Nottinghamshire County Council

Health Scrutiny Committee

Monday, 11 July 2016 at 14:00

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

1	To note the appointment by the County Council on 12 May 2016 of Councillor Colleen Harwood as Chairman of the Health Scrutiny Committee and Councillor John Allin as Vice-Chairman.	
2	Minutes of the last meeting held on 9 May 2016	3 - 10
3	Apologies for Absence	
4	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
5	Doncaster and Bassetlaw NHS Foundation Trust	11 - 16
6	Sherwood Forest Hospitals NHS Foundation Trust	17 - 54
7	Work Programme	55 - 60

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Alison Fawley (Tel. 0115 993 2534) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Monday 9 May 2016 at 2pm

Membership

Councillors

Colleen Harwood (Chairman)
John Allin
Kate Foale
Bruce Laughton
David Martin
John Ogle

District Members

A	Glenys Maxwell	Ashfield District Council
	Brian Lohan	Mansfield District Council
	David Staples	Newark and Sherwood District Council
	Susan Shaw	Bassetlaw District Council

Officers

Pete Barker	Nottinghamshire County Council
Martin Gately	Nottinghamshire County Council
Kay Massingham	Nottinghamshire County Council

Also in attendance

David Ainsworth	Mid-Notts CCG
Julie Andrews	Mansfield and Ashfield CCG
Moira Hardy	Doncaster and Bassetlaw NHS Trust
Paul Moore	Director of Governance Sherwood Forest Hospitals Trust
Abid Mumtaz	Mansfield and Ashfield CCG

MINUTES

The minutes of the last meeting held on 14 March 2016, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Kim Darby from Central Nottinghamshire Clinical Services (CNCS) submitted her apologies.

DECLARATIONS OF INTEREST

Councillor Laughton declared a private pecuniary interest as his wife now works for the Nottingham University Hospitals Trust and Councillor Martin declared a non-pecuniary interest in item 6, Underwood Surgery, as it was in his electoral division. Neither declaration precluded the Councillors from speaking or voting on any item.

CENTRAL NOTTINGHAMSHIRE CLINICAL SERVICES

Mrs Kay Darby, Interim Director of Nursing & Operations for Central Nottinghamshire Clinical Services was unable to attend the meeting therefore it was agreed that this item would be moved to the July agenda.

The Chairman requested that a letter be sent to Mrs Darby pointing out that her attendance at Committee was not optional.

SHERWOOD FOREST HOSPITALS – QUALITY IMPROVEMENT PLAN

Paul Moore, the Director of Governance, Sherwood Forest Hospitals Trust, introduced the report and informed Committee that he would verbally provide updates on latest developments where appropriate. Paul explained that there had been problems over many years, especially in the area of improving patient care, but since he had joined in January many actions had been completed, with procedures now becoming embedded. April was the first month ever where no serious incidents had occurred and this represented significant progress.

Paul informed Committee that one action was still rated as red under the Leadership Domain as it had proved problematical recruiting a medical lead for clinical governance, though colleagues from NUH have provided much needed assistance. Some thought was being given to recruiting a non-medical person. Paul explained that the governance work-stream had presented many challenges but that now he was in post and the team had been established significant progress had been made and it had been possible to focus on what was important including the duty of candour.

In terms of recruitment Paul explained that ‘Consultant Job Plans’ was rated as red but each consultant now had a plan in place and was aware of what was required of them. The action of having a nurse with a European Life Support Certificate on every shift was rated as amber. Providing the training had proved a challenge because of the pressure of work with training schedules having to be cancelled.as a result. Training had been rescheduled and was largely complete with a rota system also having been introduced.

Under the Personalised Care Domain Paul explained that 2 measures were red, mainly as a result of outstanding training. For basic End of Life training good progress had been made training nursing staff but compliance for medical staff needed improvement. In terms of End of Life training for practitioners this depended on the completion of the review by Hampshire NHS Trust which had yet to commence.

Paul explained that ‘Safety Culture’ was the biggest workstream with priority given to infant mortality, septis and patient safety. Paul spoke about Critical Care Outreach where patients did not require intensive care but did need to be monitored as sometimes there was a need to provide care urgently. Recruitment problems meant that it was not possible to achieve the aim of providing this service until 2am every day and work was ongoing to identify when peak demand occurred and how the service could be organised accordingly.

The problems with resuscitation trolleys had been caused through confusion with the procurement process and as a result completion of the action had dragged on. Paul stated that there was a need for the equipment to be checked daily and that evidence of this was currently being gathered.

Paul then told the Committee about ‘Timely Access’ that is, the flow of patients, where the action for all clinical staff on RTT and reconciliation to attend a teaching session was classed as red. Paul explained that no other hospital had been asked to train all of its staff on reconciliation stating that doctors are not normally trained as it takes them away from their day job. The CQC have been asked for clarification of who needs to be trained but that at the moment 64% of all staff had been trained.

Paul informed the Committee that good progress was being made under ‘Mandatory Training’ As far as ‘Staff Engagement’ was concerned a partnership with NUH was currently being investigated with the aim of aligning techniques which may result in the plan being adjusted.

Again, good progress was being made under the heading of ‘Maternity’ and Paul confirmed that leaflets in different languages had been produced and access to interpreters was available. Some challenges remain however, and Paul expressed his concern at the level of admin support available. In Newark Paul confirmed there were no significant problems with actions in line with strategy.

Following the introduction the following points were discussed:

- The Committee raised the issue of the relationship with the NUH, in particular the problems of funding the Kingsmill debt and other issues that may delay or even prevent the merger. Paul replied that discussions were continuing and though he did not know the outcome both parties were still at the table and there were no signs that the NUH was going to disengage.

- The problem of training medical staff was raised and the contrast with the ease with which nursing staff seem to be trained. Paul replied that the medical staff do train though it is not mandatory and because there are fewer doctors than nurses, when workloads are high the doctors need to remain on the frontline and this does set training back.

- The Committee expressed surprise that the Trust had initiated its own e-learning scheme given the amount of time and money this would have taken to develop, and queried whether there were not existing resources available at a regional or national level that could be used instead. Paul agreed that the essence of training did not change from organisation to organisation but the decision had been made to provide training in as many ways as possible with the aim of maximising the numbers of those engaging. Paul agreed to ask the network to see what other resources might be available.

- The Committee asked about the action regarding critical care outreach and queried its retention if it was not obtainable. Paul answered that he felt it was a good ambition, the need for it was being examined and if it was concluded the need was there, the action would be retained as red until progress had been made. It was possible that the solution would involve a rebalancing of resources.

- With regards to Patient Safety the Committee asked who checked the equipment and how long did it take. Paul answered that the equipment was usually checked by a nurse and that the time taken varied depending on circumstances. If the seal on a drawer was intact and the oxygen was full, the check could be completely very quickly. However, if the drawer was open all the contents needed checking and this could take an hour, or even longer in paediatrics. Paul explained that in the past this checking was not being undertaken by everyone and that the action would remain red until he was satisfied that everyone was undertaking the required checks. The Committee asked whether there was a culture problem in this area. Paul replied that he thought the culture was changing and he was trying to get the message across to everyone how important it was that such checks were carried out.

- The Committee was pleased to hear that the guidance to maternity services was available in a variety of languages but felt that this example needed to be adopted on a wider scale and asked how the public could find information about other services and procedures. Paul replied that anything could be translated and needs were identified at the first point of contact but stated that the task of harmonising/standardising patient information across 6 hospitals would take months to conclude.

