Northampton General Hospital
NHS Trust

AGENDA AND PAPERS

Public Trust Board

Thursday 31 July 2014

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 July 2014
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
INTRODUCTORY ITEMS					
09:30	**1.**	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 26 June 2014	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Dr S Swart	**Verbal**
	6.	Chief Executive's Report	Receive	Dr S Swart	**C.**
09:45	**CLINICAL QUALITY AND SAFETY**				
	7.	CQC Action Plan	Assurance	Dr S Swart	**D.**
	8.	Medical Director's Report	Assurance	Dr M Wilkinson	**E.**
	9.	Director of Nursing & Midwifery Care Report	Assurance	Mrs J Bradley	**F.**
	10.	Hard Truths Commitments and Nurse Staffing Review Update	Assurance	Mrs J Bradley	**G.**
10:20	**OPERATIONAL ASSURANCE**				
	11.	Integrated Performance Report and Quality Scorecard	Assurance	Mrs D Needham	**H.**
	12.	Finance Report Month 3	Assurance	Mr S Lazarus	**I.**
	13.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**J.**
	14.	Workforce Report	Assurance	Mrs J Brennan	**K.**
10.50	**ANNUAL REPORTS**				
	15.	Clinical Audit Annual Report	Assurance	Dr M Wilkinson	**L.**
	16.	Risk Management Annual Report	Assurance	Dr M Wilkinson	**M.**
	17.	Medical Education Annual Report	Assurance	Dr M Wilkinson	**N.**
	18.	Medical Revalidation & Appraisal Annual Report	Assurance	Dr M Wilkinson	**O.**

Time		Agenda Item	Action	Presented by	Enclosure
11. 35	**GOVERNANCE**				
	19.	Equality Delivery Stems 2 (EDS2)	Assurance	Mrs J Brennan	**P.**
	20.	TDA Self-Certification	Decision	Mr C Pallot	**Q.**
11:55	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting will be held at 09:30 on Thursday 25 September 2014 in the Board Room at Northampton General Hospital

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

A

Minutes of the Public Trust Board

Thursday 26 June 2014 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr P Farenden	Chairman (Chair)
	Mrs J Bradley	Interim Director of Nursing, Midwifery & Patient Services
	Mrs J Brennan	Director of Workforce and Transformation
	Mr S Lazarus	Director of Finance
	Mrs D Needham	Chief Operating Officer
	Mr D Noble	Non-Executive Director
	Mr C Pallot	Director of Strategy and Partnerships
	Dr S Swart	Chief Executive Officer
	Dr M Wilkinson	Interim Medical Director
	Mr P Zeidler	Non-Executive Director (Vice Chair)
In Attendance		
	Mrs S McKenzie	Committee Secretary
	Mrs W Smith	Specialist Palliative Care Team (Agenda Item 11)
Apologies		
	Mr C Abolins	Director of Facilities and Capital Development
	Mr G Kershaw	Non-Executive Director
	Mr N Robertson	Non-Executive Director
	Mrs L Searle	Non-Executive Director

TB 14/15 024 Introductions and Apologies

Mr Farenden welcomed those present to the meeting of the Trust Board.

Apologies for absence were recorded from Mr Abolins, Mr Kershaw, Mr Robertson and Mrs Searle.

TB 14/15 025 Declarations of Interest in the Proceedings

No further interests or additions to the Register of Interests were declared.

TB 14/15 026 Minutes of the meeting held on 29 May 2014

The minutes of the meeting of 29 May 2014 Board meeting were presented for approval.

The Board resolved to **APPROVE** the minutes of the 29 May 2014 as a true and accurate record of proceedings.

TB 14/15 027 Action Log and matters arising from the 29 May 2014 Board Meeting

The Board considered the action log.

Matters arising reference 30 Same Sex Accommodation Adult

Mrs Needham reported that on investigation there had been no same sex accommodation breaches in other Trusts and that they had declared compliance.

The Board **NOTED** the Action Log and Matters Arising from the 29 May 2014.

TB 14/15 028 Patient Story

Mrs Bradley presented the Patient Story.

Mrs Bradley advised the Board of a high profile complaint which had been in the Chronicle and Echo which detailed the experience of an 87 year old patient with poor mobility who had been locked in a toilet for an hour and a half because the emergency call bell in the toilet was not working. When the family arrived the Ward staff had informed the family that the patient was having physiotherapy.

Eventually the patient was found crawling out of the toilet. The patient's family commented on the fact that the patient had also not received any pain relief for over 3 hours from prescription. However no physical harm was incurred following the incident.

An investigation had shown that there had been no communication between the HCA and Ward Sister and understandably the family were very angry.
The action put in place with immediate effect was that all call bells in the bathrooms were checked and any faulty ones corrected within 36 hours. A further measure put in place had been regarding nursing staff knowing where patients were at all times. Porters, Physiotherapist and Occupational Therapists now leave a card on the patient's bed when a patient is taken off the ward for treatment. All wards now have a matron and co-ordinator checklist.

Mrs Bradley reported that a multidisciplinary team had been set up to look at pain relief and an evaluation report would be available to the Board in September. Mrs Bradley informed the Board that this had been an unfortunate incident but lessons had been learnt and that practices had been addressed and changed. She had also met with all the team on the ward and advised that stronger communications and handover had been put in place. **Action: Mrs Bradley**

The Board **NOTED** the Patient Story

TB 14/15 029 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart informed the Board that today was the first day of industrial action by the some members of staff from the Pathology Service with regard to on call harmonisation. Dr Swart advised the Board that the Executive Team were focussed on continuing to maintain an effective service and support staff within the Pathology Services who were not participating in any action.

Following a rigorous appointment process the Trust had appointed Dr Michael Cusack, a Consultant Cardiologist, to the post of Medical Director. He would join the executive team at the end of September but would be visiting the Trust over the summer and meeting with key individuals. Dr Cusack had been a Clinical Director and more recently a Divisional Medical Director of a large surgical division at Royal Wolverhampton Hospital. His responsibility there had included all Surgical Specialities, Anaesthetics, Theatres, Support services and Maternity in a medically led management model. Dr Swart thanked Dr Mike Wilkinson for his support and acting as Interim Medical Director during this period.

Dr Swart advised that following the Board's support of the recommendations from Deloittes, who were commissioned to undertake a review of our governance structures, work had started to implement a move away from our current structure of two care groups to a structure which is more manageable with three or four divisions which are clinically managed and led, with strong managerial support.

The Board were informed that the aim had been to increase the clinical voice and clarify reporting structures. A Director of Corporate Development and Assurance post would be recruited to and this would be a vital role which would also allow our Medical Director and Director of Nursing and Midwifery to concentrate on key quality issues. A work plan, communication documents, committee terms of reference, operating frameworks, scorecards and other documents were being developed and an outline paper would be presented to the Board in July. Key members of staff would be consulted with in order to develop this work.

Dr Swart had recently met with David Flory from the Trust Development Authority when he confirmed that, because of the pressures on the 'system' the NHS as a whole would receive additional help. The Trust had been struggling with all the targets, particularly the 18 week, A&E and some cancer targets. Of these the emergency were standards which continued to cause the most difficulty and also had an impact on the other main elective targets. Since that meeting It has since been reported that £250m had been allocated to help NHS providers to clear their planned care waiting list backlogs. The Department of Health also said that in 2014-15 there would be a £400m fund for 'winter pressures, £250m of which had been announced last year by NHS England. This money had been aimed at addressing pressures in accident and emergency departments. We have not been informed of what amount of funding would be allocated to NGH, but the overall aim had been to ensure we continued to provide safe, high quality care for our patients.

A report recently published by Monitor, 'Facing the Future: Smaller Acute Providers' found that small hospitals should continue to play an 'important role' in the NHS. A new study found 'no evidence' of poorer quality in clinical performance when compared with larger providers. The findings were based on an analysis of data related to patient experience, clinical effectiveness and safety. However, it was found that smaller providers may be more financially challenged. Dr Swart had recently had two meetings which were about the future of smaller hospitals and, along with seven CEOs of smaller hospitals across the UK, met with Jeremy Hunt and provided a personal perspective and contributed to the Foundation Trust Network view on what measures could be taken to support smaller hospitals.

Dr Swart advised that she had attended the NHS Confederation annual conference in early June and listened to some exceptional leaders and felt that, for the most part, the Trust was on the right track with their plans to empower more managers and clinicians to take forward quality improvement centred on the needs of the patient. There were some other key themes from the conference which included an emphasis on local leadership as the way in which we secured the gains we needed.

The Board were informed that the first-ever Strictly NGH had been enthusiastically supported by a lively audience. Dr Swart thanked all concerned and in particular to Sally Watts who had organised the event and had been judged the very deserving winner of the competition. Through sponsorship the dancers who took part had already raised almost £10,000 for the charitable fund. Dr Swart said that it had been a great exercise and was a reminder of the importance of teamwork and working together.

The Board **NOTED** the Chief Executive's Report.

TB 14/15 030 CQC Action Plan

Dr Swart presented the CQC Action Plan.

Dr Swart reported that the Trust must be complaint in respect of the CQC Warning Notice by the deadline of 30 June 2014. However there had been a small number of minor gaps which included ensuring all patient moves had been risk assessed and the time of patients' moves were consistently recorded and logged; mandatory and role specific training and appraisals. Dr Swart re-assured the Board that these issues had sufficient evidence in place before the 30 June to meet the requirements of the warning notice.

A comprehensive live action plan had been put in place to address the Compliance notice and that she had implemented a programme management approach to oversee the day to day progress of the actions. She advised that she chaired the Programme Management Board which met weekly to lead and oversee the corporate response to the CQC Report; and held officers to account to deliver the activities and milestones within it. This group also acted as the quality assurance forum for the assurance and evidence received to demonstrate success/outcomes.

Mr Noble reported that the Action Plan had been discussed in detail at the recent Integrated and Healthcare Governance Committee.

The Board **NOTED** the CQC Action Plan

TB 14/15 031 Medical Director's Quality Report

Dr Wilkinson presented the Medical Director's Quality Report.

Dr Wilkinson provided a detailed overview of the content of the report in that due to public concerns regarding the use of 'big data' derived from healthcare sources, HSCIC had delayed its transfer of SUS data to Dr Foster and there was therefore no further update since the previous report. Two months data would therefore be presented to the Board meeting in July.

He reported that 12 new serious incidents had been reported and 10 were submitted for closure and there had been no requests for extensions and all Serious Incident reports had been submitted within the 45 day timeframe. All action plans produced during the reporting period had been reviewed by the Serious Incident Group and uploaded to HealthAssure. He confirmed that actions had been monitored by the Care Group Governance Managers.

Dr Wilkinson informed the Board were informed that for 2014/15, Morbidity and Mortality Reviews would be the subject of a local CQUIN at Directorate and Trust level. He gave an overview of the summary which looked at a Trust review of 50 consecutive adult deaths in July 2013 and compared the findings to previous similar reviews carried out in 2011 and 2012. The team of reviewers were made up of 12 Consultants from a variety of specialties and 2 Specialty Doctors. Each reviewer had been asked to review up to 4 sets of notes and attended a minimum of 2 meetings where they presented and discussed their cases. A standard dataset had been completed and the data from all 50 completed proforma both quantitative and qualitative had been collated to form the report.

He advised that a number of areas previously identified had been fed back to the Patient Safety Academy. The next review, looking at December 2103, had now commenced and the review group had been extended to include senior nurses and doctors of all grades. Staff from Medicine and ED had volunteered to take part in the next round.
Mr Zeidler commented that this had been a useful process but wondered whether all clinical staff should be involved in a death review and Dr Wilkinson responded that staff were involved in the directorate review and Dr Swart advised that the hospital check was to ensure that the directorate review was correct. Mr Noble raised concern about incomplete medical notes and Dr Swart commented that the new governance process would help ensure documentation had been completed correctly.

The Board **NOTED** the Medical Director's Quality Report.

TB 14/15 032 **Director of Nursing & Midwifery Care Report**

Mrs Bradley presented the Director of Nursing & Midwifery Care Report.

Mrs Bradley informed the Board that this report provided a detailed update on a number of clinical projects and improvement strategies that the nursing & midwifery team had been working on.

She reported that the Nursing & Midwifery (N&M) Quality Dashboard (QuEST) showed a slight reduction in overall achievement this month of 79% against 83% last month. Due to the timeliness of the data further analysis was required to understand the detail behind this reduction. The N&M Quality dashboard was not available for the report this month due to the timeframe for submission, but would be available next month.

Although extensive work continued there had been a slight increase in the number of pressure ulcer incident reported. There were 28 pressure ulcers this month, 21 were validated as grade 2, and 7 were grade 3. The CQUIN for April had not been achieved, 11 avoidable grade 2 pressure ulcers were reported against a target of 7.25, grade 3 pressure ulcers reported equated to 6 avoidable against a target of 3. There had been a decrease in the number of Grade 3 pressure ulcers and a greater percentage of the pressure ulcers identified were 'device related'. The Lead Tissue Viability Nurse presented the recent thematic review and on-going action plan to the Integrated Healthcare Governing Committee last week and they considered and supported further initiatives planned.

Mrs Bradley advised that here had been 6 C.Difficile cases this year to date which had been above the Trust's monthly internal stretch target but within the Trust's national annual target of 35. With regard to proactively managing patient's pain relief, meetings had taken place with the Pain Management and Palliative Care Clinical Nurse Specialists to review the current position and how improvement can be made of this area of care. The team had reviewed the current pain assessment chart that had been used within the generic wards to ensure that was standardised across the wards and has been evidence based. A baseline audit of the pain assessment and prescribing of pain relief has been being developed and undertaken on one of our Trauma & Orthopaedic wards during the next month. Further updates would be presented to the Integrated Healthcare Governance Committee throughout the coming months.

The Board were informed that a Patient Experience questionnaire had been carried out with volunteers attending every inpatient ward and asked an average of 5 patients for their views on key issue areas in the Trust. This included the issues with noise at night. These were in the process of being analysed and results would be reported at a later date. The survey would also act as a baseline for post-implementation evaluation.

Solutions to Noise at Night had proved difficult but 'Sleep Well' packs were being piloted on 4 wards in the hospital (Allebone, Dryden, Finedon and Abington). These contained an eye mask and a set of ear plugs and had been purchased from a social enterprise in Leicester and if successful, the aim was to provide these throughout the hospital. A questionnaire had been issued to night staff asking them for their views on the disturbances on the wards at night time. These were in the process of being analysed but early interpretations suggest staff were concerned with the noise levels from patients that were suffering with dementia.

Mrs Bradley reported that The Friends and Family Test in April achieved a response rate of 33.27% in our in- patient areas against the national target of 25% and the A&E department achieved a response rate of 16.6% against a national target of 15%.

The Board **NOTED** the Director of Nursing & Midwifery Care Report

TB 14/15 033 Hard Truth Commitments regard the publishing of staffing data

Mrs Bradley presented the Hard Truth Commitments regard the 'Publishing of Staffing Data' Report.

Mrs Bradley reported that the Trust completed its inaugural May 2014 ward staffing levels return for the Hard Truths commitment, which progressed on the expectations outlined in the National Quality Board's latest guidance on safe staffing levels for patients. The impact of the right staff being in the right place with the right skills was clear. However assurance from real time data collection on a shift by shift by basis required refinement.

She gave an overview of the report and advised that the report identified the current staffing levels on 26 inpatient wards and would not focus on ongoing nurse recruitment and retention programmes, the dilution of skill mix at senior nurse level and the impact of national recruitment programmes. The completed safe staffing report confirmed staffing levels retrospectively for the previous month confirming establishment versus actual staff numbers, in consolidated monthly hours for day (amalgamated early and late shifts) and night shifts. Supernumerary staffs were not included in these calculations. Wards in the maternity and paediatric areas were consolidated into two groups as resources had been merged to be reactive and reflected demand in their specialist ward areas. Results of the data collection illustrated 88% of wards were operating at over 90% of their establishment during May 2014, with consistent use of additional HCAs to fulfil a number of roles including specialising, escalation area resourcing and patient acuity and dependency.

Further work had been required to standardise the completion and validation of staff hours worked in "real time" and develop a process that could simplify the collection and validation of staffing data. Accurate recording of the rationale for shortfall and overfill of shifts also required time to develop and embed. An electronic solution to enhance the current Healthroster system had been explored however, the success of an electronic solution would be reliant upon ward manager engagement and a changed management at system implementation.

Mrs Bradley informed the Board that the Safe Care solution would be presented to nursing management in July, with the intention of running a pilot on one or two wards to confirm the solution was effective and accurate, this would enhance and support ward manager engagement. In the interim, the current manual process would continue and had been refined to maximise its efficiency.

Mr Zeidler commented that agency and locum staff were still a big issue. Mrs Bradley confirmed that she was leading the Bank and Agency group and that agency staff could not be taken out until they had been replaced with Bank staff. The recruitment process had returned back to the ward staff and all ward sisters would be attending a back to basics course on managing a budget in July and August.

Mr Farenden requested that an update on agency and locum staff be brought back to the Board in September as much more robust assurance was needed.

Action: Mrs Bradley

The Board **NOTED** the Hard Truth Commitments regard the 'Publishing of Staffing Data' Report.

A

TB 14/15 034 Personalised Care Plan for the Dying

Mr Pallot presented the Personalised Care Plan for the Dying.

Mr Pallot provided an overview to the Board on the care plan that had been designed to replace the Liverpool Care Pathway (LCP). He advised that no national tool would be developed to replace the LCP. The End of Life Steering Group had agreed to pilot the care plan on two wards which had been supported by the Chief Executive and Medical Director. Those wards were the Emergency Assessment Unit (EAU), and Talbot Butler. The pilot commenced on 23rd June 2014. This work had enabled 'real-time' testing and evaluation of the care-plan, under close monitoring and support of the End of Life Care Facilitator and the Specialist Palliative Care Team (SPCT). An action plan for implementing the transition to the new care plans would be agreed at the next End of Life Care Strategy Group in July. Revisions to the care plan which had resulted from the pilot would be agreed at that meeting.

He confirmed that there were drop-in awareness sessions, and the Palliative/End of Life Care link nurses in each ward would also receive 'Train the Trainer' education on June 27th 2014. This would increase local expertise and the Link Nurses could help their own ward areas and influence sustainability. The Trust had a new system for raising awareness of the needs of its dying patients which started in May 2014, and used the daily 'Patient Safety Huddle' to create the 'End of Life Care Register' which had been held by the SPCT. This enabled the whole organisation to better recognised and focussed upon the needs of the dying and focussed additional staffing and specialist support where it was needed in 'real-time'. The Huddle and the End of Life Register would enable the SPCT and the End of Life Facilitator support and monitor the transition to the Personalised Care Plan across the trust from 14 July 2014.

Mr Pallot advised that a detailed individual care plan was needed to support the care of people in the last hours or days of life. The SPCT had been leading on the development of the personalised end of life care plan to be used at NGH. A multi-disciplinary steering group had been convened comprising of ward based nurses (surgery, medical, oncology, emergency assessment and critical care wards), a member of the hospital chaplaincy, PALS and the SPCT. Mrs Smith confirmed that they had been careful to ensure that nurses and doctors who provided direct care for dying people had been consulted and their feedback used in the care-plan development.

