Quality *for all*

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Quality Improvement Plan

Working document

Contents:

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.

The Executive coaching programme has commenced and executive team members are now receiving individual coaching. The second team coaching has taken place for 2 February 2015, which included personality type indicators.

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. The Interim Director of Operations participated in the team development session on the 2 February 2015. The job description has now been written in draft for a Chief Operating Officer.

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 and his objectives are drafted but not yet agreed.

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 across the Trust.

Values team conversations have taken place with many 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 are currently considered two options for Staff FFT in Quarter 4, which are:

1. In-house survey using Survey Monkey;
2. Free trial FFT survey with PickerEurope.

We are looking at these two options in order to make our decision, and in order to facilitate developing the survey in time for the Quarter 4 deadline, before 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.

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 commenced in February 2015. We invited April Strategy to attend the Medical Manager's meeting during January 2015.

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 this has commenced. Twelve medical leaders attended the Private Trust Board in January 2015.

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 April/May 2015.

We have completed the leadership and management training needs analysis in January 2015.

Our Service Line Management is being taken forward through the annual planning process for 2015/16 supported by the Head of Strategic Planning.

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 135 open risks; 57 risks have been closed and archived, 47 new risks added, 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 the data to be transferred to the DatixWeb Risk Management. This is underway and will be completed during January, with the training rolled out from February onwards. The risk register is evolving daily providing assurance that risks are being reviewed, archived and re-scored, actions and new risks added.

In December 2014, the first Risk Management Committee was established. Terms of Reference and annual work plan has been agreed. A subsequent meeting was held in January 2015. The two largest divisions (Emergency Care & Medicine and Planned Care & Surgery) had a comprehensive review of their risk register at the February 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 n 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.

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 now implemented DatixWeb across the whole Trust, with staff receiving training to use the system. Automatic feedback to the reporter is now mandatory.

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. All clinical and some non-clinical areas have learning boards. We are presenting Learning Reports to the Clinical Quality & Governance Committee and we are implementing Organisational Learning as a standing item on group/committee agendas. We are discussing at Clinical Quality & Governance Committee, the demonstration of learning and connections between complaints, incidents and feedback.

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. We have implemented intranet 'pop up' messages with key statements which include patient safety alerts.

The implementation of the Nursing and AHP Grand Rounds commenced in January 2015, with the first session on the deteriorating patient presented by ED. The Falls ground Round is planned for 23rd February 2015.

An Innovation Hub is now on the Trust's HQ corridor with plans for moving to the main reception in Quarter 1 2015/16.

The Being Open policy has been circulated through the iCare2 on the 8th January 2015. iCare2 learning event is being developed for March 2015.

Root Cause Analysis training date courses for 2015 have been published on the Trust's intranet. The first training session is 16 February 2015, and all the places have been taken. Rapid review events are being undertaken.

We have delivered dedicated sessions to the Ward Leaders forum on Organisational learning.

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 the 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 internally recruits who have not been part of our preceptor programme.

We have established skill mix in Planned Care & Surgery which has progressed to a 60:40% 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 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 have 4 out of 31 wards in January 2015 that did not meet our internal standard. However, all 4 wards were undergoing staffing reconfiguration, and Emergency Care & Medicine met the UNIFY standard in January 2015.

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 successful recruited to the Acute Physicians posts; one commenced in December 2014, and the second is to commence in February 2015. Two further posts will commence in March 2015, giving us a total of 6 Acute Physicians. 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 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 Trust and this will facilitate reporting across the region.

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 is currently being 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 will be 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.

To support the maintenance of equipment an Amnesty Day is being planned. This will enable us to identify the remaining equipment that is past its maintenance date, which will then help support the MEMD staff in the planned maintenance programme. It is currently difficult to manage the bed maintenance programme due to the current inpatient capacity, but plans are in place to hasten this programme once ward capacity is made vacant (Ward 21).

We are in the process of ordering 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 the Director of Nursing, which meets weekly to drive the improvements required for medicine safety. We have implemented many initiatives 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.

We have trialled a 'swipe action' bedside locker this was found to be unsuitable, so we are currently pursuing another company which is used by another local Trust. We have developed a medicines error policy to standardise the management of staff who make medications errors, this was presented at JSPF week commencing 16 February 2015 for final ratification.