- The Committee thanked Paul for his verbal updates and asked about the progress being made towards improvement. Paul replied that the culture was changing as a result of the many initiatives adopted and felt that things were moving in the right direction. The problem of vacancies in the acute area was a national problem but it was especially bad for the Trust and it is an ongoing problem. The Trust did not want to rely on temporary staff. The Committee stated that Nottingham University only recruited students onto the nursing degrees if they achieved ‘A’ at ‘A’ level, the Committee felt this was not relevant and even counterproductive to the recruitment of more nurses and wondered whether there was anything the Trust could do to influence Nottingham University. The Chair informed Committee that she was aware of work being undertaken into why many were training in Nottingham but moving away once they had qualified. The Committee felt that the recent removal of bursaries would not help the situation.

- The Committee thanked Paul for his report but asked if it could contain less jargon and be more ‘member-friendly’ in future. The Committee asked for a presentation to the next meeting to include the following topics:

  - End of Life Care
  - Newark
  - Emergency Department

UNDERWOOD SURGERY

David Ainsworth(Mid-Notts CCG), Julie Andrews and Abid Mumtaz (both Mansfield and Ashfield CCG) introduced the report. Abid explained that a request in writing had been received from the surgery to close down. The CCGs felt that there had not been enough consultation. Once this had taken place a second request had been received and this had been refused. The CCG's decision was final, though there was an appeals procedure in place. David explained that the main reason for the decision was based on the outcome of the consultation. A public meeting had taken place and the overriding feeling was that users did not want the surgery to close, also, the case for the need for closure had not been made.

Following the introduction the following points were raised and discussed:

- The Committee asked how the surgery was going to continue when the GP had retired. David explained that a replacement GP had been found and had been appointed on 1st May. The GP was local, having worked in Jacksdale, knew the local population and would be full-time.

- The Committee expressed concern at the quality of the accommodation at the surgery thought this may put patients at risk. Abid clarified that the references to unsuitable accommodation were to alternative sites and not the existing site which presented no problems. David informed the Committee that discussions were underway to provide an OT clinic and the accommodation provided the new GP with the room to expand their business. David thought it had been a good example of everyone involved working well together and achieving a positive outcome. The Committee expressed its thanks and felt that this was a good service that had been saved.

DONCASTER & BASSETLAW HOSPITALS TRUST DRAFT QUALITY ACCOUNT

Moira Hardy from the Doncaster and Bassetlaw NHS trust introduced the report. Moira explained that the report was in a standard format and reflected a mixture of experiences. The financial position had changed in 2015/16 due to misrepresentation and as a result the CQC and the NHS had become involved. A turnaround plan was now in place and was being progressed by an internal team with external help. Disciplinary action against internal staff was going ahead. Moira explained that the turnaround plan seemed to be working, against a target of -£38.4m the actual figure achieved was -£36.4m. Improvements in quality had also taken place. The Hospital Standardised Mortality Ratio (HSMR) had been 120 in the past but had improved now to 90. Access and treatment standards had been met and the ED rating of 94% against a target of 95% put the Trust in the top 10% nationally. Moira explained that much work had been undertaken in the fields of pressure sores and falls and that positive results have been achieved. Extra investment had been made available to pump prime certain areas to see where improvements could be made and when the CQC visited in April it concluded that 78% of the work undertaken was deemed good. Moira said that improvement was still needed but that plans were in place to achieve this.

Following the introduction the following points were raised and discussed:

- The Committee welcomed the style of the report and liked the Q&A format, though expressed concern at the lack of clarity of the Chief Executive's statement.

- The Committee queried some of the target s set and the ratings given. Moira replied that she had only been responsible for part of the report and undertook to supply the answers to queries raised via Martin Gately. The Committee thanked Moira but asked that in future could someone more senior attend who had a complete overview.

- The Committee raised the issue of the high academic entry standards for nursing courses. Moira replied that that there were a variety of routes into the profession, though some trained in nursing as they wished to enter the health profession and consequently did not work as nurses once qualified. Moira told the Committee about the agency salary cap which she regarded as a positive development but would only work if everyone adhered to the limit.

- The Committee congratulated Moira on the good performance achieved in the field of pressure sores. Moira replied that the Trust had looked into what needed to be put in place to prevent sores. In the ED Department patients underwent a 2 hour skin integrity assessment so that measures could be put in place at the beginning. Education and training had been implemented for both registered and non-registered staff. There is also a high level of scrutiny undertaken when sores do occur with a response provided to the patient in 24 hours. An examination is completed to ascertain whether the sore has been caused by the hospital in question but that sometimes a sore is the least-worst scenario. Moira informed the Committee that a numerical scoring system was in place to assess which patients are at risk but sometimes the scores were not entered correctly or errors were made in the calculations so a more visual record system would be adopted. A need has been identified for more air mattresses but this presented a challenge financially, also nurses were quick to escalate a problem but slow to de-escalate. Moira informed the Committee that ward based auditing had been introduced in wards where the incidence of sores had been high, stretch targets had also been introduced and the positive result had been that wards had got competitive in attempting to drive occurrences down. The 'skin team' are proactive and travel round wards to train staff. Senior staff have been targeted with the expectation that they will be able to cascade the training downwards. Moira stated that much money could be saved if sores were prevented in the first place, though it does get harder year on year to sustain the level of performance as the quick wins are achieved early in the process. Moira confirmed that learning is shared with new staff when they start.

- The Committee thanked Moira for presenting the report and she confirmed that she would provide answers to the Committee's outstanding questions via Martin Gately.

PUBLIC HEALTH COMMISSIONING

Kay Massingham from Nottinghamshire County Council presented the report which gave details of the directly commissioned Public Health Services as of 1 April 2016 and highlighted the 2 services due to be commissioned during 2016/17:

i) Children's Public Health services – Integrated Healthy Child Programme and Public Health Nursing Service for 0-19 years

ii) NHS Health Checks services

Following the introduction the following points were raised and discussed:

- The Committee observed that for services that had been commissioned for a number of years it was essential that the opportunity to comment was given the Committee before the expiration of the contracts. The Chair agreed and asked Martin to liaise with Barbara Brady in Public Health to arrange the submission of reports regarding the Drugs & Alcohol Services and the Obesity & Weight Management Services.

- The Chair clarified that the role of the Health Scrutiny Committee was not to commission services, which was the role of the Public Health Committee, but to investigate whether the consultation process had been carried out correctly and select which commissioned services to scrutinise.

WORK PROGRAMME

The work programme was discussed and it was agreed to delete the proposed report on Sexual Health and to add the following items to the work programme:

- Sherwood Forest Hospitals update
- Community Pharmacies
- IT Links (when re-procured)
- Doncaster & Bassetlaw Hospital Trust Accounts (to include an explanation of what has happened, why it has happened and what can be put in place to avoid any reoccurrence)
- Dentistry (Martin Gately is to visit Birmingham in June and will report back on shortcomings)

The meeting closed at 3.56pm

Nottinghamshire County Council

Report to Health Scrutiny Committee

11 July 2016

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

DONCASTER AND BASSETLAW NHS FOUNDATION TRUST

Purpose of the Report

1. To introduce information on the surgical pathway at Bassetlaw Hospital, as well as the Trust's financial position.

Information and Advice

2. Mike Pinkerton, Chief Executive of the Trust will attend the Health Scrutiny Committee to brief Members on these issues.

3. A briefing from the Trust on the surgical pathway and finances is attached as an appendix to this report.

4. Members will wish to schedule ongoing consideration of surgical pathway and financial matters at the Health Scrutiny Committee until the issues are satisfactorily resolved.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing on the surgical pathway and finances, and asks questions, as necessary

2) Schedules further consideration of issues of concern in relation to Doncaster and Bassetlaw NHS Foundation Trust, as required

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected
All

Briefing

June 2016

Surgical Pathway at Bassetlaw Hospital

At the beginning of May 2016 we had to take action to maintain the safety and efficacy of key elements of the emergency surgical service at Bassetlaw Hospital. This means that all emergency surgical patients presenting at Bassetlaw Hospital's Emergency Department (ED) will be seen by a senior surgical doctor, and GP referrals are also continuing to be received as normal.