The 'Personalised Care for the Dying Person and their Family' was a trust wide tool and would replace the generic LCP. It used a more flexible and individualised format whilst encompassing the key national priorities so that it supported good end of life care.

Mr Farenden requested that on behalf of the Board all members of staff involved were thanked.

The Board **APPROVED** the Personalised Care Plan for the Dying.

TB 14/15 035 **Organisational Effectiveness Strategy**

Mrs Brennan presented the Organisational Effectiveness Strategy.

Mrs Brennan provided an overview of the Organisational Effectiveness Strategy. She advised that Board that the strategy set out the Trust's approach called 'Connecting for Quality, Committed to Excellence', which is underpinned by seven strategic workstreams. The aim of the strategy was to identify, design and build the organisational capabilities that would enable the Trust to achieve this and ensured lasting organisational health and viability. Mrs Brennan commented that the strategy was ultimately about great alignment and that the people and systems in the organisation need to work in a joined up and connected way so that we continually innovate to improve our services and achieve best patient outcomes and best patient experience at lowest possible cost. Mrs Brennan confirmed that assurance reports would go to Integrated Healthcare Governance Committee.

She reported that managers and leaders would receive training and development in the change model as part of the Leading for Excellence development programme and Managing for Quality development programme. The Making Quality Council programme would be working with teams over the next four months and would conclude in the Autumn. It would then be rolled out to other teams.

Mr Farenden commented that the strategy addressed where the Trust wanted to go in an effective way.

The Board **ENDORSED** the Organisational Effectiveness Strategy.

TB 14/15 036 **Integrated Performance Report and Quality Scorecard**

Mrs Needham presented the Integrated Performance Report and Quality Scorecard.

Mrs Needham introduced the revised Integrated Performance Report and Quality Scorecard which provided a holistic and integrated set of metrics closely aligned between the TDA, Monitor and the CQC oversight measures used for identification and intervention. The scorecard included exception reports provided for all measures which were Red, Amber or seen to be deteriorating over this period even if they were scored as green or grey (no target); identify possible issues before they become problems. There were 22 areas that were Red rated, 3 Amber rated and 31 rated as Green.

Mrs Bradley commented on the Exception Report for 'Complaints response rate' and confirmed that this was due to a delay in recruitment response time however would be back on track in three weeks' time.

Dr Wilkinson commented that the data would be extracted to understand the unexplained increase of elective caesarean sections this month. He advised that it had not been clear if it was down to patient choice or a decision made by medical staff.

Mrs Needham reported that in May 2014 the Trust achieved 18 week RTT across all specialties, diagnostic procedures undertaken in less than 6 weeks, stroke targets and cancelled operations.

She reported that the Trust had not achieved the urgent care 4 hour standard but whilst this target had not been achieved the trust had demonstrated significant improvement again this month. The 62 day cancer standard and 2 other cancer

standards and 2ww referral and 31 day first treatment had also not been achieved. A revised action plan has been developed and performance management processes had been implemented led by Mrs Brown and Mr Pallot.

Mrs Needham informed the Board that the number of patients waiting over 26 weeks without initiation of treatment and not on a waiting list for a procedure has reduced to 41; no patient had waited over 52 weeks.

Mrs Needham advised that ECIST had been invited into the Trust on the 24 June for a review of the Emergency Care Pathway and to monitor progress and identify new areas of opportunity. The outcome of their visit would be highlighted to the Finance Committee next month.

A letter had been received from the TDA seeking assurance on the delivery of national waiting time standards and in particular A&E, a copy of which was included in the report. The TDA were seeking an Emergency Care Recovery plan and weekly exception reports along with a fortnightly meeting with the Dr Swart to discuss performance. The Trust had also been invited to a joint meeting with NHS England, CCG and the TDA to discuss system wide challenges.

Mrs Needham informed the Board that work was on-going to improve the cancer performance standards and a weekly cancer performance meeting had been re-established to ensure everyone had ownership of the patients moving through the cancer pathways. The Trust had been working closely with University Hospitals Leicester to support the future delivery of the urology and upper gastrointestinal (GI) pathways. She reported that the Trust took 18.5 breaches in May on a standard where only 10 breaches could be tolerated.

The Board **NOTED** the Integrated Performance Report and Quality Scorecard.

TB 14/15 037 **Finance Report Month 2**

Mr Lazarus presented the Finance Report Month 2.

Mr Lazarus reported that the position for Month 2 showed a £3.9m deficit which gave rise to early concern in relation to achievement of the TDA plan for 14-15. The Month 2 position included the Trust estimated provisions for potential fines, data challenges and penalties. The CCG had issued total challenges of £3m in relation to the reconciliation process for April.

Mr Lazarus reported that non-elective activity was above plan again in May which then gave rise to an increased provision for the associated MRET penalty. There was slippage evident in the IQE programme delivery in month 2 and forward risk in terms of the most likely forecast delivery. The cashflow position had remained positive although action needed to be taken to ensure loan applications were progressed in June.

The Board were informed that there had been three main issues driving the deficit; fines and penalties of £1.1m-£1.8m above plan; expenditure off plan; and CIP programme which could be heading for £4m off plan. Mr Lazarus advised that the financial position continued to demonstrate that the current run rate may lead to a significant financial deficit unless remedial action was taken to address the contractual position, CIP delivery and budgetary performance. Mr Lazarus confirmed that a report had been presented to the Finance Committee on agency and locum staff and a much more direct management approach was being taken.

The Board **NOTED** the Finance Report Month 2

TB 14/15 038 Improving Quality and Efficiency Report

Mr Lazarus presented the Improving Quality and Efficiency Report.

Mr Lazarus reported that the likely delivery at Month 2 was £8.9m, against the £12.668m required delivery, off plan by £3.7m prior to mitigation. The plan submitted to the TDA required delivery of £1.049m in the first 2 months. Actual delivery was £873k, off plan by £176k.

He informed the Board that action had been taken to mitigate the risk of under-delivery by integrating an additional £2.237m worth of new schemes into the existing work streams. Further mitigating actions had been planned in order to address the under-delivery in month 1 and 2 ensuring that the overall target of £12.668m could be delivered. Executive sponsors would be allocated and values agreed at the planning phase during June-July 2014.

Mr Lazarus reported that a number of high priority steps had been identified in order to rapidly progress the programme and ensure delivery, optimising the delivery of all schemes and themes through increased governance arrangements. The IQE Team had identified a number of 'quick wins' from the Deloitte Clinical Strategy workshops which would be included in 2014/15 programme. Work was progressing with all Directorates and Service areas to refine the scope of existing Trust wide themes to deliver a greater contribution for example, centralised procurement and improvements in patient flow.

Mr Farenden commented that there had been more confidence last month as opposed to this month that an improvement would be reported. He asked what process were put in place. Dr Swart responded that a lot of work had taken place this week with the whole Executive Team taking ownership and had looked at bank and agency staff, the way the IQE programme had been running and holding staff to account. Dr Swart acknowledged that it was a significant risk but work had been progressed.

The Board **NOTED** the Improving Quality and Efficiency Report

TB 14/15 039 Workforce Report

Mrs Brennan presented the Workforce Report.

Mrs Brennan reported that the ongoing appraisal audit combined with the new appraisal process had produced a compliance rate of 64.3% in May 2014. Whilst the level of compliance had increased it was still considered to be lower than acceptable at this stage and therefore the appraisal audit would continue until the end of June. . Areas that were off target would be put on the risk register. The planned audit on appraisal quality had been temporarily suspended until after this point in time. The current audit appraisal documentation has been assessed for completeness and challenged appropriately. Mrs Brennan commented that it has been proposed that the Trust target appraisal compliance rate of 85% should be achieved by March 2015 in accordance with the Contract Quality Schedule.

As at the end of May 2014 the current rate of Mandatory Training compliance was 78.06% and Role Specific Essential Training was 63.92%. The Mandatory & Role Specific Essential Performance Wave had been refined and all Executive Directors had now been provided with a monthly trajectory report to show compliance against the targets within their directorates. This would then be used to challenge managers and request action plans. A monthly report had been developed to go out to all Ward Sisters to give them an overview of their compliance rates with regard to Mandatory & Role Specific Essential Training and Appraisals in their ward areas.

Mrs Brennan reported that the financial year to date rate for sickness absence fell slightly to 4.16%. In month sickness absence decreased by 0.21% to 4.06% which remained above the Trust target.

In April, the Trust launched its first Friends and Family Test for Staff, with initial focus on the non-clinical support areas. Staff were asked if they would recommend the Trust for treatment; 69% said it was likely or extremely likely, 25% were not sure and 6% said it was unlikely or extremely unlikely. As a place to work, it had been a similar story with 67% likely or extremely likely, 18% unsure and 15% unlikely or extremely unlikely. Following the free text comments, there had been a strong focus on staff engagement across the Trust in the coming months and there would be some workshops to help all staff.

In relation to the Quality Scorecard Exception Report 'Staff Trust turnover rate Mr Noble requested specific figures which excluded community beds.

Action: Mrs Brennan

The Board **NOTED** the Workforce Report

TB 14/15 040 **TDA Self-Certification Report**

Mr Pallot presented the TDA Self-Certification Report.

Mr Pallot reported that in accordance with the Accountability Framework, the Trust had been required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of Monitor Licensing Requirements and Trust Board Statements self-certifications for May 2014 were discussed and approved.

The Board **APPROVED** the TDA Self-Certifications.

TB 14/15 041 **Any Other Business**

There were no items of any other business.

Date of next meeting: Thursday 31 July 2014 at 09:30 in the Board Room at Northampton General Hospital

Mr Farenden called the meeting to a close at 11:55

The Board of Directors RESOLVED to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted

Actions from Trust Board

Last update 21/07/2014

Ref	Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of Completion/Reason for Slippage
29	29/05/2014	TB 14/15 010	Infection Prevention Performance Report	Mrs Bradley informed the members that National Guidance had been published on the management of Carbapenemase-producing Enterobacteriaceae (CPE). Mrs Searle commented that she would welcome more detailed information on the Trust's approach on CPE at the IHGC in future.	Mrs J Bradley	Aug-14	On Track	Presentation at IHGC 21 Aug 2014
30	29/05/2014	TB 14/15 011	Same Sex Accommodation Audit and Update	Mr Noble asked how the Trust compared against other Trusts and Mrs Brown advised that a benchmarking exercise would be undertaken.	Mrs R Brown	Jul-14	On Track	Mrs Spellman has sent a request to the CCG for this information
31	29/05/2014	TB 14/15 015	Workforce Report	Mr Zeidler commented that it had been reported that the temporary workforce expenditure had increased however the temporary workforce capacity had decreased. Mr Lazarus commented that this could be attributed to accrued pay awards and that he would explore and share with the Board.	Mr S Lazarus/ Mrs J Brennan	Jul-14	On Track	
33	29/05/2014	TB 14/15 020	Corporate Objectives 2013/14 Report	After discussion it was agreed that the Stakeholder Engagement Strategy would be reviewed.	Mrs K Spellman	Sep-14	On Track	
34	26/06/2014	TB 14/15 028	Patient Story	Mrs Bradley reported that a multidisciplinary team had been set up to look at pain relief and an evaluation report would be available to the Board in September	Mrs J Bradley	Sep-14	On Track	
35	26/06/2014	TB 14/15 033	Hard Truths	Mr Farenden requested that an update on agency and locum staff be brought back to the Board in September as much more robust assurance was needed	Mrs J Bradley	Sep-14	On Track	
36	26/06/2014	TB 14/15 039	Workforce Report	In relation to the Quality Scorecard Exception Report 'Staff Trust turnover rate Mr Noble requested specific figures which excluded community beds.	Mrs J Brennan	Jul-14	completed	Response circulate to Board members:The revised turnover figure for the year ending April 2014 if Community Beds are excluded would be 8.44%. The revised figure for year ending May 2014 would be 8.57%.

KEY	
	Completed or on Agenda
	On Track
	Slippage - to be updated at the Meeting
	Significant Slippage

B

Report To	**Public Trust Board**
Date of Meeting	**31 July 2014**

Title of the Report	**Chief Executive's Report**
Agenda item	6
Sponsoring Director	Dr Sonia Swart, Chief Executive
Author(s) of Report	Dr Sonia Swart, Chief Executive
Purpose	For information and assurance
Executive summary The report highlights key business and service developments for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?/N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Board is asked to note content of the report.	

C

Northampton General Hospital NHS
NHS Trust

Public Trust Board
31 July 2014

Chief Executive's Report

1. Pathology

Members of Unite were called out on strike from Monday 7th July 2014 and, at the time of preparing this report, 55 members were on strike. The contingency plans developed within the pathology department have ensured that the staff working in our laboratories have processed all required tests within an acceptable timeframe, with almost all (more than 90%) being processed within one hour. The majority of our doctors and nurses requesting blood tests say they have not noticed any change in the service provided.

Initial talks at ACAS, the Advisory, Conciliation and Arbitration Service, were not fruitful, and were re-opened on Monday 21 July 2014.

On 16 July 2014 our lawyers received the details of an application by Unite for an injunction preventing us from acting in breach of the Conduct of Employment Agencies and Employment Businesses Regulations 2003.

Board members will be aware that, as a result of the action currently being taken by members of Unite, the Trust has had to source alternative labour in order to maintain the provision and quality of our pathology services.

The application for the injunction will be heard in the High Court on Thursday 24 July 2014. The Trust will vigorously defend its right to continue to provide the pathology service via lawful means.

It is important that we recognise the efforts and commitment of all staff who are working so hard to make our hospital the best it can be and, just as importantly, supporting their colleagues as they work through this challenge and continue to provide our patients with the best possible care.

2. Care Quality Commission

It is almost 3 months since our CQC inspection report was published and we anticipate receiving an unannounced inspection visit at some point during the coming month.

Our staff have been provided with updates of our progress against the recommendations in the report and our own action plan so that they are aware of developments across the wider organisation and not just within their own area of work.

3. Healthier Northamptonshire

Following the Challenged Health Economy work, we have agreed to work with colleagues from KGH on how four specialties could be redesigned for mutual benefit and provided across the county in a way that delivers both enhanced clinical quality as well as efficiencies.

The specialties that will be considered are rheumatology, ophthalmology, orthopaedics and radiology. The aim is to understand if the concept is viable and the work must be complete by the end of August 2014. A series of clinical meetings are being planned and the Board will be kept informed of developments. Clinical meetings are being planned and further updates will be provided in due course.

C

4. **Chemotherapy Appeal**
   The Northampton Chronicle & Echo have helped us formally launch our chemotherapy appeal to raise £350,000 to refurbish the chemotherapy suite. We are grateful to the Chronicle and their readers for their consistent and generous support of the hospital. I am sure, that with their help, it will not be long before our appeal target is achieved.

D

Report To	**PUBLICTRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**CQC Action Plan**
Agenda item	7
Sponsoring Director	Dr Sonia Swart, Chief Executive
Author(s) of Report	Simon Hawes, Quality Assurance Manager Caroline Corkerry, Deputy Director Quality & Governance Christine Ainsworth, Senior Quality Risk & Litigation manager
Purpose	This report is presented following the CQCs inspection of NGH to outline the findings of the inspection and detail the actions NGH have and are continuing to take to make the improvements required.

Executive summary

Following an inspection by the CQC in January 2014, the CQC sent a letter and quality report to the Trust in March 2014. The letter served notice under Section 29 of the Health and Social Care Act 2008 whereby notice was given advising the Trust were failing to comply with Regulation 10(1)(a) and 10(1)(b) and 10(2)(c)(i). The quality report identified other areas the Trust was required to improve.

In response to the findings the Governance Team created a comprehensive hierarchy of action plans were developed. These can be found at appendix 1, 2, 3 and 4 of this report.

The letter from the CQC gave a deadline of 30 June 2014 with which the Trust had to be compliant in respect of the regulations. The Trust sent a letter to the CQC on 27 June 2014 giving a detailed response to the CQC comments contained within the letter. This response contained an outline of the evidence the Trust had from its High Level Action Plan and confirmed that the Trust has met the requirements to become compliant with the regulations (Appendix 3).

At the time of writing (18 July 2014) there are some minor gaps in the collation of evidence for the Compliance Action Plan in relation to the quality report as specified below:

- Ensuring there is a robust method of capturing patient experience of patient moves. A patient leaflet has been produced advising patients of how to let the trust know of their experience if they are moved. There is also a system in place to capture patient moves but at present there is currently no system to capture the patient experience. This has been recognised and there has been a request for monthly triangulation checks on PAL's, complaints and FFT comments for any adverse patient experiences if they were moved and the intention is to report this to each Care Group on their scorecards

- Ensuring there is a plan for the regular inspection and cleaning of toys for various age groups in A&E. At present the play specialists attend every day and the matron for A&E is developing a checklist for cleaning and checking toys.

Whilst all the actions relating to the letter and High Level Action Plan have been completed a number of actions relating to the quality report Compliance Action Plan are on-going and the Governance Department continue to support the executive team and action owners in collating the evidence and are providing constructive challenge ensuring the availability of robust evidence.

It is important that corporately and through local team meetings and regular trust-wide communications, the CQC action plan, actions taken and changes that have taken place as a result are robustly disseminated to staff at all levels of the organisation regularly and consistently. In addition, the Trust needs to ensure that the actions that have been taken are sustained and evidence is available on an ongoing basis to demonstrate compliance.

The CQC will revisit the Trust unannounced shortly and they will be looking at the actions taken to address the issues identified in their letter and quality report as well as other general observations. It is vital that all actions have been embedded across the Trust and that all staff, where applicable, can provide confirmation that practices, processes and procedures are in place to ensure the highest level of patient care possible. Through continued communications, managers are continually being asked to discuss the CQC action plan and its effect on their teams at team meetings.

Related strategic aim and corporate objective	All
Risk and assurance	Failure to demonstrate compliance could result in the Trust being placed into special measures by the CQC and this would have a detrimental effect on the Trust
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper CQC registration

Actions required by the Trust Board

The Trust Board is asked to note the up to date position in relation to the action plan and have assurance that action is continuing to address the recommendations and further be assured there will be robust evidence to demonstrate compliance.

Public Trust Board
31 July 2014

CQC Action Plan

1. Introduction

In October 2013 the Care Quality Commission (CQC) released its Intelligent Monitoring report on Northampton General Hospital NHS Trust (NGH) identifying NGH as having a number of Elevated Risks and Risks. This placed NGH in Band 1 with an inspection taking place by the CQC January 2014.

During and following the visit a number of concerns were raised by the CQC with the Quality Report published March 2014 giving the hospital rating in each of the five questions:

Question	Rating
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

The report gave the hospital a rating of 'requires improvement'. Although the report recognised that the staff at NGH, are caring and services in the main are providing safe and effective care, it also identified a number of areas where improvement is required.

The Trust also received a letter from the CQC stating the Trust were failing to comply with CQC Regulations and giving a deadline of 30 June 2014 to become compliant.

This report is presented to the Board to present the actions taken by the Trust at a strategic and operational level and provide assurance that the actions implemented or in progress are sufficiently robust and their impact can be evidenced to demonstrate that the trust has acted to address the findings of the CQC.