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. The Pharmacists and nurses are undertaking twice monthly missed/omitted drug audits, which are being reported back to the Divisional Matrons to develop an action plan to improve and reduce the number of missed doses of drugs. Our missed & delayed dose audit demonstrated an improvement in late January 2015 after a dip in early January 2015. Ward Sisters are challenging the data which demonstrates an ownership of wanting to improve. We have refined the audit to identify which parts of the system are causing medicine omissions - to enable focused action. Emergency Department are introducing 'team nursing' which is expected to provide greater responsibility for medicine management.

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. 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 January 2015 was 87% (stage 1) and 66% completed (stage 2).

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 implemented of Care & Comfort Rounds on all wards at Sherwood Forest Hospitals. 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, of which 54.4% had been signed twice by the handing over and the receiving nurse.

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 0.19% of case notes missing week commencing 2 February 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. 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. This impacts upon our fluid balance work which we are addressing.

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.

Infection Prevention and Control is currently RAG rated as RED within this section, as we are currently over the trajectory (57 cases) 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. This currently remains a concern and it is not recommended that the RAG rating changes (please refer to the Trust Board Quality & Safety Report).

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.

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 January 218 patients were discharged through the Discharge Lounge which was 12.45% of the Trust's total discharges.

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 an improved performance in the operational standard in January 2015 when compared to December 2014.

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 February and the Duty Nurse Managers will be promoting this tool as a good practice for safe transfer of patients.

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 December 2014 was 'admitted '90.2%' (target 90%); 'non-admitted' 94.3% (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.

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.

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 communications have been agreed.

We are planning to implement Do Not Attend (DNA) texting service in radiology by March, and this is in place for outpatients.

The Urology tele-health monitoring is in implementation.

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 are currently reviewing our approach to Adult Safeguarding and have sought external support.

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 planning to pilot the implementation of an Android App for FFT in Emergency Department and Outpatients in February 2015.

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 is now charged with reviewing the Discharge Policy and updating 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.

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.

Key Performance Indicators:

Key Performance Indicators:	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
All Board posts are filled on substantive basis by competent individuals	Full Board	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
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%
Staff appraisal completion rates for AfC staff at 98% or more			82%	84%	81%	83%	84%	82%	84%	83%	85%	87%
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%
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%	
Infection Prevention and Control – number of C-diff – target 37 cases			**5**	**6**	**5**	**7**	**5**	**7**	3	7	9	3
Deteriorating patient escalation >95% compliance			78%	84%	**92%**	83%	73%	78%	**92%**	84%	**95%**	82%
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%
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%	TBC
Medical Outlier Decision Support Tool compliance												19%
Medical staff appraisal – 90% compliance			92%			93%			97%			98%
Missing Notes in clinic												0.19%
WHO surgical checklist compliance												87% (S1) 66% (S2)
Discharge Lounge utilisation number of patients (% of total Trust discharges)												218 pts 12.45%
Accountability Handover audit – two signature handover												54.4%

Abbreviations:

T = trained/registered nurse

UT = untrained/ healthcare assistant

A = admitted pathway

NA = non-admitted pathway

Assurance Dashboard

Whole

<< dashboard

New Metric

New Metric

Jan-15

Medicines

Fluid Management

Deteriorating Patient

Infection Control

Safeguarding

Equipment

Capa

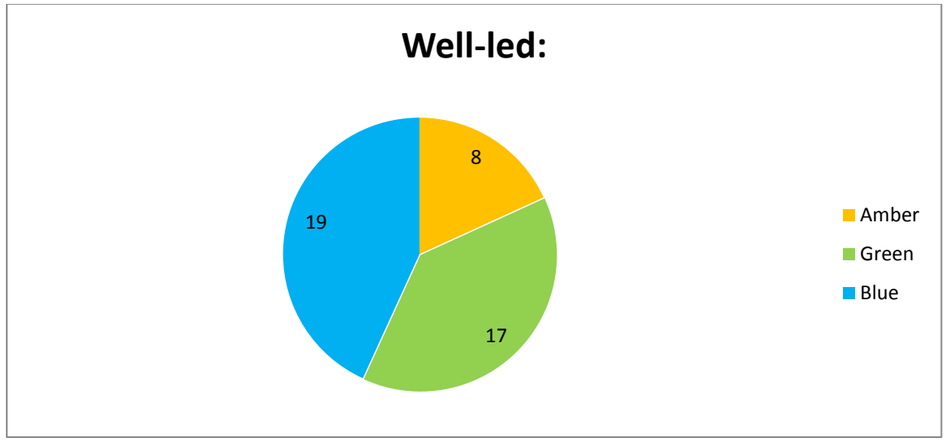
nd = No Data

	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%	89%	76%	N/A	100%	N/A	100%	14.3%
12	95%	99%	100%	67%	90%	50%	40%	50%	100%	13.8%
14	100%	N/A	N/A	75%	91%	100%	86%	100%	100%	12.3%
21	100%	97%	90%	40%	89%	75%	83%	100%	N/A	7.4%
22	100%	100%	100%	75%	90%	100%	80%	60%	100%	19.1%
23	100%	96%	100%	100%	86%	88%	100%	N/A	100%	9.7%
24	100%	98%	95%	100%	93%	84%	100%	N/A	100%	29.4%
25	100%	100%	95%	80%	N/A	100%	N/A	N/A	N/A	23.8%
31	100%	97%	100%	100%	93%	100%	100%	100%	100%	18.2%
32	100%	100%	100%	100%	92%	100%	100%	N/A	N/A	18.9%
33	100%	N/A	N/A	100%	91%	100%	100%	N/A	100%	24.7%
34	100%	100%	100%	100%	95%	93%	100%	50%	100%	46.7%
35	100%	97%	91%	N/A	95%	100%	100%	29%	100%	15.0%
36	100%	100%	100%	40%	84%	90%	100%	N/A	100%	26.5%
41	100%	100%	99%	100%	91%	90%	N/A	100%	100%	18.3%
42	100%	98%	100%	N/A	94%	N/A	100%	100%	100%	34.9%
43	95%	N/A	N/A	40%	83%	77%	N/A	N/A	N/A	10.1%
44	100%	N/A	N/A	50%	93%	100%	100%	100%	100%	13.9%
51	100%	99%	100%	71%	92%	100%	100%	N/A	N/A	34.9%
52	100%	93%	100%	67%	90%	100%	N/A	75%	100%	15.5%

53/4	100%	99%	99%	75%	91%	100%	100%	100%	100%	5.9%
Daycase	90%	N/A	N/A	0%	N/A	100%	100%	N/A	100%	17.1%
Maternity	100%	99%	100%	60%	N/A	90%	57%	N/A	100%	N/A
EAU	100%	94%	95%	80%	89%	79%	40%	100%	100%	23.7%
ED	100%	N/A	N/A	50%	N/A	50%	86%	50%	N/A	N/A
Chatsworth	100%	100%	97%	0%	N/A	100%	N/A	100%	100%	N/A
Lindhurst	95%	100%	100%	n/a	N/A	100%	100%	100%	100%	38.5%
Oakham	100%	99%	100%	100%	N/A	50%	N/A	75%	100%	55.6%
Sconce	100%	99%	100%	100%	N/A	N/A	100%	N/A	100%	27.6%
Minster	100%	N/A	N/A	n/a	N/A	N/A	100%	N/A	100%	77.3%
Total Avg	99%	98%	98%	72%	90%	89%	91%	82%	100%	19.3%

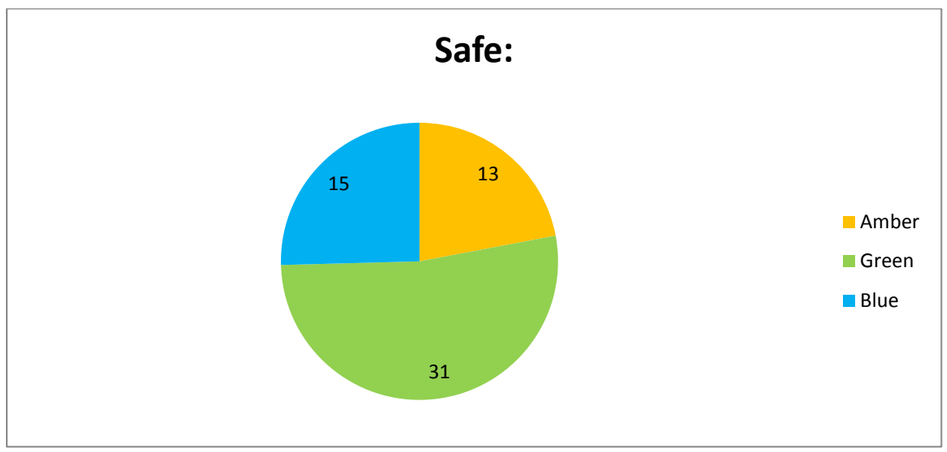
Domains:

Are we well-led?



This domain has 44 actions with 19 actions completed (43.2%) and 17 actions on track (38.6%) to be completed within the timeframe. There are 8 actions (18.2%) showing amber, indicating that progress is being made towards completion but is likely not to be within he completed date. This domain has no red actions.

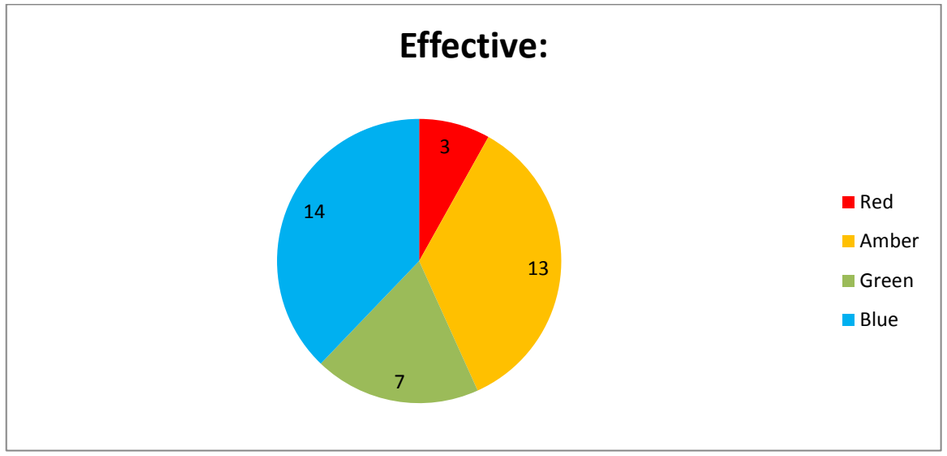
Are we safe?



This domain has 59 actions with 15 actions completed (25.4%) and 31 actions on track (52.6%) on track to be completed within the timeframe. There are 13 actions (22%) showing amber, indicating that progress is being made towards completion. 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?

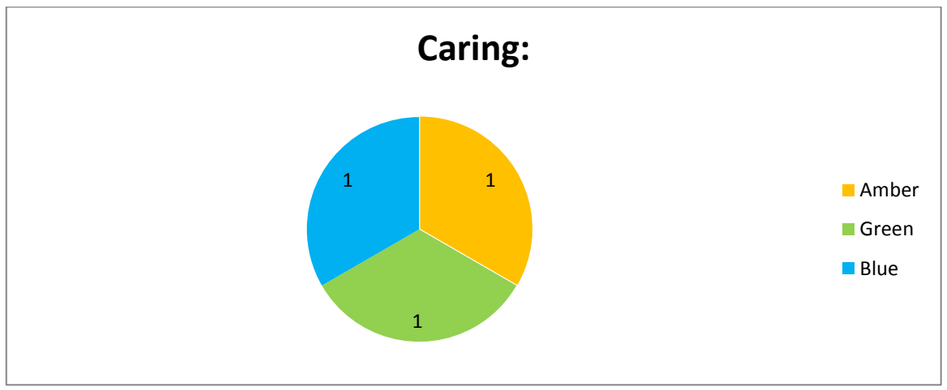


This domain has 37 actions with 14 actions (37.8%) are completed and 7 actions (18.9%) are on track to be completed within the timeframe. There are 13 actions (35.1%) which are amber, indicating that there is progress but the action will not be completed within the original timeframe.