The change has taken place as there is very limited availability of doctors for the out-of-hours and in hour's middle grade rotas. We have been trying to recruit to the positions for some time, and despite our best efforts those recruitment drives have been unsuccessful, so although this is a temporary measure it is not one that is likely to be resolved soon. There is no financial constraint on recruiting to these positions and the national drive to reduce locum expenditure through a system of caps on rates has also not affected this particular situation.

Surgical patients attending the Bassetlaw ED are triaged using an agreed tool, to assess which of following four pathways (routes to treatment) patients will follow.

1. Acutely unwell patients will be transferred to Doncaster Royal Infirmary for inpatient treatment (approximately 10 - 14 in a week).
2. Patients who require a review in ED will be seen by the consultant in the week until 6.00pm and by the speciality and associate specialist doctors out of hours.
3. "Hot" clinics will be available twice daily to book patients into for consultant review if appropriate.
4. Some patients will be directly discharged with advice.

For some years certain forms of emergency surgery have not been provided at Bassetlaw (including Vascular, ENT and Gastro Intestinal surgery) which have successfully been managed through a "stabilise and transfer" pathway for admissions, similar to that now in operation for the balance of emergency surgery. Maintaining the pathways as we have under current arrangements also means that the emergency surgical assessment service remains in place at Bassetlaw and many more patients are safely discharged following review or will be reviewed by consultants in the hot clinics than will be required to transfer.

Bassetlaw Hospital now has a Monday to Saturday surgical ward facility where mainly elective surgery will take place. This means that we are now able to transfer more elective surgical patients, currently treated at Doncaster Royal Infirmary, to Bassetlaw Hospital. Significantly the first bariatric surgery, a complex procedure requiring high dependency support for patients post procedure, has already taken place at Bassetlaw Hospital since the changes and more cases are scheduled.

We are continuing to evaluate the impact on patient flow and review it on a weekly basis. Early feedback from patients has been very positive with respect to the hot clinics where an expert consultant opinion is readily available.

Financial position update

Background

In October 2015 the Trust reported a change in position, from forecasting a small end of year surplus to a substantial deficit, after uncovering significant misreporting of the financial situation to the Board of Directors. This meant that we ended the year £46.7m in deficit of which £36.4m related to the normal operations of the trust with the other £10.3m relating to a revaluation downwards of the value of the trust's lands and buildings. Further investigation also identified that £16.5m of adjustments were required to the 2014/15 accounts leading to a deficit in that year also.

Working closely with our regulator, NHS Improvement (formerly Monitor), we appointed an independent, external investigation into the misreporting. The report of that external investigation by KPMG has now been concluded and a redacted version of the report is available to read on the Trust's website www.dbh.nhs.uk

While the investigations were taking place we as an organisation, had a clear view that the Trust was in a position of Financial Turnaround. Working with NHS Improvement, we immediately put actions in place to improve the control of our finances. This included increasing capacity of the executive team by establishing a director responsible for turnaround and creating a small, internal delivery team dedicated to the financial turnaround of the organisation with a focus on the key tasks to deliver savings, without compromising our commitment to quality. As a result we saw a reduction in expenditure of more than £1.5m from November to March, positively impacting on the forecasted year end position.

We ended the financial year £36.4m in deficit related to the normal operations of the trust, delivering cost savings of £1.85m and spending £12.8m on capital. This is around £2m better than forecast and shows the clear impact of measures we have taken to control expenditure. However, following a formal revaluation, the trust's lands and buildings value decreased by £10.3m.

At the end of the last financial year (March 2016) we shared with NHS Improvement a clear and achievable plan, delivering an £11m Cost Improvement Plan (CIP) for this year which is based on a financial framework and balance sheet that is as accurate and clear as it is possible to be.

The £11m CIP forms an integral part of our recovery plan for 2016/17. In addition to delivering the immediate recovery plans we are now working on our recovery plan for 2017/18 which will be completed by the end of July 2016. The strategy for financial

sustainability and the longer-term 5 year financial plan will be developed by the end of September, building on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) which is due to be finalised in June.

Overall, we continue to receive positive feedback and support from NHS Improvement about our approach and the progress with Turnaround. More importantly we are showing savings can be delivered and change in behaviour can be swift, supportive and sustained.

The month one (April) contribution to the CIP (which is based on when phased activity will begin to deliver savings) was set at £454k, with an additional stretch target we have set ourselves to £580k. In April delivery was £597k which is £143k ahead of the original plan and £17k ahead of the stretch plan. This contributed to the trust overall financial position which was £250K better than plan.

The early indication for month 2 (April) is that progress has continued to be made in a similar fashion.

All work to reduce and control cost is within one of the 13 identified work streams, which are being managed by the small, internal Project Management Office under the Director of Turnaround. All work streams are subject to fortnightly challenge meetings to ensure progress is on track.

Although it is incredibly important, and during a period of Financial Turnaround it will remain a key focus, it is important to remember that finance is only one of the areas where we have to deliver for our patients. We are here primarily to provide safe and effective care and in these areas the performance of the Trust has been strong over the last year, with the majority of quality and performance targets achieved, or outperformed, and 15/16 will also be remembered as the year the Trust for the first time delivered a sub 100 mortality level for our public, which includes communities with some of England's highest rates of deprivation and morbidity and hence reliance on local health and social care services. Other organisations will in future be obliged to support areas where we have already invested in strong services, such as seven day care.

So in summary, it's not finance or quality, it has to be both, and many of the measures we will take to improve efficiency will also positively impact on quality overall, and/or individual patient experience. Equally, we will ensure that relevant efficiency business cases are carefully assessed for impacts to quality and risks eliminated, or mitigated to the maximum extent possible. Our Quality Impact assessments are signed off by Medical and Nursing Directors and shared with our local CCGs, now formally part of the Turnaround programme arrangements and on an annualised basis with Integrated Care Board at Bassetlaw, which has wide organisational representation.

Nottinghamshire County Council

Report to Health Scrutiny Committee

11 July 2016

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

Purpose of the Report

1. To introduce information on Sherwood Forest Hospitals further to the Care Quality Commission (CQC) inspection.

Information and Advice

2. Ben Owens, Clinical Director, Urgent and Emergency Care, Paul Moore Director of Governance and Hayley Allison, Assistant Chief Operating Officer will attend the Health Scrutiny Committee to brief Members on the improvements that are being put in place.

3. The briefing and presentations from Sherwood Forest Hospital will cover a) all aspects of the Quality Improvement Plan b) The Emergency Department c) Newark Hospital d) End of Life Care. Briefing material and presentations are attached as appendices to this report.

4. The CQC inspection Sherwood Forest Hospitals NHS Foundation Trust are attached as links in the background papers section of this report. The overall rating for the Trust is inadequate.

5. Sherwood Forest Hospitals Trust have provided ten workstream overview reports and the Quality Improvement Plan Dashboard with a view to demonstrating the current state of progress against their improvement plan.