2. Governance Arrangements

The Quality Report contained a summary of the CQCs findings including four good practice points. It also included areas for improvement which were split into two categories:

- Action the Trust MUST take to improve (nine points); and
- Action the Trust SHOULD take to improve (nine points).

The Trust also received a letter from the CQC stating the Trust were failing to comply with CQC Regulations and giving a deadline of 30 June 2014 to become compliant. There were eight points contained within this letter that the Trust had to ensure compliance against. In response to the findings a comprehensive hierarchy of action plans were developed. These can be found at appendix 1, 2, 3 and 4 of this report where:

- Appendix 1 – Summary Treatment Plan.
  It presents the significant recommendations made by the CQC, and the trusts immediate response to these. This plan purposely focuses on short term improvements on immediate issues.

- Appendix 2 – Detailed Treatment Plan
  This underpins the Summary Treatment Plan and includes compliance actions and more detailed operational matters identified by the CQC as requiring improvement alongside the agreed actions being taken by NGH to address the issues, the sources of evidence to demonstrate their implementation and the intended outcomes to measure effectives
- Appendix 3 - High Level Action Plan.
  It addresses the recommendations within the CQC letter. All the actions contained here have been RAG rated green as completed and a response letter has been sent to the CQC advising the Trust considers itself to be compliant with the regulations. Evidence is continually added as required to further demonstrate compliance.
- Appendix 4 - Compliance Action Plan
  This addresses the recommendations within the CQC Quality Report. This plan remains dynamic and the Governance Department continue to support the executive team and action owners in collating the evidence and are providing constructive challenge ensuring the availability of robust evidence.

The Chief Executive has implemented a programme management approach to oversee the day to day progress of the actions. There is a Programme Management Board in place, chaired by the Chief Executive that meets weekly to lead and oversee the corporate response to the CQC Report; and holds officers to account to deliver the activities and milestones within it. This group also acts as the quality assurance forum for the assurance and evidence received to demonstrate success/outcomes.

As part of the internal assurance process the governance team continues to collate and challenge evidence, communications have been sent throughout the Trust stating what the CQC said, what we agreed and what we have and/or will do.

CEAC have reviewed the action plan and the supporting evidence together with visiting wards to review how the action plan and the actions have been embedded throughout the Trust.

An Oversight Group (made up of colleagues from the TDA, commissioners and Healthwatch) have looked at the overall response to the CQC report and the action plans. The Oversight Group are also monitoring the progress against the action plans and providing challenge on actions and evidence.

It is vital that corporately and through local team meetings and regular trust-wide communications, the CQC action plan, actions taken and changes that have taken place as a result are robustly disseminated to staff at all levels of the organisation regularly and consistently. In addition the Trust needs to ensure that the actions that have been taken as sustained and evidence is available on an ongoing basis to demonstrate this

3. Exceptions

There remains a risk that the CQC action plans and evidence has not been systematically and robustly disseminated throughout the trust. To mitigate this communications are taking place through the Core Brief, CEO Blog and bulletin together with word of mouth and discussions at care group, wards and team meetings. These communications need to continue to give a consistent message to all staff across the organisation, to ensure staff are familiar with the issues raised and the actions taken. Failure to demonstrate compliance could ultimately result in the Trust being placed into special measures by the CQC.

At the time of writing (18 July 2014) there are some minor gaps in the collation of evidence for the Compliance Action Plan in relation to the quality report as specified below:

- Ensuring there is a robust method of capturing patient experience of patient moves. A patient leaflet has been produced advising patients of how to let the trust know of their experience if they are moved. There is also a system in place to capture patient moves but at present there is currently no system to capture the patient experience. This has been recognised and there has been a request for monthly triangulation checks on PALs, complaints and FFT comments for any adverse patient experiences if they were moved and the aim is to report this to each Care Group on their scorecards
- Ensuring there is a plan for the regular inspection and cleaning of toys for various age groups in A&E. At present the play specialists attend every day and the matron for A&E is developing a checklist for cleaning and checking toys.

4. Next Steps

The CQC will revisit the Trust unannounced shortly and they will be looking at the actions taken to address the recommendations identified in their letter and quality report as well as other general observations. It is vital that all actions have been embedded across the Trust and that all staff, where applicable, can provide confirmation that practices, processes and procedures are in place to ensure the highest level of patient care possible.

The next CQC Oversight meeting will take place with the TDA and health economy partners in August 2014.

5. Recommendations

The Board is asked to scrutinise the action plans presented and be assured that the actions implemented or in progress are sufficiently robust and their impact can be evidenced to demonstrate that the trust has acted to address the findings of the CQC.

The Board is asked to scrutinise the actions plans presented and have assurance that actions implemented or in progress are sufficiently robust and their impact can be evidenced to demonstrate that the trust has acted to address the findings of the CQC.

CQC Report – Strategic Treatment Plan and Progress as at 21.7.2014

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must improve the emergency care pathway and bed capacity management	**We Will** • Review the emergency care flow issues and improve all processes from admission through to discharge • Track patient moves • Risk assess all patient moves • Work to understand those areas where changes to create maximum impact will be required • Work in partnership with the health and social care economy on system redevelopment • Use electronic systems to assist our processes • Understand all blocks in the system • Better understanding our demand and effectively plan capacity **Why?** To improve patient experience and outcomes by ensuring patients are admitted to and treated in the right place, first time, without having to wait longer than four hours for treatment or admission. To minimise the number of patients moves and ensure patients do not stay in hospital longer than necessary. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence' and we reflect, we learn, we improve'.	**Work to be completed by July 2014**	**McKinsey and Co**	**ON TRACK**
We must improve the robustness of our governance processes	**We Will** • Review our quality governance arrangements • Review the management structure and clarify the accountability and assurance mechanisms underpinning the Care Group structure • Review risk management arrangements • Obtain external support and challenge • Develop an implementation plan for improvement **Why?** To ensure we identify and mitigate risks to patients, learn from experience, in line with our values of 'putting patient safety above all else' and we reflect, we learn, we improve'.	**September 2014**	**Deloitte**	**ON TRACK**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must improve leadership from Board to ward – C9.2	**We will** • Accelerate a Board development programme • Recruit a substantive Executive Team • Clarify our Director's key responsibilities for ourselves and our stakeholders • Support a clinical leadership programme for senior medical staff and clinical leads • Accelerate the implementation of the trust's organisational development strategy • Review the trust management structure **Why?** To ensure that staff are confident that the organisation is well led and that the leaders are driving improvements in care to support our values of 'we reflect, we learn, we improve' and 'we respect and support each other'.	**September 2014**	**East Midlands Leadership Academy and AHSN**	**ON TRACK**
We must improve 'do not attempt cardio pulmonary resuscitation' paperwork so it is clearer -CM3.1	**We will** • Withdraw the existing documentation • Implement a redesigned document • Support the implementation of the new documentation with a programme of training and audit to ensure understanding **Why?** To ensure that paperwork is completed consistently to mitigate any risks to patients in line with our value of 'putting patient safety above all else' and improve end of life care.	**Completed**		**DELIVERED**
We must ensure that all equipment is maintained and available in clinical areas where required CM4.1 –CS4.3	**We will** • Ensure all medical equipment has been serviced by a qualified safety engineer • Implement a centralised medical equipment maintenance strategy • Develop a planned maintenance register and forward plan **Why?** To ensure we identify and mitigate risks to patients, aspire to excellence, in line with our value of 'putting patient safety above all else'.	**Aug 2014**		**ON TRACK**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must put processes in place to ensure that medication is dispensed to patients before they have left hospital **H1.3**	**We will** • Cease the practice of discharging patients home with their prescribed medication following in a taxi. • Trial using patient own medication to expedite the availability of to take home medicines ready for discharge • Update existing policy and guidance and make available to all staff • Establish safety huddles to identify potential delays in the availability of to take home medication on discharge **Why?** To ensure we identify and mitigate risks to patients, learn from experience, in line with our value of 'putting patient safety above all else'.	**Completed**		**DELIVERED**
We must strengthen the leadership of End of Life Care and ensure that there are robust mechanisms in place to inform the palliative care team of those patients who require specialist support at the end of life **C6.1 –C6.8**	**We will** • Ensure there is a named consultant for the service • Introduce the communication of patients at the end of life to the daily safety huddles • Additional actions to match the action plan to indicate this has not been delivered **Why?** To improve end of life care across the Trust by ensuring patients are cared for in line with our value of 'putting patient safety above all else'	**Completed** **Jan 2015 for last end of life action**		**ON TRACK**
We must improve arrangements for children's care in the A&E department **CM2.2**	**We will** • Ensure 24 hour access to an RSCN for A&E • Designated an area within the A&E department for use solely by children • Ensure children are appropriately prioritised in A&E • Ensure appropriate training for our A&E staff **Why?** To improve patient experience and outcomes for children and their families when they attend A&E by ensuring the environment is appropriate to their needs and appropriate trained staff are available. This supports the trusts values of 'we put patient safety above all else'.	**September 2014**		**ON TRACK**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must improve compliance with mandatory and essential to role training and appraisal **H7.1-H7.3**	**We will** • Accelerate current programmes for improving training compliance • Accelerate current programme for improving essential to role training compliance • Accelerate current programmes for improving appraisal compliance • Report on these to the Board monthly **Why?** To deliver improved outcomes to patients through the development of staff, enabling excellence though our people to deliver our values of 'we put patient safety above all else', 'we aspire to excellence' 'we reflect, we learn, we improve', and 'we respect and support each other'.	**May 2014**		ON TRACK
We must improve the follow up, completion and oversight of action plans relating to all incidents, significant incidents, complaints and clinical governance issues **H5.1**	**We will** • Continue to develop the improvement plan in place for action plans and serious incidents • Continue to develop the mortality and morbidity analysis meetings • Continue to develop the quality metrics • Improve the action plan monitoring from complaints • Establish joint meetings with all quality governance functions to identify and align themes identified from investigations and ensure that lessons are identified and disseminated across the trust. **Why?** To improve the outcomes for patients and underpin the trust values of 'we put patient safety above all else', 'we aspire to excellence' and 'we reflect, we learn, we improve'.	**June 2014**		ON TRACK
We must ensure that records are accurately completed, reflect patient needs and are accessible when needed.	**We will:** Develop and implement revised nursing documentation to launch the enhancing patient assessment initiative • Monitor improvements in the quality of documentation through the QuEST process • Ensure staff are aware of record keeping standards through the delivery of a training programme supplemented by coaching and mentorship for staff • Minimise the number of records not available at the time of a patient's outpatient appointment **Why?** To improve access to, and the quality of the documentation used in the care of our patients. This is in line with the trust values of 'we put patient safety above all else', 'we aspire to excellence' and 'we reflect, we learn, we improve'.	**July 2014**		ON TRACK

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must clarify the stroke imaging pathway for staff to avoid confusion **H3.3**	**We will:** • Define the pathway with agreed roles and responsibilities • Agree how we will measure this and report exceptions/issues • Communicate the pathway to key stakeholders **Why?** To improve patient safety and experience by ensuring that patients receive the most appropriate intervention in as soon as possible. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence'.	**April 2014**		**DELIVERED**
We must ensure that the findings of the Emergency Care Intensive Support Team are explicitly acted upon **H2.1**	**We will:** • Report further progress in implementing the actions, and their outcomes, to the Board as part of ongoing urgent care reporting **Why?** To improve patient experience and outcomes by ensuring patients are admitted to and treated in the right place, first time, without having to wait longer than four hours for treatment. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence' and we reflect, we learn, we improve'.	**June 2014**		**DELIVERED**
We must ensure that the outcomes from the trust's self-assessment of the Intensive Care Society Core Standards for Intensive Care are implemented **H1.6**	**We will:** • Undertake a self-assessment of care standards • Report the self-assessment and any required actions to the Integrated Healthcare Governance Committee. **Why?** To assure ourselves that the intensive care services patients require are of the highest quality and benchmarked against national best practice requirements. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence'.	**June 2014**		**DELIVERED**

HOW OUR PROGRESS IS BEING MONITORED AND SUPPORTED	TIMESCALE	OWNER	PROGRESS
Monthly Accountability and Oversight meeting with TDA	May 2014 onwards	Sonia Swart – Chief Executive	ONGOING
Access Support from East Midlands Leadership Academy and AHSN following receipt of Governance Review	June 2014	Sonia Swart – Chief Executive Janine Brennan - Director of Workforce Tranformation and Organisational Development	ONGOING
Weekly CEO and Chairman oversight of action plan with input from executive team	April 2014	Sonia Swart – Chief Executive Paul Farenden- Chair	ONGOING
Monthly review of improvement actions at Trust Board to be shared with CCG and TDA	April 2014	Sonia Swart - Sonia Swart – Chief Executive	ONGOING
Monthly review of individual actions in the detailed action plan at Integrated Healthcare Governance Committee as appropriate	May 2014	Graham Kershaw – Non Executive Director	ONGOING
Monthly review of additional quality metrics for quality scorecard at IHGC and Trust Board as agreed through improvement plan	May 2014	Executive Directors	ONGOING
Appointment of additional roles to support improvements in quality governance	June 2014	Sonia Swart - Sonia Swart – Chief Executive	ONGOING
Monthly Scrutiny by Clinical Commissioning Group through Clinical Quality review meetings	May 2014	Peter Boylan – CCG Mike Wilkinson – Medical Director	ONGOING
Monthly updates on progress on the Trust Website	April 2014	Sonia Swart – Sonia Swart – Chief Executive Sally Watts – Head of Communications	ONGOING
Embed improved management and leadership for quality through implementation of the Trust Organisational Development Strategy and the Making Quality Count Programme	September 2014	Janine Brennan- Director of HR , Transformation and Organisational Development Sonia Swart - Sonia Swart – Chief Executive	ONGOING

Northampton General Hospital NHS
NHS Trust

CQC Inspection – Action Plan as at 21.7.2014

Incorporating all Compliance actions identified by the CQC on their inspection of the 16 January 2014

Version 5

1. TTOs and Taxis – H1.3

Key Issue: The CQC found that NGH had not regularly assessed and monitored the quality of the provision of discharge medication to service users or assessed and managed the risk of using taxis and its potential impact upon the health and welfare of the people using services

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
1.1	Cease the practice of sending take home medication to patients via taxi	Risk mitigated	Chief Operating Officer	January 2014	E-mail stipulating taxis not to be used	Medicines Management Committee	
1.2	Compliance with request to cease practice of send take home medication to patients via taxi	Audit provided	Chief Operating Officer	Feb 2014 /June 2014	Audit to be undertaken to gain assurance the practice has ceased	Medicines Management Committee	
1.3	Ensure overarching Medicines Management (NGH-PO-249) is in date and available on the intranet.	Medicines Management Policy is due for review November 2014	Chief Operating Officer	February 2014	Policy available on the intranet	Procedural Document Group	
1.4	Ensure all guidance for staff regarding discharge medicine for exceptional circumstances is available on the Trusts intranet	Medicines Management Committee to review Policy and appendices to ensure all guidance relevant to discharge medication is available on the intranet	Chief Operating Officer	May 2014	Guidance for Obtaining Medicines Out of Hours (TTOs) available on the intranet	Medicines Management Committee	
1.5	Trial using patient own medication to expedite the availability of take home medication ready for discharge	Trial being undertaken	Chief Operating Officer	May 2014	Use of POM included in Appendix 3 of Medicines Management Policy	Medicines Management Committee	

1.6	Establish safety huddles to identify potential delays in the availability of take home medication on discharge	Email from DoN 9 April 2014 to Ward Sisters, Modern Matrons, Site Managers announcing the commencement of Safety Huddles Email with further update to Ward Sisters, Modern Matron 10 April 2014 Further email 12 April 2014 containing more update information to cascade to weekend staff Further email 22 April 2014 giving further feedback regarding changes to form	Director of Nursing, Midwifery and Patient Services	April 2014	Emails Minutes of Safety Huddle Template of Safety Huddle Report Hyperlink to Safety Huddle Folder - daily reports	Nursing and Midwifery Board	

2. Mandatory Training – H7.1; H7.2 **Key Issue:** The actions taken to manage the risks are inadequate and there remains a significant number of staff who have not received the relevant mandatory training							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
2.1	Provide a variety of options to ensure that staff are able to access mandatory training.	4 options for mandatory training currently available since Autumn 2013: 1) Classroom 2)E-Learning 3) Workbook 4) RoK (Review of Knowledge) All options are available on the intranet. Updated TNA & Course outline (planned for June 2014)	Director of Workforce	April 2014	Snapshot Intranet pages Examples of emails sent to Managers advising dates of training	Clinical Quality and Effectiveness Group	
2.2	Mandate that all A&C staff complete Mandatory Training as e-learning programmes.	Email to Managers been circulated - various managers email dated 8.4.2014, Discussed at CQEG April 2014	Director of Workforce	May 2014	Emails to managers Minutes of IHGC / CQEG Papers April 2014	Clinical Quality and Effectiveness Group	

2.3	Implement a "Mandatory Training wave approach" to forecasting compliance and performance management	Report to CQEG / IHGC April 2014 states that a 'mandatory and role specific essential training performance wave has been produced and is being shared with Ward Sisters and Managers. Email 8.4.2014 of the new Performance wave approach from T&D to all managers. Further updates have been made and Summary Report example April and Ward League Table presented at Core brief 6.6.2014 New approach to report compliance from Directors down following a meeting with managers in May 2014 Communication will be sent requesting any amber or red areas of compliance add this issue to their local risk registers. - email to be circulated w/c 9.6.2014 IHCG/CQEG reports for June 2014 refer to the "top down and bottom up approach" and also highlight the trajectory work	Director of Workforce	May 2014	Compliance Reports demonstrating improvement in compliance. Email with roll out timetable	Clinical Quality and Effectiveness Group	

2.4	Seek advice / support from other Trusts that have robust systems in place and are willing to share good practice.	Contacted Derby Hospital; Nottingham University Hospital; Royal Berkshire Hospitals	Director of Workforce	April 2014	Example of contact with Nottingham inc email and letter and link to the film for Nottingham https://www.nuh.nhs.uk/welcome-to-NUH	Clinical Quality and Effectiveness Group	
2.5	Monitor performance management of attendance takes place within CQEG; IHCG.	Workforce discussed at IHGC & Trust Board monthly	Director of Workforce	May 2014	Workforce reports to IHGC and Trust Board	IHGC	
2.6	Develop a process to monitor and review accuracy of data	Email & CQEG Paper March and April 2014 reflecting issues and progress Directorates are asked to review their compliance information and challenge any inaccuracies to help address the issues. Directorates are now (as of June 2014) being asked to update the risk register to reflect the issues with compliance if required. This has been reported to IHCG and CQEG	Director of Workforce	May 2014	External review of OLM/ESR data (McKesson) Reports to CQEG	Clinical Quality and Effectiveness Group	

2.7	Scope out what is deemed to be role specific training in each area and staff group	The Role specific course outline includes both Mandatory and Role specific training and can be accessed from the intranet. An update of the Training including outlining which is Role specific and which is Mandatory is being addressed by T&D in May 2014	Director of Workforce	Jan 2014	Up to date information regarding role specific training requirements needs to be available to all staff	Clinical Quality and Effectiveness Group	

2.8	Ensure correct information regarding role specific training is available on the intranet	Ongoing	Director of Workforce	April 2014	The T&D department are working on specific training for specific job roles which will take a while to address. Emails have now been circulated and directorates are being asked to review and define the role specific aspects. Email of 5.6.2014 circulated to GMs. Once information approved it will be transferred to templates provided by McKesson and then forwarded to McKesson who will do the mass upload. Timing of this is important as McKesson will remove current competency requirements from our system and put the new information in so this needs to be done between reports etc. Role Specific identification of Job roles has been completed by T&D. T&D are reviewing the risk register to highlight the data issues which McKesson are working with currently. This is being highlighted to IHGC & CQEG in June 2014 Internally this will continue to be monitored	Clinical Quality and Effectiveness Group	

2.9	Provide monthly reports of compliance	Reporting to Board, IHGC and CQEG commenced.	Director of Workforce	April 2014	CQEG minutes / reports IHGC minutes / reports Trust Board minutes / reports	IHGC	

3. Patient Moves at Night H1.1
Key Issue: NGH had no effective system to identify, assess and manage the risks to the health and welfare of patients who were moved at night

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
3.1	Patient Risk Assessment to be developed (which includes national criteria / local standards e.g. end of life patients / Dementia patients not to be moved after an agreed time etc.	Patient risk assessment developed	Chief Operating Officer	May 2014	Patient risk assessment Evidence of roll out	IHGC	
3.2	Ward Transfer Records to include the time of transfer	This is included in the Nurse Handover Safety Checklist	Chief Operating Officer	March 2014	Transfer Records and monitoring	IHGC	
3.3	System to be established to identify the number of patients moved / at night	All information provided	Chief Operating Officer	March 2014	Description of process Evidence of roll out Patient Movement Log Spider web	IHGC	
3.4	Report the number of patient transfers to IHGC commencing May 2014	Report to go to IHGC on 22nd May 2014	Chief Operating Officer	May 2014	Reports to IHGC and subsequent actions	IHGC	
3.5	Development of a patient leaflet informing patients that they may on occasion be moved at night	Leaflet has been drafted and has been sent out for consultation. Expected to be submitted to the Patient Information Group w/c 5th May 2014	Director of Nursing, Midwifery and Patient Services	June 2014	Draft of Patient leaflet Consultation emails	IHGC	

4. Stroke Imaging Pathway – H3.3

Key Issue: Whilst the risk posed to the health and welfare of patients admitted with a stroke had been identified and assessed they had not been effectively managed. Concerns were raised to the CQC inspection team regarding understanding of the stroke imaging pathway and confusion between the radiology and medical departments.

