	NMetrics	VitalPac	NMetrics	Nmetrics	Nmetrics	Nmetrics	Info Team
Ward / Dept										
11	100%	99%	100%	100%	90%	100%	100%	nd	100%	7%
12	93%	nd	nd	67%	92%	100%	83%	67%	100%	19%
14	100%	90%	86%	10%	96%	100%	100%	nd	100%	18%
21	nd	97%	97%	nd	93%	nd	nd	nd	nd	10%
22	97%	92%	99%	67%	90%	60%	100%	40%	100%	27%
23	93%	100%	100%	71%	89%	50%	80%	100%	20%	10%
24	100%	99%	100%	100%	94%	50%	100%	50%	100%	15%
25	100%	98%	100%	83%	nd	90%	nd	nd	100%	na
31	100%	100%	100%	80%	92%	100%	80%	100%	100%	15%
32	100%	99%	100%	100%	94%	100%	100%	nd	100%	14%
33	100%	96%	92%	50%	92%	100%	100%	100%	0%	26%
34	100%	98%	99%	75%	95%	100%	67%	100%	100%	14%
35	100%	100%	100%	50%	97%	nd	75%	75%	75%	27%
36	93%	96%	95%	33%	90%	100%	100%	25%	100%	17%
41	100%	100%	100%	100%	92%	nd	nd	67%	100%	41%
42	100%	99%	98%	100%	95%	nd	100%	50%	0%	8%
43	100%	nd	nd	100%	86%	100%	100%	100%	100%	32%
44	100%	99%	100%	100%	92%	100%	100%	nd	100%	9%
51	100%	94%	88%	50%	92%	nd	100%	nd	100%	24%
52	100%	99%	100%	50%	91%	100%	50%	50%	100%	50%
53/4	100%	96%	100%	100%	92%	100%	100%	33%	100%	43%
Daycase	nd	nd	nd	nd	92%	nd	nd	nd	nd	nd
Maternity	100%	nd	nd	100%	nd	100%	78%	nd	100%	na
EAU	100%	95%	98%	43%	89%	71%	70%	40%	100%	24.0%
ED	100%	nd	nd	nd	nd	nd	nd	nd	nd	nd
Chatsworth	100%	100%	100%	100%	nd	100%	100%	100%	100%	nd
Lindhurst	93%	99%	100%	nd	nd	100%	nd	100%	100%	39%
Oakham	100%	100%	100%	nd	nd	50%	nd	100%	100%	42%
Sconce	100%	98%	99%	nd	nd	nd	nd	nd	nd	30%
Minster	100%	nd	nd	nd	nd	nd	100%	100%	100%	92%
Total Avg	99%	98%	98%	75%	92%	89%	90%	74%	88%	26%

March 2015

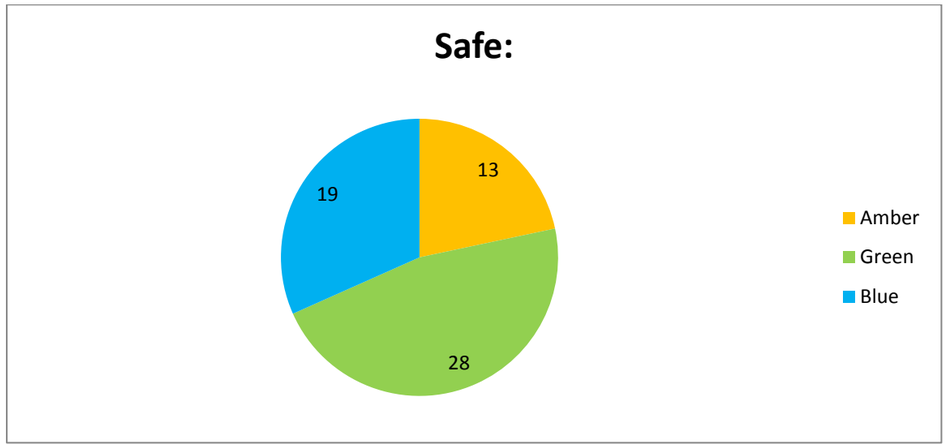
Domains:

Are we well-led?