6. Members will wish to schedule ongoing consideration the Sherwood Forest Hospitals Quality Improvement Plan at future meetings of the Health Scrutiny Committee until the issues are satisfactorily resolved.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing on the Sherwood Forest Hospitals Quality Improvement Plan, Emergency Department and Newark Hospital, and asks questions, as necessary

2) Schedules further consideration of issues of concern in relation to Sherwood Forest Hospitals, as required

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Sherwood Forest Hospitals NHS Foundation Trust Quality Report

Kings Mill Hospital Quality Report

Mansfield Community Hospital Quality Report

Newark Hospital Quality Report

Electoral Division(s) and Member(s) Affected
All

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
1. Leadership	Interim Chief Executive Officer Peter Herring	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
		R	A	G	B	B G	Grey	15	5	4
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	15	5	0	4	Total Actions in Workstream: 24		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
1.2.2 - Enhance Divisional clinical governance arrangements and appoint to five clinical governance leads.	31.12.15	Closed / to be removed – see action 5.2.1	May 2016 update: On-going discussions and potential solutions continue to be explored with NUH for the vacant positions in Medicine and Emergency & Urgent Care.	31.5.16

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
1.4.4 Develop an on-going programme of Medical Leadership	Yes	

1.5.1 Revised Board Development programme at a collective and individual level which includes effective assurance and governance disciplines and the assignment of NEDS to Execs for effective delivery of sub-committees	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	Rationale
1.1.1 Refresh the Trust strategy in light of the direction agreed with regulators and stakeholders.	Action superseded by LTP. It is not appropriate to refresh the Trust strategy in light of the LTP. Short term immediate priorities were developed to reflect the LTP and agreed by Board February 2016. The merger and new organisation will determine the future strategy.
1.1.2 Develop a revised compelling strategic narrative	Action superseded by LTP. It is not appropriate to develop a revised compelling strategic narrative in light of the LTP. Therefore short term immediate priorities were developed to reflect the LTP and agreed by Board February 2016. These strategic priorities are the strategic narrative during the LTP transition period. The new organisation will determine the future strategy and therefore the strategic narrative.
1.1.3 Develop and deliver a deployment plan to communicate and engage with staff, patients and visitors, in relation to strategy	Action superseded by LTP. Trust strategy superseded by LTP approach. Short term immediate priorities developed and implemented which reflect the LTP; communicated at staff engagement sessions and team briefings. Due to the LTP a separate SFH strategy for patients and the public is not appropriate therefore actions stayed.
1.5.5 – Robust utilisation of strategic partners to develop peer support programme for specific Non-Executive assurance visits.	Action superseded by LTP. Effective peer support partnerships were established with Non-Executives at NUH. However, due to the LTP tender process the partnerships were suspended to avoid any conflict with other potential LTP's. As part of the NUH merger, some of the NED's may form part of the new board going forward.

Quality for all

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
2. Governance	Director of Governance Paul Moore	Yvonne Simpson

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
		R	A	G	B	B G	Grey	19	32	0
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	19	4	28	0	Total Actions in Workstream: 51		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
2.1.9 – The Clinical Governance Lead for Women & Children's Division has identified that additional resources are requirement to embed this action.	The Divisional General Manager has, in budget setting, identified the resources required by the CG Lead, and is currently reviewing bank administrative support.	This has been identified as a risk to embedding not to delivery

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
2.1.10 – New Quality Governance Unit	Yes	
2.4.1 – Develop a Duty of Candour Strategy for the Organisation which is aligned to Governance	Yes	

and risk work plans so that open and transparency is business as usual		
2.5.2 – Develop a new set of pathways to support the improved interaction and decision making processes between these departments and publish on the intranet	Yes	
2.5.11 – Inappropriate patient care in the Emergency Department, such as where patients had had an interventional procedure in the department for fractures but had not had an x-ray. Trainees felt that the patients were not always properly assessed and were being sent to T&O to 'rule out' a fracture. Ensure that correct x-ray protocols are in place and are being followed.	Yes	
2.5.12 – To address concerns relating to lack of trainees supervision, over booking of clinics and absence of local protocols. Ensure that the Trust develops and implement detailed action plan for concerns raised in Ophthalmology	Yes	
2.5.13 – Create a new and standardised approach to Junior Doctors Forums. Ensure trainees are able to raise concerns quickly and safely and feedback to trainee's actions taken on any issues raised.	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
None	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
3. Recruitment & Retention	Interim Director of HR Julie Bacon	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
		R	A	G	B	B G	Grey	10	4	1
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	10	4	0	1	Total Actions in Workstream: 15		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
3.5.4 Conduct a nursing skills audit of non-MAST clinical practice capacity. Address gaps through further training and or recruitment of staff with appropriate skills. Deploy and monitor training capability for each shift. CQC Must do: Ensure that at least one nurse per shift in each clinical area (ward/department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.	31/03/16	Green	May Update: Met with Ward 25 Managers in April and rotas reworked; now have 1 EPLS trained nurse per shift from 25.4.16 to 03.07.16. Contingency plan in place for any unplanned absences of EPLS trained nurse. Additional External training being explored with LTP. Paediatric Lead confirmed Emergency Department confirmed have more than 1 EPLS trained nurse per shift. MIU Newark have 1 EPLS / PILS trained nurse per shift. Discussed and agreed with Programme Director and Improvement Director action should be green in light of action completed.	30/04/16

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
3.5.3 – Scope the functionality of the current ESR workforce information management system. Ensure alignment with capacity, demand and financial planning.	Y	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	Rationale
3.5.3 – Scope the functionality of the current ESR workforce information management system. Ensure alignment with capacity, demand and financial planning.	Action superseded by LTP. Functionality of current ESR scoped and business case developed; put on hold re LTP approach. April 16 staff in post aligned to new clinical divisional structures. Work commenced May 16 with LTP on HR Systems Review, therefore action encompassed within LTP Workstream.

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
4. Personalised Care	Chief Nurse Suzanne Banks	Val Colquhoun

Overall BRAG	Reporting Period:	Action BRAG rating analysis								
		R	A	G	B	B G	Grey	Active Actions	Assurance Actions	Long Term Partnership Actions
GREEN - Completed/ On track to deliver by target date	May 2016	3	0	17	6	4	0	20	10	0
								Total Actions in Workstream		
								30		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
4.4.4 - All frontline clinical staff complete Basic Level 1 training on End of Life Care	31/03/16	RED	High risk in delivery due to insufficient resources to support training. Exploring options to commission additional capacity. Whilst nursing compliance via mandatory training is increasing 73% completed in February and 79% 80% in March the Medical staff compliance requires improvement. Medical E-Learning training has commenced March 2016. Compliance figures monitored and awaiting numbers.	31/08/16
4.4.5 – Appropriate Specialist Nurses and End of Life champions complete advanced training on End of Life care.	31/03/16	RED	The review of training completed. Vacancy gaps and time resource preventing full realisation. In addition the outcome of the work with Hampshire 11th/12th May 2016 will inform way forward.	31/07/16

4.4.1 – End of Life Care Ensure there is a review the hours of service provided by the specialist palliative care team to consider a face to face service available seven days a week Ensure there is a service level agreement for the provision of specialist palliative care to minimise the risks associated with this service being withdrawn.	30/04/16	RED	Hampshire confirmed to support SFH with a peer review 11th/12th May 2016 to look at specialist services currently provided. The review has yet to commence and terms of reference to be agreed. The business case has separated out 1. The internal core team in the Trust 2. The financial implications 3. The external requirements EOL team to expand on the business case for the Commissioners to include data supporting improving EOL care and services, highlighting standing issues and system wide solutions. The internal service specification can be addressed however the external service specification requires further consideration and influence by their stakeholders.	31/07/16

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
4.2.3 Review and develop assessment process and documentation to include cognitive assessment for all over-75 ED attenders	Yes	
4.2.11 Secure support from Mental Health colleagues on multi-disciplinary working group	Yes	
4.2.12 Develop and implement delirium pathway	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	Rationale
None	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
5. Safety Culture	Medical Director Andy Haynes	Yvonne Simpson