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
4.1	Develop the pathway with agreed roles and responsibilities	Ratified protocol; Data & CQEG & IHCG minutes from May	Medical Director	April 2014	Copy of pathway	IHGC	
4.2	Ensure communication of pathway to all staff	Evidence from NH re radiology meeting minutes & Medicine Care Group	Medical Director	April 2014	Evidence required for: dissemination of the pathway. meeting minutes that record discussion including Radiology to confirm that the pathway is now in place and working	IHGC	
4.3	Agree process for ongoing monitoring and reporting	SSNAP audits	Medical Director	April 2014	Outcome of SSNAP audits to ensure trust maintain above National average compliance	IHGC	

5. Intensive Care Society Core Standards for intensive care units - H1.6 **Key Issue:** CQC reviewed the analysis which identified gaps against the standards including a medical consultant not being immediately available 24 hours a day and consultant work patterns to deliver continuity of care not being in place. CQC did not see evidence of what actions had been identified to address the gaps and comply with the standards. The analysis was therefore not robust as there was no evidence as to how the compliance would be achieved.							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
5.1	Report to be presented to IHGC in May 2014	A summary report on the findings, actions and progress to be presented to the IHGC in May 2014.	Medical Director	May 2014	Consultant Rota Gap analysis Actions to address deficits identified and discussed Business Case Minutes of meetings	Strategic Management Board	

6. Emergency Care Intensive Supportive Team Report – H2.1

Key Issue: During September and October 2013 the trust commissioned a review of the Accident & Emergency service, including the Emergency Care Pathway by the Emergency Care Intensive Support Team which provided recommendations for the improvement of the A&E service. There was no evidence that conclusions from this local review of the A&E service had resulted in changes to treatment or care provided to people using services at Northampton General Hospital.

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
6.1	Review October 2013 report and identify any additional actions	Actions incorporated into the Urgent Care Programme	Chief Operating Officer	May 2014	Gap analysis and action plan	IHGC	
6.2	Resultant action plan to be uploaded to HealthAssure and evidence of completion linked	Emergency Care Intensive Support Team are revisiting the Trust on 24 June 2014 Urgent care report to be presented to Board in June 2014 ECIS meeting info Autumn/ Dec 2013	Chief Operating Officer	May 2014	Report to IHGC	IHGC	

7. Follow-Up of Action Plans – H5.1

Key Issue: The follow up of action plans was identified as a concern in the minutes of the Trust Board meeting. However, there was no record of how the Trust was going to address the issue and there was no evidence that the associated risks to the health, welfare and safety of people using services at NGH had been identified, assessed and managed

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
7.1	Develop a robust process for the review and follow up of action plans	The Serious Incident Group has devised and implemented a more robust process for the management of Serious Incident action plans. The process has been included in the revised Serious Incident Policy and has been reported to CQEG, IHGC and the Trust Board. Reports on performance against the revised Serious Incident process will continue to be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness.	Medical Director	February 2014	Revised pathway demonstrating process CQEG Report Trust Board Report	Clinical Quality and Effectiveness Group	

7.2	Progress of all SI action plans monitored on HealthAssure	Reports on performance against the revised Serious Incident process will be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness. The Facilitators are reviewing all action plans from Q3 to ensure evidence is available to demonstrate completion. This will be presented to the SIAM meeting with the CCG on 16th May 2014. Q4 onwards action plans are being monitored via HealthAssure and a quarterly compliance report will be submitted to SIG	Medical Director	May 2014	Reports on compliance Review of Quarter 3 SI action plans with RAG rated progress Meeting minutes HealthAssure Reports	Clinical Quality and Effectiveness Group	

7.3	Ensure all SI action plans are signed off by the accountable committee in a timely manner	As from Feb 2014 submitted Serious Incident reports and action plans are reviewed by SIG at the next meeting to ensure that contributory factors have been fully explored and that actions are aligned with the root cause of the incidents to reduce the likelihood of recurrence. All SI action plans for Quarter 4 are now on HealthAssure and the Care Group Governance Managers will complete quarterly status updates - Status updates for Quarter 4 are in the process of being completed. SI Action plans are then monitored by the Directorate/Care Groups until completion. Completed action plans will be presented to SIG with the evidence to ensure all actions have been completed. The first action plans are expected to be presented to SIG in May 2014	Medical Director	May 2014	SIG Minutes Directorate Governance Meetings CQEG Directorate Governance Reports HealthAssure Reports	Clinical Quality and Effectiveness Group	

8. Staff Appraisal – H7.3 **Key Issue:** Suitable arrangements were not in place for ensuring the number of staff without a performance development plan were robustly managed							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
8.1	An audit will be undertaken on all areas where there is no up-to-date information on staff appraisals. This will require managers to provide appropriate evidence to the HR & L&D teams that staff have had an appraisal via one of the processes.	An increased level of appraisal compliance – aiming for 75% by the end of April 2014; incrementally progressing to 85% by March 2015.	Director of Workforce	April 2014	Audits took place in April and June. Results of audit and gap analysis and follow up Example of monthly report	IHGC	
8.2	Where appraisals have not been undertaken within the last year, managers will be required to provide a plan of how this will be achieved within a given time frame. If this is not aligned to staff increments managers will be required to do an appraisal; however a further review will be required to provide assurance to payroll and L&D that staff can incrementally progress	A detailed action plan has been developed for Appraisals and Training and this is discussed at Trust Board	Director of Workforce	April 2014	Papers & Minutes IHGC Papers of Trust Board & Minutes Trust Board	IHGC	

8.3	Monitor performance management of attendance	Appraisal audit is continuing although there is little improvement this month. All ward areas to receive monthly update to say what their compliance levels, and the requirement to provide an action plan and put on their Risk Register will apply to appraisals.	Director of Workforce	April 2014	Papers & Minutes IHGC Papers of Trust Board & Minutes Trust Board	IHGC	
8.4	Continue to embed the new appraisal process aligned to incremental progression	Performance management process -75% by June; should be 80% by Oct and 85% March 2015	Director of Workforce	April 2014	Review Trust target (May) - 85% - Report to IHGC in May 2014	IHGC	

9. Do Not Attempt CPR Paperwork – CM3.1 **Key Issue:** The do not attempt cardio pulmonary resuscitation (DNACPR) paperwork was misleading and being incorrectly completed and used							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
9.1	Withdraw existing documentation	Friday 17th January 2014 1900hrs onwards - All forms were removed and replaced with copies of the DNACPR form only. This was verbally handed over to the Nurse in charge in all in patient areas, A&E, operating theatres and escalation areas. An accompanying memo to explain the rationale for change and completion process was also provided with mobile contact number for 24/7 advice or support if required during the pending weekend.	Director of Nursing, Midwifery and Patient Services	January 2014	Documentation withdrawn from all areas Emails Screensavers	Clinical Quality and Efficiency Group	

9.2	Redesign and implement revised documentation	Monday 20th – The Resuscitation team visited all in patient areas with further hard copies of the carbonated versions of the DNACPR to resume the required audit trail. The resuscitation team followed up all patients who had a DNACPR decision made since Friday evening and copies were taken for audit purposes. Monday 20th January 0830hrs – Consultation with Doctors of all grades (including the 2222 emergency team) to capitalize on gaining further feedback regarding refinement and potential improvements for the form. Form redesigned to align the process. New artwork was produced with the assistance of NGH Medical Illustration with two forms produced which sat on one A3 backboard, thus allowing for the TEP form to be used independently or in conjunction with the DNACPR form if appropriate. Revised form was then shown discussed with medical staff. The final draft version was presented to Dr Swart at 1530hrs on Monday 20th January 2014. Approval was agreed that the form could go to print and launched as a development document	Director of Nursing, Midwifery and Patient Services	January 2014	Copy of revised DNACPR form Revised DNARCPR form included in Resuscitation Policy	Clinical Quality and Efficiency Group	

9.3	Support the implementation of the revised documentation with a programme of training, support and audit	All resuscitation sessions and courses include appropriate training on DNACPR DNACPR compliance with correct completion of forms has risen from 54% (Dec) to 87% (March) Monthly audits continue	Director of Nursing, Midwifery and Patient Services	February 2014	Training programme Audit results Evidence of distribution (i.e. meeting minutes etc.)	Clinical Quality and Efficiency Group	

10. Safety Testing of Medical Equipment – CM4 **Key Issue:** Equipment was not being adequately tested or maintained							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
10.1	Review planned preventative maintenance register of equipment ensuring all medical equipment is listed	Immediately after the concerns raised by CQC, TBS engineers were called in to inspect and action the maintenance of equipment in the following areas: Main Theatres, Manfield Theatres; Gynae Theatres; Day Surgery Unit; ITU and Paediatrics. Subsequently TBS were asked to go to all areas and carry out planned maintenance TBS produced the following KPIs on February 2014 as a progress update: • Planned Maintenance: 86% instead of 90% • Performance Verification Testing: 54% instead of 60% TBS currently on track to meet Trust standards of planned maintenance KPIs by end of March 2014 TBS to produce a Trust wide planned maintenance plan for the next 12 months by end of March 2014	Director of Facilities	Aug 2014	Progress report Minutes of meetings where discussed	Medical Equipment Group	

10.2	Identify any medical equipment which has not been tested and carry out risk assessment for inclusion on Risk Register	Contained within the risk register CQEG Reports	Director of Facilities	March 2014	For inclusion in compliance report to CQEG Minutes and report to Risk Group	Medical Equipment Group	

11. Capnography Machines – CM4.2
Key Issue: Ensure adequate supply and use of capnography machines in theatres

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
11.1	Review availability of capnography machines and identify shortfall	Business Case developed showing sufficient capnographs in the system	Director of Facilities	May 2014	Assurance of required stock and requirements if additional equipment required.	Medical Equipment Group	
11.2	Where a shortfall is identified, carry out a risk assessment for inclusion on Risk Register	Managed and monitored through the risk register		May 2014	Assurance of required stock and requirements if additional equipment required.	Medical Equipment Group	

12. Dispensing Medication after Patients are Discharged – CM1.4
Key Issue: Medication is being dispensed after patients have left hospital, it is being delivered by a taxi and no risk assessment of the medication, the delay and the impact and risk of this action is taking place

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
12.1	Cease the practice of sending take home medication to patients via taxi	Practice has been stopped	Chief Operating Officer	January 2014	Practice has been stopped Documentation available on Wards Policy amendment	Medicines Management Committee	

13. Off-site Pharmacy Support – CM3.2 **Key Issue:** Address the lack of pharmacists allocated to the off NGH site ward to review and advise on medication arrangements							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
13.1	Review the requirement for pharmacy support for off-site ward areas	For CCH and Isebrook the arrangements were that pharmacy needs were to continue to be supported contractually by KGH upon transfer of the clinical areas to NGH. The substantive pharmacy support from Provider services for Corby and Hazelwood did not transfer when areas transferred to management of NGH. There was ad hoc support from the part time pharmacist at Danetre to review the stock levels at Corby and Hazelwood wards and to remove the controlled drugs when required.	Chief Operating Officer	March 2014	As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT	Medicines Management Committee	

14. Children and A&E – CM2.2, C2.3, C2.4, C2.5 **Key Issue:** Children are being treated in an adult A&E department. There are very limited dedicated facilities or specialist staff to care for children							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
14.1	Formal review of the NSF for children required to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this.	Issue is being progressed at joint paediatric/A&E meeting. Inaugural meeting 15/4/14. Group consists of Consultants, Service managers and Matrons from each area	Director of Nursing, Midwifery and Patient Services	Sept 2014	Formal review of the NSF for children to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this. Minutes of the meeting and resulting plans	Strategic Management Board	

14.2	RSCN to be rostered providing 24 hour access for children attending A & E	There are currently 5.06wte paediatric trained nurses available for A&E (5.68wte being required to provide 1 nurse per shift) - this leaves a vacancy of 0.62wte and the posts are currently advertised on NHS Jobs. We plan to over recruit to our nursing posts. - Band 5 Paediatric nurses have now been appointed (start dates August/September), however band 6 position remains out to advert – currently there have been no applicants. Paediatric nurses identified separately on the rota and the offer of support from within Paediatrics has been made on a short term basis for approximately 1 long day pre week during the month of July. A separate roster for paediatric nurse cover has been added to the main A&E roster template to be able to clearly identify this.	Director of Nursing, Midwifery and Patient Services	Sept 2014	Copy of advert Copy of job description VCP confirmation Copy of roster Copy of minutes of joint A &E and Paediatrics Meeting Email from DoN	Nursing and Midwifery Board	

14.3	Identify a designated area within A & E for sole use by children and their families	The separation of the play area and paediatric cubicle will be completed before the end of June. To ensure the environment is appropriate for children a meeting to sign off the design is planned between Matron A & E; Matron Children's and Estates. Appropriate decoration will also be discussed This location is now in use as at July 2014	Director of Facilities	June 2014	Plans for A & E rebuild programme Revised timetable	Strategic Management Board	
14.4	Full review & itinery of the availability of toys for various age groups. There should also be a plan for regular inspection to ensure fit for purpose, not damaged, cleaned regularly and be EU marked for safety	It was initially agreed that this point would be completed by the play specialists. Given current vacancies within that team the Matron A & E has allocated time on Tuesday 6th May to review all toys within the play area and will discuss further requirements with the play specialist. Once this has been completed the Matron A & E will develop the protocol for cleaning etc.	Director of Nursing, Midwifery and Patient Services	Sept 2014	Full review & itinery of the availability for toys for various age groups. these should also have a plan for regular inspection to ensure fit for purpose, not damaged, cleaned and must all be EU marked for safety - protocol required as evidence	Strategic Management Board	

14.5	Review the requirement for a dedicated or decorated room for minor injuries	This area has since been closed as the department is having a rebuild. There are toys available in the main A&E children's waiting area. This has now been completed	Director of Nursing, Midwifery and Patient Services	June 2014	Minutes of meetings	Strategic Management Board	

14.6	Review triage process to ensure children attending A&E are appropriately prioritised	Issues discussed at joint paediatric/A&E meeting. Group consists of Consultants, Service managers and Matrons from each area. Agreed - 2 nurses in triage – one of which will be assigned to fast track children and young persons through the triage process as soon as they have registered their attendance. C&YP will then be directed to paediatric area once works completed. A streaming process is to be introduced by a nurse to determine appropriateness for A&E attendance. Matron A&E to implement fast track and Consultant A&E to liaise with working group to ascertain what provision will be introduced for children and young people. Comparison of Data from symphony pre and post	Medical Director	Sept 2014	Minutes from meeting Audit against "recognised standards"	Clinical Quality and Effectiveness Group	

14.7	There needs to be a consultant nominated as the lead for children's care in A&E	Julia Weatherill is the consultant lead for children's and Lisa Barnes and Vicky Write are the Sisters responsible for children's. Matron - A & E has sent a memo to all staff informing them of above. A photo poster is being developed which will be displayed jointly next to the safeguarding teams within the department	Medical Director	Sept 2014	Dr Julia Weatherill is lead A&E Consultant for Children - minutes of joint paediatric / A&E meeting to confirm Photo poster displayed in A&E	Strategic Management Board	
14.8	Use the same audit tools as the children's ward when auditing children's care in A&E	The Matrons from A & E and Children's have reviewed the QUEST audit that is completed in paediatrics. They have agreed which questions from the Paediatric QUEST audit should be incorporated into the A & E monthly QUEST to provide consistency. The Matron A & E is meeting with the Apps team on 6th May to review and update the monthly QUEST audit tool	Director of Nursing, Midwifery and Patient Services	June 2014	Completed audits	Nursing and Midwifery Board	

15. Patient Moves around the Hospital – CM1.5

Key Issue: Patients are being regularly moved around the hospital and there is no system in place to monitor this and the impact it is having on patients and their treatment, their length of stay and their experience

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
15.1	Patient Risk Assessment to be developed	Patient risk assessment developed	Chief Operating Officer	May 2014	Risk Assessment and monitoring tool for assessing the impact of moves on a patient's treatment, length of stay and experience Minutes of meetings Evidence of roll out	Clinical Quality and Effectiveness Group	
15.2	Ward Transfer Records to include the time of transfer	This is included in the Nurse Handover Safety Checklist	Chief Operating Officer	May 2014	Minutes of meetings	Clinical Quality and Effectiveness Group	
15.3	System to be established to identify the number of patients moved	Monitoring process needs to be agreed	Chief Operating Officer	May 2014	Minutes of meetings Spider web Database	Clinical Quality and Effectiveness Group	
15.4	Report the number of patient transfers to IHGC commencing May 2014	received draft minutes - awaiting final approved	Chief Operating Officer	May 2014	Evidence in report detailing the impact on patient	Clinical Quality and Effectiveness Group	
15.5	Develop a method of capturing patient experience and once this and risk assessments have been fully embedded and number of moves is below 5 undertake RCA into moves to understand impact and effect on patients	AD to provide a monthly check and report to Care Group Board	Chief Operating Officer	June 2014	Process for capturing patient experience following ward moves	Clinical Quality and Effectiveness Group	

15.6	Development of a patient leaflet informing patients of why they may be moved. Leaflet to include details of how patient can report if they are unhappy about being moved which will enable this data to be captured	Leaflet has been drafted and has been sent out for consultation Patients asked to contact PALS if they have concerns about being moved - PALS will then log this information as a 'patient who has been moved'	Director of Nursing, Midwifery and Patient Services	June 2014	Draft of Patient leaflet Consultation emails	Clinical Quality and Effectiveness Group	

16. Maternity Labour Ward Entrance – CM3.6 **Key Issue:** The door leading in to the maternity labour ward could be left open and posed a risk of unauthorised access to this high risk area							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
16.1	Spot checks to be carried out to ensure the door is closed	Spot checks carried out 3 times a day to ensure door closed. Raised staff awareness of need to keep door closed and audited (3x daily spot checks documented). 100% compliance mid April 2014 and 100% compliant end of April 2014 Compliance with audit has been reported to Governance Group (awaiting minutes of meeting for evidence of completion) Note: the outer door of labour ward allows access to lobby area only. Two further security doors are used to gain access to the labour ward and MOW. The reception desk has barrier glass to ensure safety of receptionist. No access to clinical area by this single outside door.	Director of Nursing, Midwifery and Patient Services	March 2014	Spot checks to be carried out to ensure the door is closed Raised staff awareness of need to keep door closed and audited (3x daily spot checks documented). 100% compliance mid-April 2014. Compliance with audit to be reported to Governance Group	Strategic Management Board	

17. Management of Serious Incidents – CS5.2

Key Issue: The management of serious incidents within the trust is not robust; the process of reporting is delayed, training in report writing is absent, monitoring of action plans is not consistent or timely. Organisational learning is limited if not absent. However there was evidence of learning in the area where the incident occurred.