This domain has 59 actions with 25 actions completed (42%) and 16 actions on track (27%) to be completed within the timeframe. There are 18 actions (31%) showing amber, indicating that progress is being made towards completion but is likely not to be within the timeframe. This domain has no red actions.

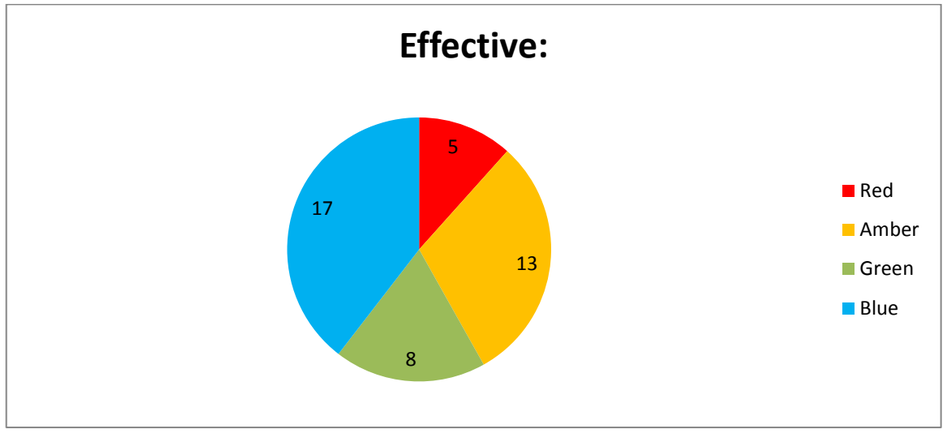
Are we safe?



This domain has 60 actions with 19 actions completed (31%) and 28 actions on track (47%) on track to be completed within the timeframe. There are 13 actions (22%) showing amber, indicating that progress is being made towards completion, but not within the timeframe. This domain has no red actions.

The majority of the amber actions relate to recruitment of nursing and medical staff which is being addressed through international and newly qualified registered nurse recruitment. The Trust maintains its commitment to the nursing strategy and its three year implementation plan to increase staffing across the inpatient areas, in line with the Keogh recommendations in 2013.

Are we effective?

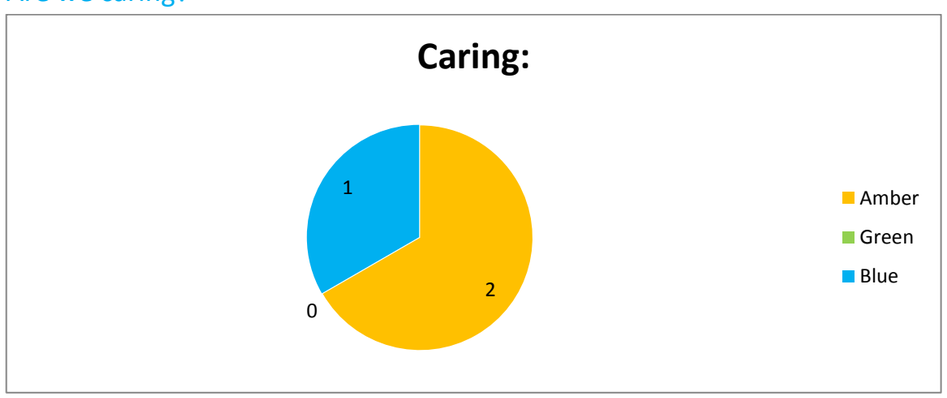


This domain has 43 actions with 17 actions (40%) are completed and 8 actions (18%) are on track to be completed within the timeframe. There are 13 actions (30%) which are amber, indicating that there is progress but the action will not be completed within the original timeframe.