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
GREEN - Completed/ On track to deliver by target date	May 2016	R	A	G	B	B G	Grey	37	26	0
		2	0	37	14	22	0	Total Actions in Workstream: 75		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
5.1.1 – Establish a Patient Safety Culture Team with clinical lead and project support team to drive the programme of work	31/01/16	GREEN	The Safety Culture Clinical Lead has been identified and the Safety Culture Lead, to work in conjunction with the team from NUH. Recommend that this action moves to GREEN	30/04/16
5.1.2 – Establish resource requirements (patient safety champions, clinical lead, full-time project manager), programme structure, objectives and timeline	31/01/16	GREEN	The Safety Culture Clinical Lead has been identified and the Safety Culture Lead, to work in conjunction with the team from NUH. The draft Project Initiation Document has been drawn up and KPIs are being agreed Recommend that this action moves to GREEN	30/04/16
5.2.1 – All divisions will have a senior Clinical Governance Lead with responsibility to ensure issues of concern are highlighted, escalated and acted on	31/01/16	RED	Two divisions remain without a Clinical Governance Lead, and we are now discussing with Nottingham University Hospitals for support. To incorporate Action 1.2.2 from Leadership Workstream.	30/06/16

5.3.26 – Extended Critical Care Outreach (CCOT) support to give access until 02.00 hours on a daily basis and utilising Vital Pac real-time monitoring as appropriately	31/10/15	RED	The CCOT rota is currently unsustainable due to vacancies and long term sickness. Therefore, the extended CCOT hours have been delayed. A benchmarking exercise with other local Trusts has been agreed at the Quality Improvement Board and to be reported in May 2016.	30/06/16
5.6.7 – Anywhere not utilising resus trolleys to have quality assurance solution similar to that implemented with trolleys	29/02/16	GREEN	The Paediatric Ward 25 is currently good compliance with PREM trolley checks, and the Emergency Department is currently on daily reports to the Director of Governance. Recommend this action moves to GREEN.	31/05/16

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
5.3.16 – Sepsis presentation included in locum induction; 5.3.19 – Sepsis update added to 'Green Card' checklist for Agency Nurse induction	These actions are being monitored through the Sepsis Taskforce Group. However, the evidence of locum medics and nurses induction is currently not consistent.	This has been identified as a risk to embedding not to the delivery of the action
5.6.6 – Resuscitation trolleys and daily checks. There is insufficient assurance that there are regular resuscitation trolley checks on the wards.	This action is to be discussed at an escalation meeting with the Chief Nurse.	Counter measures are in place to remedy deficits.

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
5.3.3 – Establish monthly audit for Sepsis Screening in all ward areas on all three hospital sites	Yes	
5.3.4 – Establish monthly audit for Sepsis 6 Bundle compliance in all ward areas on all three sites	Yes	
5.3.5 – Retrospective audit of Sepsis Screening in all admission areas for national CQUIN	Yes	
5.3.6 – Retrospective audit of antibiotic administration in severe sepsis in all admission areas for national CQUIN	Yes	
5.3.9 – Monthly review of RCA reviews of cardiac arrests in septic	Yes	

patients		
5.3.17 – Sepsis and Fluid Management included in induction of all nurses	Yes	
5.5.9 – Put in place temperature checking sheets with both maximum and minimum recordings. Ward managers to ensure this is completed and daily review by the matrons	No	QIB requested further evidence – Defer to June 16
5.6.5 – Process for regular checking of resus equipment and trollies in MIU to be reviewed to ensure it corresponds with trust standards	Yes	
5.6.12 – Needs assessment of IT requirements in ED to be undertaken – where further computers needed to be undertaken with IT to source and provide computers.	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
None	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
5. Safety Culture	Medical Director Andy Haynes	Yvonne Simpson

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
		R	A	G	B	B G	Grey	38	37	0
GREEN - Completed/ On track to deliver by target date	May 2016	2	0	36	14	23	0	Total Actions in Workstream: 75		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
5.1.1 – Establish a Patient Safety Culture Team with clinical lead and project support team to drive the programme of work	31/01/16	GREEN	The Safety Culture Clinical Lead has been identified and the Safety Culture Lead, to work in conjunction with the team from NUH. Recommend that this action moves to GREEN	30/04/16
5.1.2 – Establish resource requirements (patient safety champions, clinical lead, full-time project manager), programme structure, objectives and timeline	31/01/16	GREEN	The Safety Culture Clinical Lead has been identified and the Safety Culture Lead, to work in conjunction with the team from NUH. The draft Project Initiation Document has been drawn up and KPIs are being agreed Recommend that this action moves to GREEN	30/04/16
5.2.1 – All divisions will have a senior Clinical Governance Lead with responsibility to ensure issues of concern are highlighted, escalated and acted on	31/01/16	RED	Two divisions remain without a Clinical Governance Lead, and we are now discussing with Nottingham University Hospitals for support. To incorporate Action 1.2.2 from Leadership Workstream.	30/06/16

5.3.26 – Extended Critical Care Outreach (CCOT) support to give access until 02.00 hours on a daily basis and utilising Vital Pac real-time monitoring as appropriately	31/10/15	RED	The CCOT rota is currently unsustainable due to vacancies and long term sickness. Therefore, the extended CCOT hours have been delayed. A benchmarking exercise with other local Trusts has been agreed at the Quality Improvement Board and to be reported in May 2016.	30/06/16
5.6.7 – Anywhere not utilising resus trolleys to have quality assurance solution similar to that implemented with trolleys	29/02/16	GREEN	The Paediatric Ward 25 is currently good compliance with PREM trolley checks, and the Emergency Department is currently on daily reports to the Director of Governance. Recommend this action moves to GREEN.	31/05/16

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
5.3.16 – Sepsis presentation included in locum induction; 5.3.19 – Sepsis update added to 'Green Card' checklist for Agency Nurse induction	These actions are being monitored through the Sepsis Taskforce Group. However, the evidence of locum medics and nurses induction is currently not consistent.	This has been identified as a risk to embedding not to the delivery of the action
5.6.6 – Resuscitation trolleys and daily checks. There is insufficient assurance that there are regular resuscitation trolley checks on the wards.	This action is to be discussed at an escalation meeting with the Chief Nurse.	Counter measures are in place to remedy deficits.

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
5.3.3 – Establish monthly audit for Sepsis Screening in all ward areas on all three hospital sites	Yes	
5.3.4 – Establish monthly audit for Sepsis 6 Bundle compliance in all ward areas on all three sites	Yes	
5.3.5 – Retrospective audit of Sepsis Screening in all admission areas for national CQUIN	Yes	
5.3.6 – Retrospective audit of antibiotic administration in severe sepsis in all admission areas for national CQUIN	Yes	
5.3.9 – Monthly review of RCA reviews of cardiac arrests in septic	Yes	

patients		
5.3.17 – Sepsis and Fluid Management included in induction of all nurses	Yes	
5.5.9 – Put in place temperature checking sheets with both maximum and minimum recordings. Ward managers to ensure this is completed and daily review by the matrons	No	QIB requested further evidence – Defer to June 16
5.6.5 – Process for regular checking of resus equipment and trollies in MIU to be reviewed to ensure it corresponds with trust standards	Yes	
5.6.12 – Needs assessment of IT requirements in ED to be undertaken – where further computers needed to be undertaken with IT to source and provide computers.	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
None	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
6. Timely Access	Interim Chief Operating Officer Jon Scott	Kim Ashall

Overall BRAG	Reporting Period:	Action BRAG rating analysis								
		R	A	G	B	B G	Grey	Active Actions	Assurance Actions	Long Term Partnership Actions
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	9	14	17	1	9	31	1
								Total Actions in Workstream		
								41		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
6.1.6 – introduce new transfer protocol to transfer patients back to Wards from theatre	Yes	The theatre team have reduced the time taken to transfer a patient from theatre back to the ward from an average of 27 minutes to an average of 13 minutes, once the patient is ready for discharge from recovery. Importantly the team are engaged in further improvements to the time.