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
17.1	Ensure incidents which fulfil the criteria of a serious incident are reported as per the national framework timescales	The Serious Incident Group now meet weekly to expedite the agreement & external notification of Serious Incidents (SI). A process flow chart has been developed to support identification, confirmation and external reporting of Serious Incidents in a timely manner to meet external reporting requirements Compliance with timescales is reported quarterly to CQEG and IHGC	Medical Director	April 2014	Process for identification of incidents which fulfil the classification of an SI Quarterly report to IHGC demonstrating compliance with the National Framework for Reporting & Investigating Serious Incidents	Clinical Quality and Effectiveness Group	

17.2	Provision of training for staff in root cause analysis	External training provider being sourced - planned for July 2014. Consultant Governance Leads and Band 8a and above identified to attend Risk Manager and Senior Quality, Risk & Litigation Manager provide support for SI leads and quality assure all serious incident investigation reports prior to submission. In addition an in-house training package for RCA and incident investigation is under development	Medical Director	Sept 2014	Training programme Attendance log	Clinical Quality and Effectiveness Group	
17.3	Develop a clear pathway which demonstrates the dissemination of lessons learnt at individual directorate, department, care group, trust wide and the wider health economy	A clear pathway has been developed to demonstrate the dissemination of lessons learnt at individual; Directorate/Department; Care Group; Trust wide and the wider health economy levels (see attached). The pathway commenced roll out in February 2014.	Medical Director	February 2014	Revised pathway demonstrating process Trust Board Report / Minutes CQEG Report / Minutes IHGC Report / Minutes Care Group Governance Minutes Directorate Minutes	Clinical Quality and Effectiveness Group	

17.4	Serious Incident Group Liaise with Patient Safety Academy to implement simulation training based on learning from serious incidents	The Governance Team are working with the Patient Safety Academy to implement Simulation Training Sessions based on learning from Serious Incidents simulation suite training info to be also added	Medical Director	May 2014	Simulation training plan Attendance logs	Clinical Quality and Effectiveness Group	
17.5	Development of quarterly staff newsletter 'Quality Street' to include lessons learnt	All Trust Governance leads and managers have been emailed to request submission of articles The Governance Team have written articles on Datix upgrade; Duty of Candour; lessons learnt from incidents, serious incidents Photographs of team taken by Medical Illustrations to improve profile of Governance Team Medical Illustrations to publish first publication Published copy June 2014 for Quarterly publication	Medical Director	May 2014	Copies of Quality Street	Clinical Quality and Effectiveness Group	

17.6	Development of a Standard Operating Procedure to ensure lessons learnt are disseminated to ward level	"This is included in the Nursing & Midwifery Quality Agenda and the development of Standard Operating Procedures (SOP). A standard template was developed by the Head Nursing & Midwifery, Professional, Practice Development. Although evidence reflects compliance concerns were raised as part of the CEAC review and this has been Corporate Lead nurses meeting. Further discussion regarding the SOP and standing agenda will take place at NMB and Matrons and Sisters meeting"	Medical Director	May 2014 revised date Aug 2014	Copy of SOP Ward minutes to demonstrate discussion	Clinical Quality and Effectiveness Group	

18. Emergency Call Alarms – CS4.3

Key Issue: Access to equipment is an issue within the Trust (there were no emergency call alarms in the anaesthetic rooms or operating theatres in the main theatres suite which does not comply with the NHS Estate Health Building Note 26 (HBN 26)

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating

18.1	Undertake survey work to determine requirements.	This has been recognised as an issue and work is currently underway within the capital programme. To date anaesthetic rooms and PAR in Main, Manfield and Gynae theatres have had alarms installed and survey work is being undertaken in the remaining theatre areas to determine requirements.	Director of Facilities	Aug 2014	Completed action plan	Strategic Management Board	

19. Complaints – CS5.4

Key Issue: Actions following a complaint are realised and logged. However there are considerable delays in initiating actions; some actions from complaints remain outstanding three months after the actions have been agreed and the complaint has been responded to.

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating
19.1	Develop a robust process for the review and follow up of action plans	The Governance IT Facilitator and Complaints Manager have met to discuss the process. Agreed to adopt the same process as Serious Incident Action plans SI Action Plan assurance pathway to be adapted and distributed to care	Director of Nursing, Midwifery and Patient Services	Sept 2014	HealthAssure process plan Dissemination to Care Groups/Directorates	Clinical Quality and Effectiveness Group	
19.2	Progress of all action plans monitored on HealthAssure		Director of Nursing, Midwifery and Patient Services	Sept 2014	CQEG reports Directorate Governance Reports	Clinical Quality and Effectiveness Group	

19.3	Ensure all action plans are signed off by the accountable committee in a timely manner	Groups/Directorates All Complaints action plans from 1st April 2014 in the process of being uploaded to HealthAssure Q1 data to be presented to CQEG / Care Groups / Directorates – Sept 2014	Director of Nursing, Midwifery and Patient Services	Sept 2014		Clinical Quality and Effectiveness Group	

20. Records – CS8.1

Key Issue: Records were not available when required and were not always accurately completed with information regarding patients specific needs

Ref	Agreed Actions	Progress	Owner(s)	Timescales	Sources of Evidence	Assurance Committee	RAG Rating

20.1	Print off the batch lists for all records sent to specific outpatient clinics.	Spreadsheet documenting number of records requested for clinic and number available. Ongoing data collection from within medical records using batch list and clinic lists. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability	Director of Strategy and Partnerships	April 2014	Gap analysis	Medical Records Group	
20.2	Audit list against clinic list tracked to the department / outpatient clinic	This is now completed and presented at Medical Records Group monthly from May 2014	Director of Strategy and Partnerships	April 2014	Audit results Minutes of meetings where results are discussed	Medical Records Group	

20.3	Print off batch list for all medical records sent to a clinic including the 7 & 2 day changes. Audit those records that were requested from other departments / offices for availability at the clinic	Ongoing data collection from within medical records using batch list and clinic lists. The audit is now taking place and the information is to be provided as evidence. Discussions are taking place with IT to get some smarter reports to address this in a more robust manner. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability.	Director of Strategy and Partnerships	May 2014	Copy of audit results as evidence Monitoring	Medical Records Group	Was amber

20.4	Book OPAs prior to the 2 day cut-off within medical records. Review utilising Infoview report	Data/Graphs on number of records tracked out of medical records and into a specified clinic. Appendix 2 & 4 provide evidence of numbers tracked out of medical records, the tracking in clinics and availability. Further evidence will be captured through improvements in the patient document tracking universe. (review booked 2 days; on day and after clinic information) OPA booking will be discussed at the Health Records Group (HRG) and data sent out to service managers to action.	Director of Strategy and Partnerships	Aug 2014	Exception report	Medical Records Group	
20.5	Ensure all departments email additions to the medical records clerks to enable pulling to be completed in a timely manner	This process already takes place however a more robust process is being looked into currently. Provide a report on a monthly basis to the Service Managers review the reports and issues are discussed at Governance and or operational meetings	Director of Strategy and Partnerships	Sept 2014	Exception report	Medical Records Group	

20.6	Training staff who require access to medical records to ensure they understand how to track records in and out of areas	Examples of training logs are provided. Discussions are to take place with T&D & IT to review the training including looking at the possibility of making tracking notes a role specific training requirement for A&C staff. Increase profile of tracking etc. - Screensavers to be created to remind people that training is provided. Email has been sent to all admin managers to request all relevant staff have tracking training Email to T&D has been instigated A Risk Assessment or audit of the clinics where records are reported as missing against Med Records department info should be looked into	Director of Strategy and Partnerships	Sept 2014	Training records and attendance logs	Medical Records Group	

20.7	Improve portering and filing services to ensure more records are held within the library rather than in offices / storage areas in clinics	Reduced number of records awaiting collection in departments. Proposal to be developed and submitted to the HRG for approval. An increase of the portering staffing has taken place in the afternoons. Porters are working with all departments to track records in on delivery. Changes in med rec processes to enable a seamless service of records being returned to the department and take out for delivery. Update intranet page to give help on how to track, other user information and how to access the training. PR campaign on reminder for tracking notes.	Director of Strategy and Partnerships	Sept 2014	Monitoring Evidence	Medical Records Group	

20.8	Stronger monitoring of Datixs by undertaking RCAs and reporting back to all concerned	Datix's are now monitored and a log is available for review. The process is discussed at the Health records Group meetings and is also followed up with the specific department at the time. Some further challenge is required where secretaries and other departments have the notes where the tracking has not taken place	Director of Strategy and Partnerships	Sept 2014	Process for Medical Records to monitor Datix Reports / Minutes	Medical Records Group	
20.9	Patient assessments were not comprehensively documented within the notes .	Examples of completed assessment forms are disseminated and the process of completion demonstrated which is then disseminated through the ward teams at handover. The effectiveness is reviewed by the Quest process and dashboard.	Director of Nursing	April 2014	New nursing documentation has been introduced. The PD Team then follow this up with the wards on a regular basis and can be called upon for updates.	Nursing & Midwifery Board	

21. Nutritional Supplements – CS3.4 **Key Issue:** The CQC found food supplements and nutritional drinks were not monitored to ensure consumption within expiry dates.							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
21.1	Matrons must check the stock in their areas to ensure it is in date	The checking of expiry dates will take place through 2 avenues once a month – the pharmacy technicians and on the environment audit undertaken through Infection Prevention.	Director of Nursing, Midwifery and Patient Services	April 2014	Matrons checklist Exception reports	Nursing & Midwifery Board	
21.2	Ensure nurses responsible for administering these are aware of the need to fully check the labelling including the expiry date before administering to patients.	Sample of meeting minutes received - needs checking to ensure all areas are covered	Director of Nursing, Midwifery and Patient Services	April 2014	Evidence of discussions at meetings	Nursing & Midwifery Board	

21.3	Ensure stock rotation and stock management is appropriate	The principles of good practice will be cascaded through the ward huddles and a quick check will be performed through 2 routes – a question through the walk round to random staff regarding how they put stock away and on the 'Beat the Bug, Stop the Clock' again a verbal check with staff plus a check of the stock in the cupboards/fridge etc of the front and back with any variance on dates ie soonest at the front. Following CEAC review and areas highlighted as concern further actions are required to demonstrate compliance: discussed at Corporate Lead nurses meeting issues raised in regards to storage facilities on some wards. Risk assessment to be completed	Director of Nursing, Midwifery and Patient Services	Aug 2014	Audit of supplements to ensure that these are stock rotated and as with any medication/ product expiry date checked.	Nursing & Midwifery Board	

22. BMI Calculations – CS3.5 **Key Issue:** The CQC found evidence that Body Mass Index (BMI) calculations were being guessed							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**

22.1	Implementation of the nationally recognised MUST nutrition assessment tool in nursing documentation	The Adult in-pt. admission / discharge assessment tool includes the new MUST tool. Alongside this is the Dieticians folder that contains the relevant height/weight/ BMI chart on the wards. A laminated chart on the ward (in new dietician folders) to calculate the BMI that is used as part of the MUST assessment. Weigh day Wednesdays	Director of Nursing, Midwifery and Patient Services	May 2014	Weigh Day Wednesday Audit as part of Matrons Check QuEST	Nursing & Midwifery Board	

22.2	Provision of extensive training by the practice development team for the whole Admissions & Discharge documentation	The Practice Development Team disseminated the reviewed nursing documentation on 25th April to all the adult inpatient wards. Prior to this the ward sisters were sent details of the reviewed documents and copies to share with their staff during daily huddles and ward meetings in preparation. The on call sisters and night practitioners were requested to speak to staff and raise any issues with the PD team – none received. The PD team are keeping a log of staff who have been spoken to in respect of the revised documentation. Details of contact numbers were left with the wards if they had any concerns of questions The PD Team went out again on the 30th April to all the wards to speak with staff.	Director of Nursing, Midwifery and Patient Services	May 2014 Revised Aug 2014	Training programme Attendance at training records	Nursing & Midwifery Board	
22.3	Monitoring of compliance via monthly QuEST audits	QuEST data	Director of Nursing, Midwifery and Patient Services	June 2014	QuEST audits	Nursing & Midwifery Board	

23. Care Record Templates and Audits – CS8.2 **Key Issue:** Care record templates and audits were based on an acute hospital setting and not necessarily appropriate for a community hospital service							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
23.1	As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT Completed	Complete	Director of Nursing, Midwifery and Patient Services	April 2014	Transfer Documentation		

24. Dissemination of Learning from Incidents – CS5.3 **Key Issue:** Staff reported that learning from incidents and feedback when they reported incidents was not always given							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
24.1	Upgrade Datix reporting system to ensure full feedback capability of system. Development of a user guide to ensure staff are aware of whose responsibility it is to feedback to the reporter of the incident	Upgrade of Datix completed by Company March 2014. Gap analysis and redesigning of incident report forms by Governance team has taken place. Discussed at Governance meeting on 25 April 2014 and redesigned form agreed - minutes of meetings awaited User guide in process of development Roll out end May 2014	Director of Nursing, Midwifery and Patient Services Medical Director	May 2014	User guide Evidence of roll out / dissemination Ward Minutes Directorate Governance Group Minutes Care Group Governance Minutes Trust Board Minutes	Clinical Quality and Effectiveness Group	

24.2	A standard operating procedure for ward meetings has been launched which includes standing agenda items these include the months incidents	The Ward Meeting SOP was developed by a ward sister and shared with their peers. It sets out a standard of each ward holding monthly ward meetings with a set agenda template that includes sharing of a patient story and learning from complaints and incidents.	Director of Nursing, Midwifery and Patient Services Medical Director	May 2014	Standard Operating Procedure Minutes of meetings	Clinical Quality and Effectiveness Group	
24.3	Minutes of the ward meeting will be generated and a sign off sheet to say staff have read them if they were not present at the meeting Evidence of standard agenda's for ward/ dept meetings , minutes from meetings to demonstrate discussions / feedback &copy of the SOP required.	The SOP also includes a standard template for the minutes and a sign off form providing evidence that staff have read the minutes. It is monitored through the Nursing & Midwifery Quality Dashboard and QuEST. We are reviewing the performance criteria of this SOP to reflect completion of the standard templates.	Director of Nursing, Midwifery and Patient Services Medical Director	May 2014	Minutes of meetings Sign off sheet	Clinical Quality and Effectiveness Group	

25. Multi-Faith Spiritual Support -CS3.8 **Key Issue:** There are no formal arrangements in place to provide multi faith spiritual support, even in areas where end of life care is given							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
25.1	This finding was associated with the assessment of care at Danetre Hospital. Formal arrangements are in place in the Acute Care Trust	As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT	Director of Nursing, Midwifery and Patient Services	March 2014	Information for provision of multi faith spiritual support is available on the intranet	Clinical Quality and Effectiveness Group	

26. Urgent Care and Bed Flow Management – C1.2 **Key Issue:** Non elective activity levels exceeding plan leading to inability to safely manage urgent care patients, urgent care standards and achieve 95% of patients seen within 4 hours.							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
26.1	Review the emergency care flow issues and improve all processes from admission through to discharge Understand all blocks in the system Better understand our demand and effectively plan capacity Work in partnership with the health and social care economy on system redevelopment	In March 14, NGH employed McKinsey & Company to support this work providing realignment of the internal Urgent Care Programme. Working with NGH, the team have evaluated and realigned the existing work streams The cumulative work led to a 'Breaking the Cycle' week where all new processes and treatments were implemented, creating a 'new and sustainable normal' for the entire Trust.	Chief Operating Officer	July 2014	'One version of the truth' 2 by 12 Ward handover Breaking the cycle information inc Sustained delivery of the 4 hour transit time target Report to reflect Reduction in number of patient moves	Trust Board	

27. End of Life Care C6.1, C6.2 **Key Issue:** The Trust must strengthen the leadership of End of Life Care and ensure that there are robust mechanisms in place to inform the palliative care team of those patients who require specialist support at the end of life							
Ref	**Agreed Actions**	**Progress**	**Owner(s)**	**Timescales**	**Sources of Evidence**	**Assurance Committee**	**RAG Rating**
27.1	To increase visibility on the wards enabling clinicians to provide high quality End of Life Care incorporating the five key enablers outlined in the National End of Life Transformation programme.	End of life opiate audit is being undertaken by Karin Start	Director of Strategy and Partnerships	May 2014	End of life opiate audit is being undertaken by Karin Start	IHGC	
27.2	To lead the implementation of the National Principles replacing the Liverpool Care Pathway.	An end of Life competency workbook has been developed Progress on education and training compliance wil be monitored through the End of Life Steering Group	Director of Strategy and Partnerships	June 2014	Clarification around Liverpool Care Pathway or the National Principles	IHGC	
27.3	Promote best practice and support to clinicians to enable them to identify patients approaching the End of Life ensuring a patient centred plan of care is put in place and reviewed regularly.	End of Life Care questions: Named Consultant / Senior Nurse Huddle was rolled out in May 2014 Transforming End of Life Care Improving Quality info for all Acute Trusts reviewed regularly Rolling quarterly agenda item to the End Of Life Risk Strategy Group to ensure compliance is monitored after quarterly submission	Director of Strategy and Partnerships	Sept 2014		IHGC	