There are three actions (8.2%) showing red, these actions are:

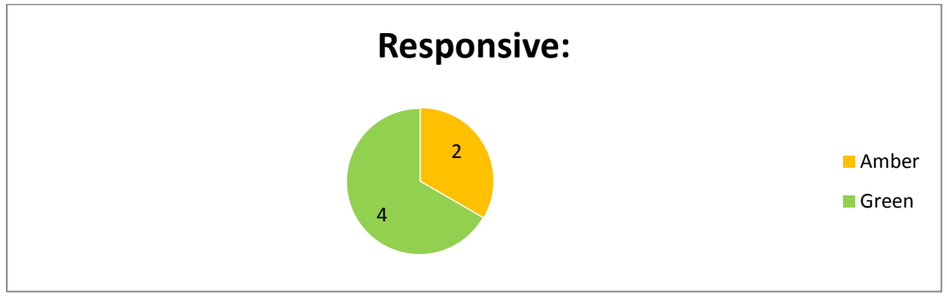
- Infection Prevention & Control – this will be reviewed at the next Quality Improvement Meeting on the 26 January where the Nurse Consultant will provide the group with evidence of the actions being undertaken;
- Improve patient flow of emergency admission/ Medical Day Case facilities (2 red actions) – 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 Emergency Flow Resilience Group.

Are we caring?



This domain has 3 actions with 33.3% (1) showing that the action has been completed, 33.3% (1) action is on track to be completed within the timeframe, and 33.3% (1) action is showing amber indicating that there is progress but the action will not be completed within the original timeframe.

Are we responsive?



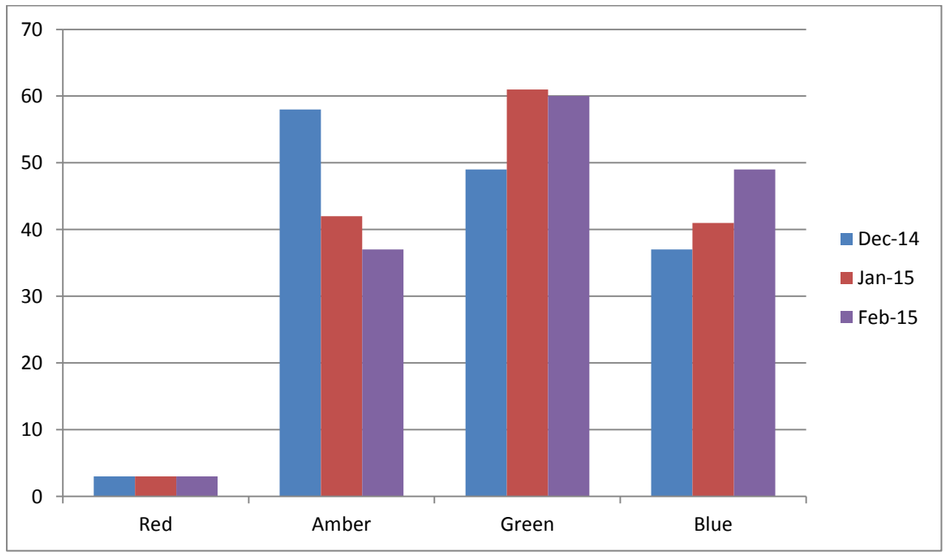
This domain has 6 actions with 67% (4) actions demonstrating that they are on track, and 33% (2) actions which are amber, indicating that there is progress on the actions, but the actions will not be delivered within the original timeframe.

All the amber actions are related to End of Life care, which has been identified as a resource issue, which has not be supported with a whole time equivalent post supporting End of Life care.

What has changed since January 2015?

- 1.4.2 has been added – Recruitment of the Chief Operating Officer;
- 5.1 has been merged with 4.8 – same statement
- 11.3.1 and 11.3.2 has been merged – same statement
- 16 actions in Section 11 have been shaded out and will be monitored through the Resilience Group;
- 3 actions have been added to Section 14 – Adult Safeguarding.

Have we improved?



The comparison of the position of the actions in January 2015 has improved. The number of actions which are in progress but will not be delivered within the timeframe has reduced (Amber). The number of actions which are now on track to deliver in the timeframe has increased (Green), and the number of actions which have been completed has increased.