6.2.3 – Using the ambulatory networks toolkits for 'breaking the cycle' methodology every 8 weeks.	Yes	SFH calls it's breaking the cycle' methodology 'There's No Place Like Home' (TNPLH). It has run four TNPLH events since October 2015. Whilst increasing ambulatory care was a specific part of the first and second cycles of the process, there was less focus on the third and fourth iterations. Nevertheless the use of CDU has increased and patients with a 0 LoS in EAU has decreased. TNPLH continues.
6.3.1 – work with commissioners as well as social care and community care providers as part of the system resilience group to re-locate the assessments to community based locations	Yes	Mid Notts System Resilience Group is committed to the development and implementation of an electronic single assessment process. The pilot for the software has been delayed and is currently planned for June 2016. Whilst the health community has enabled the transfer of patients from an acute bed to a nursing home bed in order to have their DST (Decision Support Tool) undertaken, there is less support for that action to be taken for patients who require a Health Needs Assessment (HNA). This is partly because SFH are commissioned to undertaken HNA's and is it good practice to complete the assessment by a member of staff who knows the patients, albeit for a number of days during their acute hospital admission. There has been one occasion when a patient was transferred from KMH to a nursing home to have their HNA completed, but this was seen as a 'one-off' and was a consequence of extreme bed pressures. The CCG have confirmed there is nothing more SFH can do in order to speed up the pilot of the electronic support tool.
6.5.11 – Teaching session to all clinical staff on RTT and reconciliation	Yes	This action was devised by the organisation in response to the Section 29a of the CQC which recognised the organisation had

		not progressed in a timely way its response to the backlog of unreconciled patient who had not got a follow up appointment booked. This action sat alongside one to ensure all appropriate administrative staff were properly trained in using the Medway PAS system. This was to ensure that the staff were able to do not only reconciliation but a number of other administrative processes associated with safe and timely processing of patients attending for an outpatient appointment. The organisation now has good compliance with reconciliation. Up to 3rd May 2016 there were 908 patients who still required reconciliation of their OP appointments. 72.5% of the relevant clinical staff have now been trained on how to reconcile appointments on Medway PAS, but the view is that the safest way to ensure the process is followed is to rely on our trained administrative colleagues. The organisation considers it has made significant progress in the management of reconciliation in OPs.

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
6.6.13 – Review risks and functionality of Medway PAS (as part of review of migration)	This action has now been superseded by the LTP. SFH will work with NUH, to secure a one organisation functional Medway PAS.

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
6. Timely Access	Interim Chief Operating Officer Jon Scott	Kim Ashall

Overall BRAG	Reporting Period:	Action BRAG rating analysis								
		R	A	G	B	B G	Grey	Active Actions	Assurance Actions	Long Term Partnership Actions
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	9	15	16	1	9	31	1
								Total Actions in Workstream		
								41		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
6.1.6 – introduce new transfer protocol to transfer patients back to Wards from theatre	Yes	The theatre team have reduced the time taken to transfer a patient from theatre back to the ward from an average of 27 minutes to an average of 13 minutes, once the patient is ready for discharge from recovery. Importantly the team are engaged in further improvements to the time.

6.2.3 – Using the ambulatory networks toolkits for 'breaking the cycle' methodology every 8 weeks.	Yes	SFH calls it's breaking the cycle' methodology 'There's No Place Like Home' (TNPLH). It has run four TNPLH events since October 2015. Whilst increasing ambulatory care was a specific part of the first and second cycles of the process, there was less focus on the third and fourth iterations. Nevertheless the use of CDU has increased and patients with a 0 LoS in EAU has decreased. TNPLH continues.
6.3.1 – work with commissioners as well as social care and community care providers as part of the system resilience group to re-locate the assessments to community based locations	Yes	Mid Notts System Resilience Group is committed to the development and implementation of an electronic single assessment process. The pilot for the software has been delayed and is currently planned for June 2016. Whilst the health community has enabled the transfer of patients from an acute bed to a nursing home bed in order to have their DST (Decision Support Tool) undertaken, there is less support for that action to be taken for patients who require a Health Needs Assessment (HNA). This is partly because SFH are commissioned to undertaken HNA's and is it good practice to complete the assessment by a member of staff who knows the patients, albeit for a number of days during their acute hospital admission. There has been one occasion when a patient was transferred from KMH to a nursing home to have their HNA completed, but this was seen as a 'one-off' and was a consequence of extreme bed pressures. The CCG have confirmed there is nothing more SFH can do in order to speed up the pilot of the electronic support tool.
6.5.11 – Teaching session to all clinical staff on RTT and reconciliation	Yes	This action was devised by the organisation in response to the Section 29a of the CQC which recognised the organisation had

		not progressed in a timely way its response to the backlog of unreconciled patient who had not got a follow up appointment booked. This action sat alongside one to ensure all appropriate administrative staff were properly trained in using the Medway PAS system. This was to ensure that the staff were able to do not only reconciliation but a number of other administrative processes associated with safe and timely processing of patients attending for an outpatient appointment. The organisation now has good compliance with reconciliation. Up to 3rd May 2016 there were 908 patients who still required reconciliation of their OP appointments. 72.5% of the relevant clinical staff have now been trained on how to reconcile appointments on Medway PAS, but the view is that the safest way to ensure the process is followed is to rely on our trained administrative colleagues. The organisation considers it has made significant progress in the management of reconciliation in OPs.

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
6.6.13 – Review risks and functionality of Medway PAS (as part of review of migration)	This action has now been superseded by the LTP. SFH will work with NUH, to secure a one organisation functional Medway PAS.

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
7. Mandatory Training	Interim Director of HR Julie Bacon	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis								
		R	A	G	B	B G	Grey	Active Actions	Assurance Actions	Long Term Partnership Actions
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	6	1	0	0	5	1	0
								Total Actions in Workstream		
								6		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
7.2.2 –Agree the revised incremental pay progression policy changes with Trade Unions	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	Rationale
None	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
8. Staff Engagement	Interim Chief Executive Officer Peter Herring	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
		R	A	G	B	B G	Grey	9	2	1
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	9	2	0	1	Total Actions in Workstream: 12		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
Reduced capacity within the Communications department and the LTP priority may affect Communications ability to fully support the Workstream.	Exploring a shared Communications service with the LTP.	

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
8.3.1 Revise, consult and agree a Staff Engagement Strategy	Yes	
8.5.1 Develop a toolkit to support managers in communicating and engaging staff	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
8.4.4 Improve the staff suggestions on how they are actioned and celebrated.	Action stayed as superseded by LTP. Workstream failed to enhance intranet staff suggestion scheme page re process and re-launch to raise staff's awareness, feedback and celebrate success. Executive Team briefing explored 'Just Do It' scheme operate by NUH for potential adoption at SFH; however approach requires resources to implement. May update: OD Specialist working with Interim Head of Comms to refresh the current Staff Suggestion scheme intranet site re process, plus empower staff to take forward quality improvements with their Ward / Dept Leader and how these can be celebrated. Agreed with Programme Director and Improvement Director for action to be stayed as superseded by LTP.