27.4	Provide ward based education in relation to DNAR and TEP with respect to End of Life care planning.	Work with L&D to establish the registration of Core compliance of training can be evidenced on OLM/ESR. Discussions have taken place with Maggie Coe within the education and training strategy and further confirmation is required about moving this process forward	Director of Strategy and Partnerships	Sept 2014		IHGC	
27.5	Support clinicians to identify patients with unmet needs, ensuring they are referred to the Specialist Palliative Care Team.	Additional training available to Clinical staff	Director of Strategy and Partnerships	June 2014		IHGC	
	Increased visibility on the wards of the End of Life Care Facilitator	"End of Life Care Facilitator attending daily "huddle" meeting, in her absence a member if the SPCT. Screening tool completed by EOL team post safety huddles and ensure relevant information is updated on "work space" New "work space" information to be used and information to be emailed directly to EOL team . Information just shared by IT - roll out is commencing. This is being discussed at July EOLSG	Director of Strategy and Partnerships	Sept 2014	End of Life Care Facilitator role reviewed to include daily visits to the ward where End of Life care patients have been identified to ensure an End of Life care Screening tool post safety huddles	IHGC	

27.6	Identify funding for a full time consultant in Palliative Medicine who will act at the End of Life Care Lead for the Trust. Address how the current gap is going to be actioned	Dr David Riley, Consultant in Palliative Medicine provides 3.5 clinical PAs to the Trust and acts as the named Consultant for the Specialist Palliative Care Team. Dr Christine Elwell, Consultant Clinical Oncologist acts as the Trust End of Life Care Lead and will be part of the Operational Group delivering the CQC action plan. Business Case submitted to CCG for identification of funding. CCG funding has been approved. An application to the East Midlands is being made for a year's funding. A job description has now been developed	Director of Strategy and Partnerships	December 2014	Business Case; Job description and Job Plan	IHGC	
27.7 (C6.3)	To lead the development and support the implementation and assessment of competencies across the Trust.	Prioritise training needs as a result of the heat map demonstrating end of life care activity across the Trust. Including educational training strategy and end of life training register	Director of Strategy and Partnerships	June 2014	Competencies in providing high quality End of Life Care will be assessed during the appraisal process.	IHGC	
27.8 (C6.3)	Identify a specific team of individuals whose responsibility it is for delivering EoLC leadership.	Business case developed for a dedicated team	Director of Strategy and Partnerships	June 2014		Clinical Quality and Effectiveness Group	

27.9 (C6.5)	Liaise with the Countywide group to develop guidelines based on the National Principles for End of Life Care	County wide guidelines for Care of the Dying	Director of Strategy and Partnerships	Oct 2014		Clinical Quality and Effectiveness Group	
27.10 (C6.5)	Communicate the End of Life Care principles across the Trust	Increase in the use of the LCP in May and June	Director of Strategy and Partnerships	July 2014		Clinical Quality and Effectiveness Group	
27.11 (C6.5)	Embed the principles into Clinical Practice through the End of Life Care team.	Audit of End of Life care built into the clinical audit programme across the Trust	Director of Strategy and Partnerships	Sept 2014		Clinical Quality and Effectiveness Group	
27.12 (C6.3)	To enable seven day a week face to face contact in line with National Directives. To provide out of hours telephone advice to clinical teams in line with National Directives. Respond to End of Life patients identified with unmet needs. To lead the implementation of QELCA across the Trust. To develop a robust link nurse system across the Trust.		Director of Strategy and Partnerships	June 2014	Care of the dying audit report "Minutes of meetings CQEG reporting to be bi monthly from July 2014 and will be escalated to IHGC Newsletters circulated twice a year Macmillan meetings monthly	Clinical Quality and Effectiveness Group	
27.13 (C6.3)	Facilitate education and training related to Palliative and End of Life care.		Director of Strategy and Partnerships	June 2014	Presentation to Matrons and Sisters in June 2014 including minutes	Clinical Quality and Effectiveness Group	

27.14 (C6.4)	To redefine the End of Life Care Strategy Group ensuring TOR is updated to reflect core membership and clarification of roles and responsibilities Provide a formal report to CQEG/IHGC	TOR developed Strategy Group meets monthly First CQEG paper will be presented at July meeting and any concerns will be escalated to IHGC	Director of Strategy and Partnerships	April 2014	Terms of Reference Minutes of meetings where this has been discussed	End of life Strategy Group / CQEG/ IHCG	
27.15 (C6.4)	Develop annual plan	Annual Work plan developed and will be monitored at End of Life Strategy group in line with the End of Life Strategy. Draft end of Life Strategy been circulated for consultation April 2014	Director of Strategy and Partnerships	July 2014	Work Programme	End of life Strategy Group / CQEG/ IHCG	
27.16 (C6.6)	Liaise with the Service Manager at CSH to formalise an SLA to provide out of hours telephone support until the full complement of the Palliative Care Team is established.	Discussions have taken place with Dr Riley however no formal SLA as no funding available. This is currently a courtesy agreement. Correspondence is on-going. Latest correspondence confirmed the Team are keen to be involved and further information to follow (2nd July 2014) Correspondence to Specialist Palliative Care Team at NGH is an informal process but does continue. This takes place via phone and is on specific patients with some information on the Summerset system	Director of Strategy and Partnerships	July 2014	Written Agreement Process for communicating advice back to the Specialist Palliative Care Team at NGH	End of life Strategy Group / CQEG/ IHCG	

27.17 C6.7	Incorporate the identification of End of Life patients onto the "Ward Work Space" Develop an electronic system to alert the End of Life Care team about patients approaching the End of Life using ICE Prevent the movement of patients at End of Life unless in their best interest	A weekly register is now collated Bid for end of life register with CCG & Hospice. The EOL register is now in place. Audits are monitored daily "The process has now been developed using ""Work space"" not ice. IT have just emailed an example which it is hoped will alert EOL team as a patient is identified on the ward (this will also prevent transfer of those patients). Information is being shared through the CQEG report to the directorates on the new process. " Ward huddles information and movement - awaiting further assurance of info from Wendy Smith when meeting Risk Assessments are now completed for all patient moved. EOL team also monitor all of the patients daily to ensure transfers are kept to a minimum or investigated if that is not the case	Director of Strategy and Partnerships	Jan 2015	Register of end of life patients by wards Audit of identification of End of Life patients built into the clinical audit programme across the Trust Monitor the movement of patients approaching End of Life	End of life Strategy Group / CQEG/ IHCG	

27.18 C6.8	Development and ratification of Palliative opioid administration guidance "Dissemination of initiation and prescription guidance "Develop Opioid Leaflet for palliative patients Review the possibility of incorporating strong opioids on the critical medicine list in the Medicines Management Policy and recorded on the drug chart	Guidance has been reviewed and minuted at NMB 29..1.2014. This has now been approved by NMC and is now with MOC (meeting cancelled in June). Appendix 3 of the Trust Board paper reflects the draft guidance Karin Start (Pharmacy) is the key contact information still to be provided - WS is chasing Karin currently. A discussion has taken place at NMB "Opioid Leaflet for palliative patients has been developed, approved by Trust Board and is currently with MOC for approval prior to PIG & Med Illustrations Medicines Management Policy is being updated by MOC and evidence of recorded on the drug chart is being investigated including incorporating within the teaching	Director of Strategy and Partnerships	Jan 2015	Six monthly real time audit built into the Clinical Audit Programme across the Trust	End of life Strategy Group / CQEG/ IHCG	

1. HIGH LEVEL Patient Flow

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
H1.1	CQC High Level Compliance Notice Point 6 and CQC Summary Point 15.	The CQC found that NGH had no effective system to identify, assess and manage the risks to the health and welfare of patients who were moved at night	Patient Risk Assessment to be developed (which includes national criteria / local standards e.g. end of life patients / Dementia patients not to be moved after an agreed time etc.	COO	Andy Daly / Bill Wood	Simon Hawes	Patient risk assessment Evidence of roll out	May-14	Patient risk assessment being developed (and will need to be shown to be rolled out across the Trust)		1. Patient Flow\W1.1\Risk assessment blank.pdf	SAFE - Identify, monitor and manage risks to people who use, work in or visit the service. (outcome 16)	People who are moved at night are not put at risk	CQEG / IHGC
											1. Patient Flow\W1.1\Risk assessment completed.pdf			
											1. Patient Flow\W1.1\Risk Assessment for In-patient Movesv2.docx			
											1. Patient Flow\W1.1\FW_ Risk Assessment			
											1. Patient Flow\W1.1\Risk Assessment for			
			Ward Transfer Records to include the time of transfer. This is included in the Nurse Handover Safety Checklist		Bill Wood		Transfer Records	Mar-14	Completed checklist to be sent		1. Patient Flow\W1.1\W1.1.2 Nurse Handover Safety Checklist for Ward Transfers sheet BW LB March 2014 v4.docx		Decision making procedures and lines of accountability for patient moves are clear	
			System to be established to identify the number of patients moved / at night including how this is monitored and reported		Andy Daly		Description of process Evidence of roll out Patient Movement Log Spider web	Mar-14			1. Patient Flow\W1.1\Patient Movement Log 2014.xlsx		Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement	
											1. Patient Flow\W1.1\April Patient			
											1. Patient Flow\W1.1\May Patient			
											1. Patient Flow\W1.1\SPIDER May Patient			
											1. Patient Flow\W1.1\May Patient			
			Report the number of patient transfers to IHGC commencing May 2014		Andy Daly		Reports to IHGC and subsequent actions	May-14	Draft minutes received - final approved awaited		1. Patient Flow\W1.1\1 0 DRAFT IHGC Minutes 22 May 2014.docx		Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement	IHGC
			Use of 4Cs and development of a patient leaflet informing patients that they may on occasion be moved at night	DoN/COO	Natalie Green / Bill Wood	Chris Ainsworth	Draft of Patient leaflet Consultation emails	Jun-14	Leaflet has been drafted and has been sent out for consultation. Comments received and leaflet updated. Version 2 circulated Expected to be submitted to the Patient Information Group - June 2014 - Require copy and NGV no		1. Patient Flow\W1.1\W1.1.5 Patient Move Leaflet Drafts and Consultation			
H1.3	CQC High Level Compliance Notice Point 4 and CQC Summary Point 1	The CQC found that NGH had not regularly assessed and monitored the quality of the provision of discharge medication to service users or assessed and managed the risk of using taxis and its potential impact upon the health and welfare of the people using services	Cease the practice of sending take home medication to patients via taxi	COO	Paul Rowbotham	Simon Hawes	E-mail stipulating taxis not to be used	Jan-14	Risk removed		1. Patient Flow\W1.3\W1.3.1.CQC Inspection - Immediate actions required.msg	SAFE Medication will not be sent home in Taxi's and this is underpinned by policy (outcome 9)	TTOs are no longer transported via taxi's	Medicines Management Committee
			Compliance with request to cease practice of send take home medication to patients via taxi`	COO	Tim Mead		Audit to be undertaken to gain assurance the practice has ceased	Feb-14	Audits provided		1. Patient Flow\W1.3\W1.3.2 Audit of Taxis		100% compliance	
								Jun-14			1. Patient Flow\W1.3\FW_ TTO's and Taxis.msg			
			Ensure overarching Medicines Management (NGH-PO-249) is in date and available on the intranet.	COO	Paul Rowbotham		Policy available on the intranet	Feb-14	Medicines Management Policy is due for review November 2014		1. Patient Flow\W1.3\W1.3.3 Medicines Management NGH-PO-249 Nov 2014.pdf		Revised Policy is ratified and uploaded	Procedural Document Group
			Ensure all guidance for staff regarding discharge medicine for exceptional circumstances is available on the Trusts intranet	COO	Paul Rowbotham		Guidance for Obtaining Medicines Out of Hours (TTOs) available on the intranet	May-14	Medicines Management Committee to review Policy and appendices to ensure all guidance relevant to discharge medication is available on the intranet		1. Patient Flow\W1.3\ClinicalSOPOutofHoursMeds(Takehomemeds)FINAL April 2014.doc		Staff have access to up to date policy and g	
											1. Patient Flow\W1.3\Discharging Patients home .msg			
											1. Patient Flow\W1.3\MOC Minutes 2014-04.doc			
			Trial using patient own medication to expedite the availability of take home medication ready for discharge	COO	Bill Wood / Natalie Green		Use of POM included in Appendix 3 of Medicines Management Policy	May-14	Trial being undertaken		1. Patient Flow\W1.3\RE_ CQC action plan and medicines.msg		Outcome of Trial to be shared	
											1. Patient Flow\W1.3\RE_ CQC action plan and medicines1.msg			Medicines Management Committee

1. HIGH LEVEL Patient Flow

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
			Establish safety huddles to identify potential delays in the availability of take home medication on discharge	DoN	Jane Bradley	Chris Ainsworth	Emails Minutes of Safety Huddle Template of Safety Huddle Report Hyperlink to Safety Huddle Folder - daily report	Apr-14	Email from DoN 9 April 2014 to Ward Sisters, Modern Matrons, Site Managers announcing the commencement of Safety Huddles Email with further update to Ward Sisters, Modern Matron 10 April 2014 Further email 12 April 2014 containing more update information to cascade to weekend staff Further email 22 April 2014 giving further feedback regarding changes to form		1. Patient Flow\W1.3\W1.3.1 Safety Huddles information		No delay of discharge due to medication	committee
H1.6	CQC High Level Compliance Notice Point 8 and CQC Summary Point 5	Intensive Care Society Core Standards for intensive care units. CQC reviewed the analysis which identified gaps against the standards including a medical consultant not being immediately available 24 hours a day and consultant work patterns to deliver continuity of care not being in place. CQC did not see evidence of what actions had been identified to address the gaps and comply with the standards. The analysis was therefore not robust as there was no evidence as to how the compliance would be achieved.	Report to be presented to IHGC in May 2014	MD	Chris Leng	Caroline Corkerry	Consultant Rota Gap analysis Actions to address deficits identified and discussed Business Case Minutes of meetings	Jun-14	A summary report on the findings, actions and progress to be presented to the IHGC in May 2014. Minutes of meetings where this has been discussed		1. Patient Flow\W1.6\C9.5.1 Gap Analysis Core Standards for Intensive Care Units 1.docx 1. Patient Flow\W1.6\C9.5.2 Critical Care Business Case 24 10 13 Version 7.pdf 1. Patient Flow\W1.6\W9.5.3 ITU Consultant cover Jan - Apr 2014.pdf 1. Patient Flow\W1.6\CAIDG - Minutes 24 1 2014.doc 1. Patient Flow\W1.6\DMB mins 17 April 2014.doc 1. Patient Flow\W1.6\SNG minutes May 2014 - Copy.doc 1. Patient Flow\W1.6\May 2014 ward meeting.doc 1. Patient Flow\W1.6\Minutes 09 05 14.doc	SAFE - Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16)		Strategic Management Board

2. HIGH LEVEL Urgent Care

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
H2.1	CQC High Level Compliance Notice Point 9	During September and October 2013 the trust commissioned a review of the Accident & Emergency service, including the Emergency Care Pathway by the Emergency Care Intensive Support Team which provided recommendations for the improvement of the A&E service. There was no evidence that conclusions from this local review of the A&E service had resulted in changes to treatment or care provided to people using services at Northampton General Hospital .	Review October 2013 report and identify any additional actions	COO	Richard Wheeler	Simon Hawes	Gap analysis and action plan	May-14	Actions resulting from the review have been incorporated into the Urgent Care Programme		2. Urgent Care\W2.1\W2.1.1 ECIST - CQC Update.docx	SAFE - Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16)		Strategic Management Board
			Resultant action plan to be uploaded to HealthAssure and evidence of completion linked				Report to IHGC		Emergency Care Intensive Support Team are revisiting the Trust on 24 June 2014 Urgent care report to be presented to Board in June 2014 ECIS meeting info Autumn/ Dec 2013		2. Urgent Care\W2.1\W2.1.2 report to Board Urgent Care Report 31 Oct 2013.pdf 2. Urgent Care\W2.1\W2.1.2 Urgent care Trust Board Approved Public Minutes 28.11.13.docx 2. Urgent Care\W2.1\20140512 IHGC Urgent Care Programme.docx			

3. HIGH LEVEL Responsiveness - Safety

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
H3.3	CQC High Level Compliance Notice Point 7 and CQC Summary Point 4	Whilst the risk posed to the health and welfare of patients admitted with a stroke had been identified and assessed they had not been effectively managed (Concerns were raised to the CQC inspection team regarding understanding of the stroke imaging pathway and confusion between the radiology and medical departments.)	Develop the pathway with agreed roles and responsibilities	MD	Lyndsey Brawn / Richard Jones	Caroline Corkerry	Copy of pathway	Apr-14	Ratified protocol		3. Responsiveness to Care\W3.3\Protocol for Acute Stroke Nurses to request CT Head scans for suspected acute stroke patients.pdf	Outcome: SAFE - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met (Outcome 4)	A robust pathway that does not delay patients scans	CQEG / IHGC
									Data		3. Responsiveness to Care\W3.3			
									Add CQEG & IHCG minutes from May		3. Responsiveness to Care\W3.3\SSDG Minutes 24 April 2014.docx			
											3. Responsiveness to Care\W3.3\1 0 DRAFT IHGC Minutes 22 May 2014.docx			
			Ensure communication of pathway to all staff				Evidence required for: dissemination of the pathway. meeting minutes that record discussion including Radiology to confirm that the pathway is now in place and working	Apr-14	Evidence from NH re radiology meeting minutes & Medicine Care Group (spk to WW / LSW)		3. Responsiveness to Care\W3.3\DMB Minutes 17th March 2014.doc		Appropriate staff are aware and utilised the correct pathway	
											3. Responsiveness to Care\W3.3\ROM Minutes 11th March 2014 .doc			
											3. Responsiveness to Care\W3.3\SSDG Minutes 24 April 2014.docx			
			Agree process for ongoing monitoring and reporting				Outcome of SSNAP audits to ensure trust maintain above National average compliance	Apr-14	Add SSNAP audits from LB / Liz Gill		3. Responsiveness to Care\W3.3\W3.3 ssna		The Trust will achieve consistent compliance against the SSNAP audit	