There are five actions (12%) showing red, these actions are:

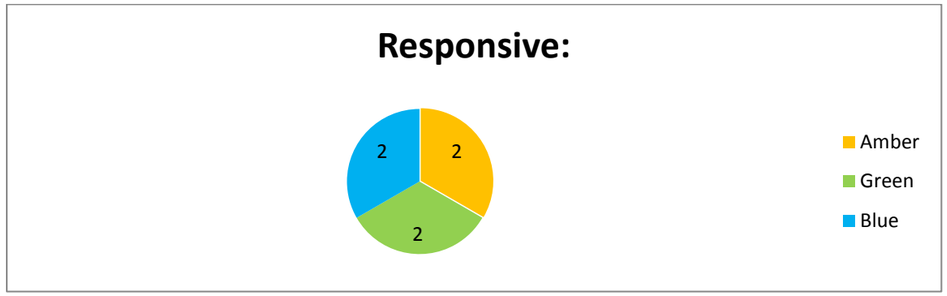
- Infection Prevention & Control – the C-diff trajectory for 2014/15 was 37 and the Trust to date has breached this target;
- Improve patient flow of emergency admission – this action will remain red as the flow and capacity remains an issue for the Trust, this has now been shaded on the Quality Improvement Plan and will be managed through the System Resilience Action Plan;
- Adult Safeguarding – this action is a new action to the Quality Improvement Plan, with concerns raised from different sources;
- Mortality – this action has changed RAG rating as there is a rise in mortality despite the variation between weekday and weekend mortality figures being similar;
- HEEM visit – this action has changed RAG rating as a further two visits have highlighted further issues.

Are we caring?



This domain has 3 actions with 33.3% (1) showing that the action has been completed, 66.6% (2) action is on track to be completed within the timeframe.

Are we responsive?

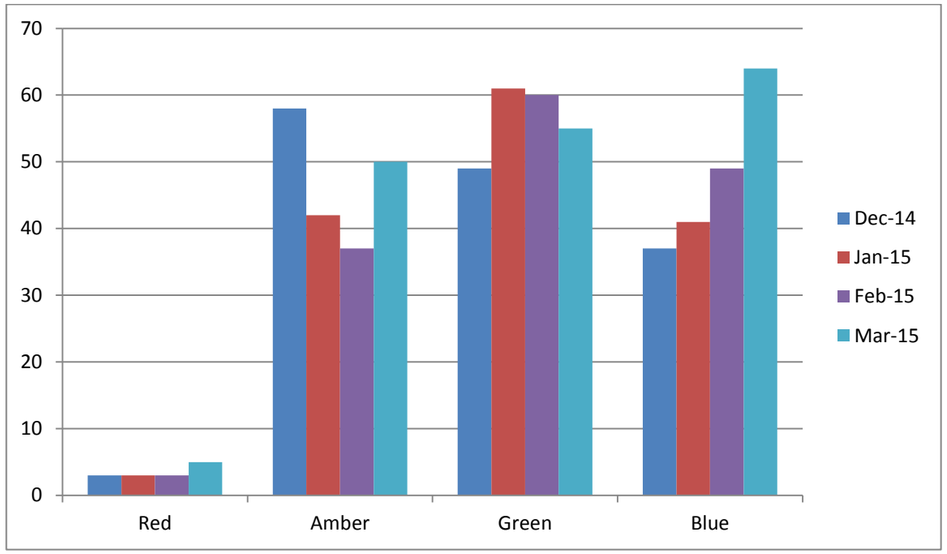


This domain has 6 actions with 33.3% (2) actions demonstrating that the actions have been completed 33.3% (2) actions demonstrating that they are on track, and 33.3% (2) actions which are amber, indicating that there is progress on the actions, but the actions will not be delivered within the original timeframe.

What has changed since February 2015?

- We have added some of the actions from the SMART action plan that have been agreed with Monitor;
- We have added a new key action 17 – Adult Safeguarding;
- We have added 19 new actions under various headings;
- We have made action 10.5 – infection prevention & control a key action which has become key action 18;
- We have section 11 shaded in parts as these parts are being monitored on the System Resilience Action Plan;
- There are three new RED actions identified, which are:
  Adult Safeguarding
  Mortality
  HEEM visit
- We have completed all the work in section 12, and this will be monitored in June for sustain and review;

Have we improved?



The comparison of the position of the actions in February 2015 is difficult to measure as the Quality Improvement Plan has an increase in the number of actions and key actions. There has been a significant increase in the number of completed actions (blue); and a decrease in the number of on track actions (green). There has been an increase in the number of actions where there are progress has not been made which are actions which have been added to the dashboard this month.