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
9. Maternity	Medical Director Andy Haynes	Yvonne Simpson

Overall BRAG	Reporting Period:	Action BRAG rating analysis								
		R	A	G	B	B G	Grey	Active Actions	Assurance Actions	Long Term Partnership Actions
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	19	4	0	0	19	4	0
								Total Actions in Workstream		
								23		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
9.1.1 – Review model of care to ensure optimum multi-disciplinary working within the division, across divisions and externally 'Consider appointing a designated bereavement midwife and a diabetic specialist midwife'	Yes	
9.2.8 – Information regarding pregnant women using steroid medication has been accurately	Yes	

recorded and reported as part of the CQUIN		
9.3.2 – Incident are shared in the Labour Ward Forum to learn from the mistakes and used to better the procedures and process	Yes	

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	**Rationale**
None	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
10. Newark	Director of Strategic Planning and Commercial Development Peter Wozencroft	Carl Ellis

Overall BRAG	Reporting Period:	Action BRAG rating analysis						Active Actions	Assurance Actions	Long Term Partnership Actions
		R	A	G	B	B G	Grey	8	2	0
GREEN - Completed/ On track to deliver by target date	May 2016	0	0	8	2	0	0	Total Actions in Workstream: 10		

Key

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.
- Actions superseded by Long Term Partnership.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
None		

Actions Superseded by Long Term Partnership (LTP)

Action (Number then action narrative)	Rationale
None	

QUALITY IMPROVEMENT PLAN - Overview dashboard
27.05.16
Mock template

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Accountability:	
Senior Responsible Officer	Peter Herring Interim CEO
Quality Improvement Plan - Programme Director:	Paul Moore
Date:	27.05.16
Version history:	Version V5.16.3

Governance arrangements:	
Trust Board	Monthly
Executive Team Meeting	Weekly
Quality Committee	Monthly
Quality Improvement Board	Monthly

Workstream	Executive Lead	Overall BRAG	BRAG analysis B	R	A	G	Blue subject to CQC confirmation	Grey	Executive lead commentary	Programme Director commentary
Leadership	Peter Herring	G	5	-	-	15	-	4	Actions continue to be progressed and agreed to be on track; BRAG rating agreed with Programme director and Improvement Director; 21 actions are now completed (84%), of these 3 BLUES. 2 BLUES being presented to QIP for consideration of being embedded. No AMBER actions. 1 RED action remains re appointment of clinical governance leads within the 2 Medical divisions; there are on-going discussions and potential solutions being explored with the LTP. Overall Workstream rating GREEN as solutions to the red action continue to be explored and does not delay delivery of the other Workstream objectives.	The immediate strategic priorities for the Trust for 2016/17 were agreed by the Board of Directors in February 2016 within the context of the Long-term Partnership with Nottingham University Hospitals NHS Trust. These priorities have been communicated via Team Brief to all clinical leaders and managers and for wider cascade to all staff. A new style bulletin - ' Quality through Merger' for staff and managers is circulated weekly. The vast majority of actions remain on track, the exception being appointment to Divisional Clinical Governance Leads in each Division. We have one appointment to conclude before this action is completed. We are working with Nottingham University Hospitals NHS Trust to support our activities in this area. Throughout the confirm and challenge process this month it became clear that a small number of actions have been superceded by the Long-term Partnership arrangements. Although these actions remain within the Workstream Programmes they have been shaded grey.
Governance	Paul Moore	G	4	-	-	18	29	-	All actions discussed with owners and updates logged in QIP; BRAG ratings agreed with Programme Director & Improvement Director; All actions are GREEN. The Improvement Director and the Workstream Executive Lead have agreed that 2.4.1 has two distinct actions, and this has now been amended to demonstrate two clear actions (2.4.1 and 2.4.2). There are 3 risks identified which have been raised with the Programme Director, full details can be seen in the Workstream overview report. Overall Workstream rating GREEN as the red action does not lead me to believe that delivery of the Workstream objectives should be delayed/compromised, and the advanced state of completion and number of BLUE (BLUE/GREEN)actions suggest good progress is being made toward delivery of the objectives.	A series of 'Governance Masterclasses' continue to be delivered and these have been well attended to date. Further progress has been made with regards to the alignment and strengthening of the Governance teams both centrally and at Divisional level. The suite of formats for reporting risk has been agreed by the Trust Risk Management Committee and we continue to track and monitor compliance with Duty of candour. The Trust regularly meets with Health Education East Midlands (HEEM) and has plans in place to manage issues and concerns raised. The Junior Doctor Forums are now well-established with good attendance. AQuA Patient safety Interventions are planned for the Emergency Department. All milestones are on track with embedded dates expedited where possible.
Recruitment & Retention	Julie Bacon	G	4	-	-	10	-	1	Workstream continues to make steady progression across the actions. BRAG rating agreed with Programme Director & Improvement Director; 11 actions are complete (73%); 4 BLUES embedded, no AMBER. Previous RED re 1 EPLS trained nurse per shift on children's ward / department now completed therefore changed to green with Programme Director and Improvement Director approval; assured rotas reworked in April to be compliant from 26.4.16 to 03.07.16, plus contingency plan to cover for unplanned absences. Health Roster rule set to ensure future rota coverage. Additional external EPLS training being explored with LTP to ensure staffs training is up to date and increases EPLS trained numbers per rota. ED have more than 1 EPLS trained nurse per shift and MIU confirmed 2/2/16 one PILS/EPLS trained nurse per shift, plus Drs 24/7 are EPLS trained. All medical job plans developed; next step is sign off. Other workstream actions to timescale, therefore the overall Workstream rating is GREEN.	Recruitment processes across the organisation were reviewed and continue to drive improvements with the electronic recruitment system. Training for managers was delivered throughout March. Divisions have agreed their retention targets and specific interventions to support new starters have been developed. The Trust concluded the work to ensure consultant jobs plans were agreed and in place for 2016/17. The Trust continues to work on arrangements to ensure that at least one nurse in each clinical area within the Children's and Young People's Service is current with European Paediatric Life Support (EPLS) certification. Operational demands on the service during March resulted in the postponement of planned training on site in order to maintain patient safety. We have made arrangements to address the training need, and we also plan to modify eroster to provide the necessary skill mix on a shift by shift basis.
Personalised Care	Suzanne Banks	G	6	3	-	17	4	-	All actions discussed with action owners at regular meetings with the Chief Nurse; BRAG ratings agreed with overall GREEN with Programme Director & Improvement Director No Amber There are two actions out of the possible 3 for 4.4.1 rated Red - see Workstream overview report There are two other actions rated as RED 4.4.4 and 4.4.5 - see Workstream report . Hampshire undertaking review 11th/12th May 2016 and will inform way forward to progress workstreams All other actions making steady progress and remain on track to deliver.	The Trust continues to roll out the 'Proud to Care' programme. The Ward Accreditation Programme was piloted in March. We are currently evaluating the feedback and developing the framework accordingly. Audits were completed in March to identify, acknowledge and remedy potential ligature points in high-risk clinical areas. Action plans have been agreed to further explore the safety of high risk clinical environment. The Trust commissioned an independent peer review of paediatric services to challenge the Trust capacity to provide an effective safeguarding service. As a result, changes have been implemented to support and develop the effectiveness of the safeguarding team. The Trust is working closely with Hampshire Hospitals NHS Foundation Trust to review the provision of End of Life Care; and advise the Chief Nurse on the suitability of current training programmes and standards for End of Life Care. This is in addition to the support provided by Nottingham University Hospitals NHS Trust.
Safety Culture	Andy Haynes	G	14	2	-	36	23	-	I have discussed all actions with Workstream leads. BRAG ratings agreed with Programme Director & Improvement Director. There are currently two actions recorded as RED. The RED actions are the appointment of Clinical Lead; the appointment of the Divisional Clinical Governance Leads for Emergency and Urgent Care, and the extension of Critical Care Outreach (CCOT) support to give access until 02.00am. It was agreed at the Quality Improvement Board that a benchmarking exercise would be undertaken with local DGH's to understand their CCOT operational hours and report in May 2016, which has been completed and the Nurse Consultant is to undertake an analysis of the workload from 20.00 to 08.00 hours. Overall, this workstream remains GREEN as the Executive Lead is confident on the delivery of the actions.	We have now identified the appropriate individuals to form our 'Safety Culture' team and we are in discussion with Nottingham University Hospitals NHS Trust to see where they could provide further support. The AQuA Plan is now in place with funding secured for the first 12 months of the programme. Good progress continues to be made with regards to the screening for Sepsis and appropriate antibiotic administration for Severe Sepsis. Excellent progress has been made specifically in our emergency and acute admitting areas with our focus turning to our inpatient areas. Weekly audits are carried out in all inpatient areas, including Newark and Mansfield Community Hospitals and are reported to the Sepsis Task Force for inclusion in the weekly submission to CQC. Although 3 of the 5 Divisional Governance Leads have been appointed and are now in post a risk remains around the appointment of suitable Governance Leads for the Emergency and Urgent Care and Specialty Medicine Divisions. Nottingham University Hospitals NHS Trust are providing support. The Trust aspires to extend the CCOT service to 2am daily, however, gaps in the rotas caused by sickness/absence and difficult market conditions for recruitment have challenged our ability to deliver an extended service as planned. It is vital to ensure at all times a safe and sustainable rota. Whilst we endeavour to extend this service, we can only achieve this when it is safe to do so. We continue to work on this. We have applied a sharper focus to the delivery of assurance relating to utilisation of resuscitation trolleys. We anticipate this action to conclude shortly.
Timely Access	Jon Scott	G	14	-	-	9	17	1	There continues to be progress made against the one outstanding red item in the Timely Access Workstream. It is proposed that this action is submitted for consideration to change the status to embedded. There has been a significant improvement in the reconciliation process for OP appointments. The Workstream will present a further three actions for consideration to 'embed' at the QIB. If accepted the Workstream only has 9 actions left to 'embed'. The Workstream is now developing its own process of assurance that those actions which turned 'blue' earlier in the lifecycle of the QIP are still embedded.	Work has been undertaken within the Emergency Department to improve handover times and turnaround times for ambulances in addition to completing the action to improve performance for inter-facility transfers. Improved signage has been put up in the Emergency Department to aid patients in navigating their way around. The Trust is implementing all recommendations from the Intensive Support Team in relation to the management of our 18 week performance.
Mandatory Training	Julie Bacon	G	1	-	-	5	-	-	Workstream group continues to make steady progress with the actions. BRAG ratings agreed with Programme Director & Improvement Director; 5 actions complete (83%); no RED or AMBER actions. One BLUE to be presented to QIP for approval. Deferment of incremental pay progression review process and guidance is developed. Quality and patient safety focussed mandatory training posters distributed for display; 12 months of pop-ups scheduled to reinforce compliance. All actions on track to deliver to timescales therefore Workstream rating is GREEN.	We continue to deliver all actions in respect of Mandatory Training.
Staff Engagement	Peter Herring	G	2	-	-	9	-	1	Workstream making steady progress with actions and remain on track with target completion dates. BRAG ratings agreed with Programme Director & Improvement Director 9 actions completed (75%); 2 BLUES to be presented at QIB for approval; no AMBER and 1 RED action re staff suggestion scheme; to refresh the intranet site with process and empower staff to take forward quality / service improvements with their Ward / Dept Manager. Agreed with Programme Director and Improvement Director this action is stayed as will be superseded by LTP; staff suggestion scheme to be confirmed once merged. Overall Workstream rating is GREEN as the red action does not delay delivery of the other Workstream objectives.	All actions are on plan to deliver. A revised Staff Engagement Strategyhas been agreed by the Staff Engagement Group in view of the new Long-term Partnership arrangements.
Maternity	Andy Haynes	G	4	-	-	19	-	-	I have discussed all actions with Workstream lead and action owners; BRAG ratings agreed with Programme Director & Improvement Director; 23 actions now complete or embedded (100%); 3 actions are due to be embedded this month; Overall Workstream rating is GREEN as I believe that delivery of the Workstream objectives should be on track.	We continue to deliver all actions as planned.
Newark	Peter Wozencroft	G	2	-	-	8	-	-	Actions continue to progress towards the development of a Newark Strategy, to be completed June 2016	The Trust is engaging with local stakeholders to consult on the services that will be delivered and good progress is being made.
			56	5	0	146	73	7		