5. HIGH LEVEL Governance

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
H5.1	CQC High Level Compliance Notice Point 10	The follow up of action plans was identified as a concern in the minutes of the Trust Board meeting. However, there was no record of how the Trust was going to address the issue and there was no evidence that the associated risks to the health, welfare and safety of people using services at NGH had been identified, assessed and managed	Develop a robust process for the review and follow up of SI action plans	MD	Chris Ainsworth	Caroline Corkerry	Revised pathway demonstrating process CQEG Report Trust Board Report	Feb-14	The Serious Incident Group has devised and implemented a more robust process for the management of Serious Incident action plans. The process has been included in the revised Serious Incident Policy and has been reported to CQEG, IHGC and the Trust Board. Reports on performance against the revised Serious Incident process will continue to be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness.		5. Governance\W5.1\Action Plan Assurance Process.docx 5. Governance\W5.1\CQEG Feb 2014 (for Jan 2014.doc 5. Governance\W5.1\Trust Board SI for Feb2014.doc	Outcome : SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16)	Action plans are evaluated to see if risks are addressed and improvements made.	CQEG
			Progress of all SI action plans monitored on HealthAssure				Reports on compliance Review of Quarter 3 SI action plans with RAG rated progress Meeting minutes HealthAssure Reports	May-14	Reports on performance against the revised Serious Incident process will be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness. The Governance Facilitators are reviewing all SI action plans from Q3 to ensure evidence is available to demonstrate completion. This was presented to the SIAM meeting with the CCG on 16th May 2014. Q4 onwards SI action plans are being monitored via HealthAssure and a monthly compliance report is submitted to SIG SIG have reviewed 5 SI action plans for sign off		5. Governance\W5.1		Action plans are evaluated to see if risks are addressed and improvements made.	
			Ensure all SI action plans are signed off by the accountable committee in a timely manner				SIG Minutes Directorate Governance Meetings CQEG Directorate Governance Reports HealthAssure Reports	May-14	As from Feb 2014 submitted Serious Incident reports and SI action plans are reviewed by SIG at the next meeting to ensure that contributory factors have been fully explored and that actions are aligned with the root cause of the incidents to reduce the likelihood of recurrence. All SI action plans for Quarter 4 are now on HealthAssure and the Care Group Governance Managers will complete quarterly status updates - Status updates for Quarter 4 are in the process of being completed. SI Action plans are then monitored by the Directorate/Care Groups until completion. Completed action plans will be presented to SIG with the evidence to ensure all actions have been completed. The first SI action plans are expected to be presented to SIG in May 2014 Minutes of SIG from 27th May SIG Forward Plan		5. Governance\W5.1		Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement	

7. HIGH LEVEL Mandatory Training & Appraisal

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
H7.1	CQC High Level Compliance Notice Point 5 CQC Must point 9	Mandatory Training. The actions taken to manage the risks are inadequate and there remains a significant number of staff who have not received the relevant mandatory training	Provide a variety of options to ensure that staff are able to access mandatory training.	DoW&T	Sandra Wright	Sue Cross	Snapshot Intranet pages Examples of emails sent to Managers advising dates of training	Apr-14	4 options for mandatory training currently available since Autumn 2013: 1) Classroom 2)E-Learning 3) Workbook 4) RoK (Review of Knowledge) All options are available on the intranet. Updated TNA and update of Rosle specific has been completed and uploaded to Intranet		7. Mandatory Training & Appraisal\7.1\7.1 Mandatory Training NGH-PO-306.pdf 7. Mandatory Training & Appraisal\7.1\7.1 Cluster-Day-Programme-April-to-Dec-FINAL2014.docx 7. Mandatory Training & Appraisal\7.1\7.1 e-learning guidance-Jan-2014.doc 7. Mandatory Training & Appraisal\7.1\7.1 RoK-information-to-staff-v2.docx 7. Mandatory Training & Appraisal\7.1\7.1 Mandatory Training information inc ROK email for weeks commencing 21st 28th http://thestreet/CorporateInformation/Departments/LearningandDevelopment/Mandatory-Training.aspx 7. Mandatory Training & Appraisal\7.1\update of TNA and Course outline email 16.6.2014.msg	WELL-LED People who use services are safe and their health and welfare needs are met by competent staff and ensure that staff are properly trained, supervised and appraised. (outcome 14)	Information to be available to all staff	CQEG
			Mandate that all A&C staff complete Mandatory Training as e-learning programmes.				Emails to managers Minutes of IHGC / CQEG Papers April 2014	May-14	Email to Managers been circulated - various managers email dated 8.4.2014, Discussed at CQEG April 2014		7. Mandatory Training & Appraisal\7.1\7.1.2 evidence FW re.msg; Mandatory Training for AC staff email 7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 Enc 1 CQEG minutes 28th April 2014 V2.docx 7. Mandatory Training & Appraisal\7.1\7.1.2 E-Learning Workbooks for AC staff groups 4.6.2014.msg		Improve numbers of A&C staff	CQEG
			Implement a "Mandatory Training wave approach" to forecasting compliance and performance management				Compliance Reports demonstrating improvement in compliance. Email with roll out timetable	May-14	Report to CQEG / IHGC April 2014 states that a 'mandatory and role specific essential training performance wave has been produced and is being shared with Ward Sisters and Managers. Email 8.4.2014 of the new Performance wave approach from T&D to all managers Further updates have been made and Summary Report example April and Ward League Table presented at Core brief 6.6.2014 New approach to report compliance from Directors down following a meeting with managers in May 2014 Communication will be sent requesting any amber or red areas of compliance add this issue to their local risk registers. - email to be circulated w/c 9.6.2014 IHCG/CQEG reports for June 2014 refer to the "top down and bottom up approach" and also highlight the trajectory work		7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 CQEG minutes Draft 19th May 2014 V2 .docx 7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 DRAFT IHGC Minutes 22 May 2014.docx 7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers 7. Mandatory Training & Appraisal\7.1\W7.1.3 Performance wave role out of info\7.1.3 Example of Pathology Mandatory Role specific compliance email 9.4.2014 FW Overall % Report - March 2014.msg 7. Mandatory Training & Appraisal\7.1\W7.1.3 Performance wave role out of info\7.1.3 Email Re Wave roll out.msg 7. Mandatory Training & Appraisal\7.1\W7.1.3 Performance wave role out of info\7.1.3 Performance Wave report sent to Directorates email 8.4.2014 7. Mandatory Training & Appraisal\7.1\W7.1.3 Performance wave role out of info\7.1.3 MT performance wave flowchart RSETWave v2.pptx 7. Mandatory Training & Appraisal\7.1\W7.1.3 Performance wave role out of info			
			Seek advice / support from other Trusts that have robust systems in place and are willing to share good practice.				Contacted Derby Hospital; Nottingham University Hospital; Royal Berkshire Hospitals	Apr-14	Example of contact with Nottingham inc email and letter and link to the film for Nottingham https://www.nuh.nhs.uk/welcome-to-NUH. NGH have also initiated a countywide steering group and the next meeting is 25th June 2014. Horizon scanning is a regular activity of the team and areas are adopted that are suitable		7. Mandatory Training & Appraisal\7.1\7.1.4 Communication with other Trusts\7.1.4 email FW Meeting up! NHFT KGH 19.2.2014 next mtg 7. Mandatory Training & Appraisal\7.1\7.1.4 Communication with other Trusts			CQEG
			Monitor performance management of attendance takes place within CQEG; IHCG.				Workforce reports to IHGC and Trust Board	May-14	Workforce discussed at IHGC & Trust Board monthly latest documents are June 2014		7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers		Managers and Trust are aware of compliance levels against Trust target	CQEG
			Develop a process to monitor and review accuracy of data				6. External review of OLM/ESR data and provide reports to CQEG/IHGC	May-14	Email & CQEG Paper March and April 2014 reflecting issues and progress Directorates are asked to review their compliance information and challenge any inaccuracies to help address the issues. Directorates are now (as of June 2014) being asked to update		7. Mandatory Training & Appraisal\7.1\7.1.6 Email Northampton General - OLM Resolutions 16.4.2014 Data Accuracy.msg			CQEG

7. HIGH LEVEL Mandatory Training & Appraisal

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
									the risk register to reflect the issues with compliance if requried. This has been reported to IHCG and CQEG		7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 CQEG_minutes_Draft_19th_May_2014_V2.docx			
H7.2	CQC High Level Compliance Notice Point 5	Clarification and roll out of role specific training (relevant)	Scope out what is deemed to be role specific training in each area and staff group Ensure correct information regarding role specific training is available on the intranet	DoW&T	Sandra Wright	Sue Cross	Up to date information regarding role specific training requirements needs to be available to all staff	Jan-14	The Role specific course outline includes both Mandatory and Role specific training and can be accessed from the intranet. An update of the Training including outlining which is Role specific and which is Mandatory is being addressed by T&D in May 2014		http://thestreet/CorporateInformation/Departments/TrainingandDevelopment/Downloads/Mandatory-Training-Roles-Specific-checklists-version-8-Sept-2012.doc		Patients are protected from risk of harm	CQEG
									The T&D department are working on specific training for specific job roles which will take a while to address. Emails have now been circulated and directorates are being asked to review and define the role specific aspects. Email of 5.6.2014 circulated to GMs. Once information approved it will be transferred to templates provided by McKesson and then forwarded to McKesson who will do the mass upload. Timing of this is important as McKesson will remove current competency requirements from our system and put the new information in so this needs to be done between reports etc. Role Specific identification of Job roles has been completed by T&D. T&D are reviewing the risk register to highlight the data issues which McKesson are working with currnetly. This is being highlighted to IHGC & CQEG in June 2014 Internally this will continue to be monitored		7. Mandatory Training & Appraisal\7.2\7.2.1 Example of Pathology Mandatory Role specific compliance email 9.4.2014 FW Overall % Report - March 2014.msg			
											7. Mandatory Training & Appraisal\7.2\7.2.1 Email to GMs re			
											7. Mandatory Training & Appraisal\7.2\7.2 FW Scoping of Role Specific Training 5.6.2014.msg			
											7. Mandatory Training & Appraisal\7.2\7.2.1 Master Data Sheet For Training May 2014.xlsx			
			Provide monthly reports of compliance				CQEG minutes / reports IHGC minutes / reports Trust Board minutes / reports	Apr-14	Trust Board minutes / reports inc Role specific information IHCG minutes / reports inc Role specific information CQEG minutes / reports inc Role specific information appendix 1 for role specific		7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 DRAFT IHGC Minutes 22 May 2014.docx			CQEG
											7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1 TB Workforce Report April 2014.pdf			
											7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 CQEG_minutes_Draft_19th_May_2014_V2			
H7.3	CQC High Level Compliance Notice Point 11	Suitable arrangements were not in place for ensuring the number of staff without a performance development plan were robustly managed	An audit will be undertaken on all areas where there is no up-to-date information on staff appraisals. This will require managers to provide appropriate evidence to the HR & L&D teams that staff have had an appraisal via one of the processes. 2. Where appraisals have not been undertaken within the last year, managers will be required to provide a plan of how this will be achieved within a given time frame. If this is not aligned to staff increments managers will be required to do an appraisal; however a further review will be required to provide assurance to payroll and L&D that staff can incrementally progress 3. Monitor performance management of attendance 4. Continue to embed the new appraisal process aligned to incremental progression	DoW&T		Sue Cross	Audits took place in April and June. Results of audit and gap analysis and follow up has been reported. Example of monthly reports. Papers & Minutes IHGC Papers of Trust Board & Minutes Trust Board Review Trust target (May) - 85% - Report to IHGC in May 2014	Apr-14	An increased level of appraisal compliance – aiming for 75% by the end of April 2014; incrementally progressing to 85% by March 2015. An action plan has been developed for Appraisals and Training and this is discussed at Trust Board. Appraisal audit is continuing although there is little improvement this month. All ward areas to receive monthly update to say what their compliance levels, and the requirement to provide an action plan and put on their Risk Register will apply to appraisals. Performance management process -75% by June; should be 80% by Oct and 85% March 2015		7. Mandatory Training & Appraisal\7.3\7.3 Appraisals audit - message sent on behalf of Dr Sonia Swart CEO.msg	WELL-LED - Enable staff to acquire further skills and qualifications that are relevant to the work they undertake. (outcome 14)	The organisation are aware of which staff have had not had appraisals There is robust monitoring in place for the staff appraisals and Managers and Trust are aware of compliance levels against Trust target At least 85% of staff will have had an appraisal by March 2015	CQEG
											7. Mandatory Training & Appraisal\7.3\7.3 Screensavers for Appraisals			
											7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers			
											7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers\7.1.3 DRAFT Public TB Minutes 27.03.14.docx			
											7. Mandatory Training & Appraisal\7.3\7.3 Appraisals email re compliance 14.5.2014.msg			
											7. Mandatory Training & Appraisal\7.3\APPRAISAL Policy NGH-PO-863.pdf			
											7. Mandatory Training & Appraisal\7.3\7.3 Appraisals as at 19 May 2014.xlsx			

1. Patient Flow

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
C1.2		Review patient flows to ensure: • Achieve 4 hour target • Optimise patient flow through A&E • Bed capacity is optimised • Discharges are safe and timely • Pre-empt and flex capacity based on expected demand • Direct admission to Benham and EAU	Establish 'one version of the truth'	COO	Rob Bleasedale / Jason King	Simon Hawes	2 by 12 Ward handover	Jul-14	Handover information developed		1. Patient Flow\C1.2\C1.2.1 Critical Care 2 by 1200.msg 1. Patient Flow\C1.2\C1.2.1 2 by 1200 v2 as at 31.3.2014.docx 1. Patient Flow\C1.2\C1.2.1 Ward Handover Sheet BW LB March 2014 v4.docx	SAFE - Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16)		
			Implement 'Breaking the cycle'		Andy Daly		Breaking the cycle information		Introduction in the breaking the cycle		1. Patient Flow\C1.2\C1.2.2 Breaking the cycle information\C1.2.2 20140321 Breaking the cycle working group kick off deck v5.pptx 1. Patient Flow\C1.2\C1.2.2 Breaking the cycle information			
			Drive sustained performance through transparent reporting		Richard Wheeler		Reports		Urgent Care report is being presented Figures reflect May 94.6; June >95% A daily performance target is circulated		1. Patient Flow\C1.2\Patient Care Trust Performance at a glance.pptx email 18.7.2014.msg			
CM1.4	CQC Must point 4 summary action 12	Medication is being dispensed after patients have left hospital, it is being delivered by a taxi and no risk assessment of the medication, the delay and the impact and risk of this action is taking place	Cease the practice of sending take home medication to patients via taxi	COO	Paul Rowbotham	Simon Hawes	Practice has been stopped Documentation available on wards Policy amendment MOC Minutes Audit	Jan-14	Practice has been stopped		1. Patient Flow\CM1.4\W1.1.2 TTO in taxis audit 6.5.2014.docx 1. Patient Flow\CM1.4\Discharging Patients home .msg 1. Patient Flow\CM1.4\MOC Minutes 2014-04.doc	Outcome: SAFE Medication will not be sent home in Taxi's and this is underpinned by policy (outcome 9)		Medicines Management Committee

1. Patient Flow

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CM1.5	CQC Must point 7 Summary action 15	Patients are being regularly moved around the hospital and there is no system in place to monitor this and the impact it is having on patients and their treatment, their length of stay and their experience	Patient Risk Assessment to be developed	COO	Andy Daly / Bill Wood	Simon Hawes	Risk Assessment and monitoring tool for assessing the impact of moves on a patient's treatment, length of stay and experience Minutes of meetings Evidence of roll out	May-14	Risk Assement document has been developed		1. Patient Flow\CM1.5\Risk assessment blank.pdf 1. Patient Flow\CM1.5\Risk assessment completed.pdf 1. Patient Flow\CM1.5\Risk Assessment for In-patient Moves v2.docx 1. Patient Flow\CM1.5\FW_ Risk_ 1. Patient Flow\CM1.5\Risk Assessment_	CARING: Robust clinical governance process supporting patients moves around the hospital (outcome 16)	CARING All patients who are moved around the hospital will have a robust risk assessment completed prior to move	CQEG
			Ward Transfer Records to include the time of transfer		Bill Wood		Minutes of meetings	May-14	The information is being added to the transfer documents and the importance of the documentation is being reiterated		1. Patient Flow\CM1.5\CM1.5.2 Ward Handover Sheet BW LB March 2014 v4.docx			
			System to be established to identify the number of patients moved		Andy Daly		Minutes of meetings Spider web Database	May-14	A database has been developed together with a spider chart		1. Patient Flow\CM1.5\April Patient Movement Chart.docx 1. Patient Flow\CM1.5\May Patient Movement Chart.docx 1. Patient Flow\CM1.5\Patient Movement log 2014.xlsx 1. Patient Flow\CM1.5\SPIDER May Patient Movement Chart 2.docx 1. Patient Flow\CM1.5\May Patient Movement Chart 2.docx			
			Report the number of patient transfers to IHGC commencing May 2014		Andy Daly		Evidence in report detailing the impact on patient	May-14	received draft minutes - awaiting final approved		1. Patient Flow\CM1.5\1 0 DRAFT IHGC Minutes 22 May 2014.docx		CARING Information about the number of transfers safety is gathered and consistently monitored	
			Develop a method of capturing patient experience and once this and risk assessments have been fully embedded and number of moves is below 5 undertake RCA into moves to understand impact and effect on patients		Andy Daly		Process for capturing patient experience following ward moves	Sep-14	AD to provide a monthly check and report to Care Group Board					
			Development of a patient leaflet informing patients of why they may be moved. Leaflet to include details of how patient can report if they are unhappy about being moved which will enable this data to be captured	DoN	Natalie Green / Bill Wood		Draft of Patient leaflet Consultation emails	Jun-14	Leaflet has been drafted and has been sent out for consultation Patients asked to contact PALS if they have concerns about being moved - PALS will then log this information as a 'patient who has been moved'		1. Patient Flow\CM1.5\CM1.5.6 Patient Move Leaflet Drafts and Consultation			

2. Urgent Care

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CM2.2	CQC Must point 6, summary action 14	Children are being treated in an adult A&E department. There are very limited dedicated facilities or specialist staff to care for children	Formal review of the NSF for children required to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this.	DoN	Matt Tucker / Fiona Lennon	Chris Ainsworth	Formal review of the NSF for children to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this. Minutes of the meeting and resulting plans	Sep-14	Issue will be taken forward at joint paediatric/A&E meeting. Inaugural meeting 15/4/14. Group consists of Consultants, Service managers and Matrons from each area		2. Urgent Care\C2.2\minutes from meeting 15th April 2014.doc	SAFE - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met including making reasonable adjustments to reflect children's needs. (Outcome 4)	SAFE Children are cared for in a safe and appropriate environment in accordance with NSF for children	Strategic Management Board
			RSCN to be rostered providing 24 hour access for children attending A & E		Matt Tucker / Fiona Lennon		Copy of advert Copy of job description VCP confirmation Copy of roster Copy of minutes of joint A &E and Paediatrics Meeting Email from DoN	Sep-14	There are currently 5.06wte paediatric trained nurses available for A&E (5.68wte being required to provide 1 nurse per shift) - this leaves a vacancy of 0.62wte and the posts are currently advertised on NHS Jobs. We plan to over recruit to our nursing posts Interviews took place 9th and 13th May 2014 - Band 5 Paediatric nurses have now been appointed (start dates August/September), however band 6 position remains out to advert – currently there have been no applicants. Paediatric nurses identified separately on the rota and the offer of support from within Paediatrics has been made on a short term basis for approximately 1 long day pre week during the month of July. A separate roster for paediatric nurse cover has been added to the main A&E roster template to be able to clearly identify this. Email from DoN to Lead Nurse to draft up a plan to ensure Paediatric nurse coverage in A & E with a timeline. For review early June		2. Urgent Care\C2.2\ AE VCP band 5.msg 2. Urgent Care\C2.2\Trust Job Description band 5 child A&E.doc 2. Urgent Care\C2.2\20140430123355197.pdf 2. Urgent Care\C2.2\minutes from meeting 3rd June 2014.doc 2. Urgent Care\C2.2\FW RSCN in AE.msg 2. Urgent Care\C2.2\A&E Trust Job Description band 5 2011.doc		SAFE Children are cared for by appropriately trained staff	Nursing & Midwifery Board
			Identify a designated area within A & E for sole use by children and their families	DoF&CD	Matt Tucker / Fiona Lennon	Caroline Corkerry	Plans for A & E rebuild programme Revised timetable Minutes	Jun-14	The separation of the play area and paediatric cubicle will be completed before the end of June. To ensure the environment is appropriate for children a meeting to sign off the design is planned between Matron A & E; Matron Children's and Estates. Appropriate decoration will also be discussed. This lcoation is now in use as at July 2014		2. Urgent Care\C2.2\A&E plan with notes.pdf 2. Urgent Care\C2.2\minutes from meeting 3rd June 2014.doc 2. Urgent Care\C2.2\signed off plan.pdf 2. Urgent Care\C2.2\5-13_15D_Childrens_Area.pdf 2. Urgent Care\C2.2\NGH - A & E Department - CHILDRENS AREA - Minutes of Pre-Contract Meeting -30-05-14.pdf		SAFE Provision of an appropriate and suitable area for children and their families within the A&E department	Strategic Management Board
			Full review & itinery of the availability of toys for various age groups. There should also be a plan for regular inspection to ensure fit for purpose, not damaged, cleaned regularly and be EU marked for safety	DoN	Fiona Lennon	Chris Ainsworth	Full review & itinery of the availability for toys for various age groups. these should also have a plan for regular inspection to ensure fit for purpose, not damaged, cleaned and must all be EU marked for safety - protocol required as evidence	Sep-14	It was initially agreed that this point would be completed by the play specialists. Given current vacancies within that team the Matron A & E has allocated time on Tuesday 6th May to review all toys within the play area and will discuss further requirements with the play specialist. Once this has been completed the Matron A & E will develop the protocol for cleaning etc. A drfaft SOP is being developed currnetly by the new Matron				SAFE Provision of an appropriate and suitable area for children and their families within the A&E department	Strategic Management Board
			Review the requirement for a dedicated or decorated room for minor injuries		Fiona Lennon		This area has since been closed as the department is having a rebuild. There are toys available in the main A&E children's waiting area. Minutes of meetings	Jun-14	As part of the A&E plan is a separate A&E minor injury & waiting area planned that can be decorated specifically for children? This has now been completed		2. Urgent Care\C2.2\minutes from meeting 3rd June 2014.doc 2. Urgent Care\C2.2\A&E plan with notes.pdf		SAFE Children are appropriately priorities and treated	Strategic Management Board