QIP Glossary of Terms / Abbreviations

Abbreviations	Terms
ANP	Advanced Nurse Practitioner
BAF	Board Assurance Framework
BoD	Board of Directors
CCG	Clinical Commissioning group
CCOT	Critical Care Outreach Team
CDU	Clinical Decisions Unit
CIP	Cost Improvement Plan
CQC	Care Quality Commission
DGM	Divisional General Manager
DST	Decision Support Tool
EAU	Emergency Assessment Unit
EC & M	Emergency Care & Medicine
ED	Emergency Department
EMAS	East Midlands Ambulance Service
EoL	End of Life
ESR	Electronic Service Record
GSU	Governance Support Unit
HEEM	Health Education East Midlands
HR	Human Resources
JAG Accreditation	Joint Advisory Group Accreditation
KMH	Kings Mill Hospital
KPI(s)	Key Performance Indicator(s)
LTP	Long Term Partnership
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act
MCH	Mansfield Community Hospital
MIU	Minor Injuries Unit
NED(s)	Non-Executive Director(s)
NHCPG	Newark Healthy Communities Partnership
NICE	National Institute for Health and Care Excellence (NICE) guidance
NUH	Nottingham University Hospitals NHS Trust
OD&W	Organisational Development & Workforce
OPD	Outpatients Department
PC & S	Planned Care & Surgery
PDMs	Practice Development Matrons
PSC	Patient Safety Collaborative
QIA	Quality Impact Assessment
QIP	Quality Improvement Plan
RCA	Root Cause Analysis
RTT	Referral to Treatment
SAU	Surgical Assessment Unit
SFH	Sherwood Forest Hospitals NHS Foundation Trust
T&O	Trauma & Orthopaedics
TNA	Training Needs Analysis

Nottinghamshire County Council

Report to Health Scrutiny Committee

11 July 2016

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information and Advice

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations and reviewing other issues which impact on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and agrees the content of the draft work programme.

2) That the Health Scrutiny Committee suggests and considers possible subjects for review.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2016/17

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
11 July 2016				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust (with focus on Emergency Department and End of Life Care)	Scrutiny	Martin Gately	Ben Owens, Clinical Director, Urgent and Emergency Care, Paul Moore SFHT and Newark and Sherwood CCG
Doncaster and Bassetlaw Hospitals – Cancelled Emergency Operations and Financial Position	Examination of the current position in relation to cancelled emergency operations, as well as the Trust's financial position.	Scrutiny	Martin Gately	Mike Pinkerton, Chief Exce DBH Trust .
26 September 2016				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust	Scrutiny	Martin Gately	TBC
28 November 2016				
23 January 2017				

27 March 2017				
26 June 2017				
24 July 2017				
To Be Scheduled				
Sexual Health	Further briefing and scrutiny on issues associated with the re-procurement of sexual health services.	Scrutiny	Martin Gately	

Potential Topics for Scrutiny:
Never Events

Health Inequalities
Substance Misuse

Suggested Topics

Improving IT links between GP services and Hospitals (CCGs) – Cllr Lohan
Unsafe Discharge/Assess Team/Discharge Team – Cllr Harwood & Cllr Lohan
Recruitment (especially GPs)
Rushcliffe CCG Pilots Update