2. Urgent Care

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
C2.3			Review triage process to ensure children attending A & E are appropriately prioritised	MD / DON	Rob Bleasdale / Jason King	Chris Ainsworth	Minutes from meeting Audit against "recognised standards"	Sep-14	Issues discussed at joint paediatric/A&E meeting. Group consists of Consultants, Service managers and Matrons from each area. Agreed - 2 nurses in triage – one of which will be assigned to fast track children and young persons through the triage process as soon as they have registered their attendance. C&YP will then be directed to paediatric area once works completed. A streaming process is to be introduced by a nurse to determine appropriateness for A&E attendance. Matron A & E to implement fast track and Consultant A & E to liaise with working group to ascertain what provision will be introduced for children and young people. Comparison of Data from symphony pre and post		2. Urgent Care\C2.2\minutes from meeting 15th April 2014.doc		SAFE Children are appropriately priorities and treated	CQEG
C2.4			There needs to be a consultant nominated as the lead for children's care in A & E	MD	Fiona Lennon	Chris Ainsworth	Dr Julia Weatherill is lead A&E Consultant for Children - minutes of joint paediatric / A & E meeting to confirm Photo poster displayed in A & E	Sep-14	Julia Weatherill is the consultant lead for children's and Lisa Barnes and Vicky Write are the Sisters responsible for children's. Matron - A & E has sent a memo to all staff informing them of above. A photo poster is being developed which will be displayed jointly next to the safeguarding teams within the department		Nominated Lead for Children and Young People in A&E is Dr J. Weatherall		SAFE All A&E staff are aware of who the nominated consultant is for children's care	Strategic Management Board
C2.5			Use the same audit tools (QuEST) as the children's ward when auditing children's care in A & E	MD	Matt Tucker / Fiona Lennon	Chris Ainsworth	Completed audits	Sep-14	The Matrons from A & E and Children's have reviewed the QUEST audit that is completed in paediatrics. They have agreed which questions from the Paediatric QUEST audit should be incorporated into the A & E monthly QUEST to provide consistency. The Matron A & E is meeting with the Apps team on 6th May to review and update the monthly QUEST audit tool. The Quest Tool is curmetly under development with the new Matron		2. Urgent Care\C2.5\Example A&E Quest 2014-15 2014-06.xlsx		SAFE Consistent process for monitoring the children's care throughout the Trust	Nursing & Midwifery Board
C2.6		Ensure resuscitation trolley is not blocked by other trolleys or equipment	Comment will be added to the Senior Nurse shift leader checklist in A&E to confirm that access to resuscitation equipment is maintained at all times	COO	Rob Bleasdale / Jason King	Simon Hawes	Senior nurse/shift leader checklist for A&E	Jun-14	Checklist and confirmation of sign		2. Urgent Care\C2.6\RE CQC evidence - senior nurse checklist and resus trolley.msg 2. Urgent Care\C2.6\20140623183318041.pdf			Nursing & Midwifery Board
C2.7		Improve compliance with Level 3 Safeguarding children for staff in A&E	Continue with planned sessions of bespoke training [low level training had been previously identified]; in order to increase current training compliance.	DoN	Ben Leach	Chris Ainsworth	Training records	Apr-14	The safeguarding children training for staff in A & E is currently 80%, which is 5% above the Trust target of 75% Further work continues to increase and maintain compliance		2. Urgent Care\C2.7\FW CQC actions.msg			

3. Responsiveness - Safety

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CM3.1	CQC Must point 1	The do not attempt cardio pulmonary resuscitation (DNACPR) paperwork was misleading and being incorrectly completed and used	Withdraw existing documentation	DoN	Celia Warlow	Chris Ainsworth	Documentation withdrawn from all areas Emails Screensavers	Jan-14	Friday 17th January 2014 1900hrs onwards - All forms were removed and replaced with copies of the DNACPR form only. This was verbally handed over to the Nurse in charge in all in patient areas, A&E, operating theatres and escalation areas. An accompanying memo to explain the rationale for change and completion process was also provided with mobile contact number for 24/7 advice or support if required during the pending weekend.		3. Responsiveness to Care\CM3.1\CQC Inspection - Immediate actions required email 17.1.2014.msg	SAFE - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met (Outcome 4)	Removal of documentation	CQEG
											3. Responsiveness to Care\CM3.1\Screensaver - DNACPR Interim Forms CQC.pptx			
											3. Responsiveness to Care\CM3.1\Report DNACPR CQC January 2014 v3.doc			
			Redesign and implement revised documentation				Copy of revised DNACPR form Revised DNARCPR form included in Resuscitation Policy	Jan-14	Monday 20th – The Resuscitation team visited all in patient areas with further hard copies of the carbonated versions of the DNACPR to resume the required audit trail. The resuscitation team followed up all patients who had a DNACPR decision made since Friday evening and copies were taken for audit purposes. Monday 20th January 0830hrs – Consultation with Doctors of all grades (including the 2222 emergency team) to capitalize on gaining further feedback regarding refinement and potential improvements for the form. Ford redesigned to align the process. New artwork was produced with the assistance of NGH Medical Illustration with two forms produced which sat on one A3 backboard, thus allowing for the TEP form to be used independently or in conjunction with the DNACPR form if appropriate. The revised form was then shown discussed with medical staff. The final draft version was presented to Dr Swart at 1530hrs on Monday 20th January 2014. Approval was agreed that the form could go to print and launched as a development document		3. Responsiveness to Care\CM3.1\DNACPR Jan 2014.pdf		Revised DNAR is available in all areas and staff are utilising this appropriately	
											3. Responsiveness to Care\CM3.1\Screensaver - Launch of new			
											3. Responsiveness to Care\CM3.1\TEP Jan 2014.pdf			
											http://srv-wap-001/IG_DocControl/HG_ViewDoc.aspx?HG_DocID=0655408e-1a5b-4189-b4de-973764471778			
			Support the implementation of the revised documentation with a programme of training, support and audit				Training programme Audit results Evidence of distribution (i.e. meeting minutes etc.)	Feb-14	All resuscitation sessions and courses include appropriate training on DNACPR DNACPR compliance with correct completion of forms has risen from 54% (Dec) to 87% (March) Monthly audits continue		3. Responsiveness to Care\CM3.1\Resuscitation Training Current levels for Doctors.xlsx		Information about the quality and safety is gathered and consistently monitored	
											3. Responsiveness to Care\CM3.1\Cardiac Arrest Prevention & BLS Staff Training Current Figures.xlsx			
											3. Responsiveness to Care\CM3.1\DNACPR Compliance Evidence 2013 - 2014.xlsx			
											3. Responsiveness to Care\CM3.1\Report DNACPR CQC January 2014 v3.doc			
											to discuss the new re-designed DNAR Form and TEPP Management Plan, in use throughout the Trust,			
											3. Responsiveness to Care\CM3.1\CQC Feedback for TEP and DNACPR.msg			

3. Responsiveness - Safety

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CM3.2	CQC Must point 5, summary action 13	Address the lack of pharmacists allocated to the off NGH site ward to review and advise on medication arrangements	Review the requirement for pharmacy support for off-site ward areas	DoS&P	Rita Reeves	Sue Cross	n/a as NHFT site now	Mar-14	For CCH and Isebrook the arrangements were that pharmacy needs were to continue to be supported contractually by KGH upon transfer of the clinical areas to NGH which ensured supply of stock and non-stock medication as well as TTOs. This also included a visit every 3 months to the ward to ensure the checking of Controlled Drugs. This was changed to every 6 months by KGH. The substantive pharmacy support from Provider services for Corby and Hazelwood did not transfer when areas transferred to management of NGH. There was ad hoc support from the part time pharmacist at Danetre to review the stock levels at Corby and Hazelwood wards and to remove the controlled drugs when required. Danetre was previously covered with locum support 2 days per week, this transferred as well when service came under NGH: This post was then re-evaluated and notice given to enable a substantive post to be recruited across all 3 community hospital sites; how-ever recruitment was then put on hold when decision made for NGH to de-invest into the community hospital beds. As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT and is completed		n/a as NHFT site now	SAFE (outcome 9)		n/a
CS3.4	CQC Should point 5, summary action 21	The CQC found food supplements and nutritional drinks were not monitored to ensure consumption within expiry dates.	Matrons must check the stock in their areas to ensure it is in date	DoN	Bill Wood / Natalie Green	Chris Ainsworth	Matrons checklist Exception reports	Apr-14	The checking of expiry dates will take place through 2 avenues once a month – the pharmacy technicians and on the environment audit undertaken through Infection Prevention.		3. Responsiveness to Care\C3.4\RE Stock Rotation on Wards.msg	SAFE - Identify, monitor and manage risks to people who use, work in or visit the service. (outcome 16)	A process for stock control is established	Nursing & Midwifery Board
			Ensure nurses responsible for administering these are aware of the need to fully check the labelling including the expiry date before administering to patients.				Evidence of discussions at meetings	Apr-14	Sample of meeting minutes received - needs checking to ensure all areas are covered		3. Responsiveness to Care\C3.4\Ward Evidence			
			Ensure stock rotation and stock management is appropriate				Audit of supplements to ensure that these are stock rotated and as with any medication/ product expiry date checked.	Aug-14	The principles of good practice will be cascaded through the ward huddles and a quick check will be performed through 2 routes – a question through the walk round to random staff regarding how they put stock away and on the 'Beat the Bug, Stop the Clock' again a verbal check with staff plus a check of the stock in the cupboards/fridge etc of the front and back with any variance on dates ie soonest at the front. Following CEAC review and areas highlighted as concern further actions are requried to demonstarte compliance: discussed at Corporate Lead nurses meeting issues raised in regards to storage facilities on some wards. Risk assmessment to be completed		3. Responsiveness to Care\C3.4\Key Information for Huddles - Nutritional Supplements.docx			

3. Responsiveness - Safety

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CS3.5	CQC Should point 5, summary action 22	The CQC found evidence that Body Mass Index (BMI) calculations were being guessed	Implementation of the nationally recognised MUST nutrition assessment tool in nursing documentation	DoN	Bill Wood / Natalie Green	Chris Ainsworth	Weigh Day Wednesday Audit as part of Matrons Check QuEST	May-14	The Adult in-pt. admission / discharge assessment tool includes the new MUST tool. Alongside this is the Dieticians folder that contains the relevant height/weight/ BMI chart on the wards. A laminated chart on the ward (in new dietician folders) to calculate the BMI that is used as part of the MUST assessment. Weigh day Wednesdays		\\srv-filer-001\Nursing_Indicators$\Matrons Dashboards\Dashboards 2014-15\Weighing Audits 3. Responsiveness to Care\C3.5\Adult Admission Discharge - ADL Mar 14 NGV1580.pdf	CARING - Patients Care and treatment is delivered in accordance with the care plan to ensure healthy living choices (outcome 4)		Nursing & Midwifery Board
			Provision of extensive training by the practice development team for the whole Admissions & Discharge documentation		Bill Wood / Natalie Green		Training programme Attendance at training records	01/05/2014 revised date 01/08/2014	The Practice Development Team disseminated the reviewed nursing documentation on 25th April to all the adult inpatient wards. Prior to this the ward sisters were sent details of the reviewed documents and copies to share with their staff during daily huddles and ward meetings in preparation. The on call sisters and night practitioners were requested to speak to staff and raise any issues with the PD team – none received. The PD team are keeping a log of staff who have been spoken to in respect of the revised documentation. Details of contact numbers were left with the wards if they had any concerns of questions The PD Team went out again on the 30th April to all the wards to speak with staff. Evidence submitted to demonstrate compliance with above. Following CEAC review and some concerns raised by nursing staff further training required Discussed at corporate leads meeting.		3. Responsiveness to Care\C3.5\Evidence regards new nursing documentation (3).docx			
			Monitoring of compliance via monthly QuEST audits				QuEST	Jun-14	Awaiting QuEST data		\\srv-filer-001\Nursing_Indicators$\Matrons Dashboards\Dashboards 2014-15\Quest\Monthly			
CM3.6	CQC Must point 8 Summary action 16	The door leading in to the maternity labour ward could be left open and posed a risk of unauthorised access to this high risk area	Spot checks to be carried out to ensure the door is closed	DoN	Anne Thomas	Chris Ainsworth	Audit results Minutes of meetings where results are discussed	Mar-14	Spot checks carried out 3 times a day to ensure door closed. Raised staff awareness of need to keep door closed and audited (3x daily spot checks documented). 100% compliance mid April 2014 and 100% compliant end of April 2014 Compliance with audit has been reported to Governance Group (awaiting minutes of meeting for evidence of completion) Note: the outer door of labour ward allows access to lobby area only. Two further security doors are used to gain access to the labour ward and MOW. The reception desk has barrier glass to ensure safety of receptionist. No access to clinical area by this single outside door.		3. Responsiveness to Care\CM3.6\Checks for status of front door to labour ward.pdf	SAFE The environment is safe and fit for purpose (outcome 10)	SAFE	Strategic Management Board
C3.7		Ensure all forms for pathways available in clinical areas are relevant to that area and are completed appropriately	• Falls • Nursing Assessment Form	DoN	Lead Nurses	Chris Ainsworth	Revised nursing documentation Training logs	Jun-14	Revised nursing documentation implemented Training sessions carried out by PD team		3. Responsiveness to Care\C3.7\Adult Admission Discharge - ADL Mar 14 NGV1580.pdf			
CS3.8	CQC Should point 9	There are no formal arrangements in place to provide multi faith spiritual support, even in areas where end of life care is given	This finding was associated with the assessment of care at Danetre Hospital. Formal arrangements are in place in the Acute Care Trust	DoN	Eileen Ingram	Chris Ainsworth	Information for provision of multi faith spiritual support is available on the intranet	n/a	As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT		n/a as NHFT site now	SAFE (outcome 9)		n/a

4. Medical Equipment

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CM4.1	CQC Must point 2 Summary action 10.	Equipment was not being adequately tested or maintained	Review planned preventative maintenance register of equipment ensuring all medical equipment is listed	DoF&CD	Hassan Aghourime	Caroline Corkerry	Progress Report Minutes of meetings where discussed	Aug-14	Maintenance Prior to the CQC visit: A comprehensive review of both internal and external maintenance carried out. Last KPIs reported in September 2013 shows: • Planned Maintenance: 78.6% instead of 90% • Performance Verification Testing: 54.5% instead of 60% Gaps identified including backlog of planned maintenance and potential non-compliance with CQC requirements. Risk assessment carried out and risk register updated. Maintenance centralisation and consolidation strategy approved. Maintenance of medical equipment tendered TBS GB awarded the contract to provide comprehensive equipment maintenance. TBS started new service mid October 2013. Agreed with TBS a plan of action to achieve compliance by end of March 2104 After CQC visit: Immediately after the concerns raised by CQC, TBS engineers were called in to inspect and action the maintenance of equipment in the following areas: Main Theatres, Manfield Theatres; Gynae Theatres; Day Surgery Unit; ITU and Paediatrics. Subsequently TBS were asked to go to all areas and carry out planned maintenance TBS produced the following KPIs on February 2014 as a progress update: • Planned Maintenance: 86% instead of 90% • Performance Verification Testing: 54% instead of 60% TBS currently on track to meet Trust standards of planned maintenance KPIs by end of March 2014 TBS to produce a Trust wide planned maintenance plan for the next 12 months by end of March 2014. This has monitored through internal KPI, and monitored through the medical devices committee		4. Medical Equipment\CM4.1\NORTHAMPTON GENERAL HOSPITAL MEDICAL DEVICE MAINTENANCE KEY PERFORMANCE INDICATORS.pdf			
											4. Medical Equipment\CM4.1\Document 4 - Context of Medical Equipment Maintenance.docx		Properly maintained and safe for use	
			Identify any medical equipment which has not been tested and carry out risk assessment for inclusion on Risk Register				For inclusion in compliance report to CQEG Minutes and report to Risk Group	Mar-14	Contained within the risk register		4. Medical Equipment\CM4.1\Document 6 - Datix re equipment.pdf			
											4. Medical Equipment\CM4.1\Document 7- Datix re equipment.pdf			
									CQEG report		4. Medical Equipment\CM4.1 Medical Equipment Management Report- CQEG April2014.pdf	SAFE People who use services and people who work in or visit the premises are not at risk of harm from unsafe or unsuitable equipment (outcome 11)	Trust are aware of which equipment has not been tested and plans are in place to rectify and omit the risk	Medical Equipment group
CM4.2	CQC Must point 3, summary action 11.	Ensure adequate supply and use of capnography machines in theatres	Review availability of capnography machines and identify shortfall	DoF&CD	Hassan Aghourime	Caroline Corkerry	Confirmation	May-14	Received confirmation that all areas specified have sufficient capnographs or would highlight if this was different.		4. Medical Equipment\CM4.2\FW Capnographs email MW 17.4.2014.msg			
			Where a shortfall is identified, carry out a risk assessment for inclusion on Risk Register				Governance Meeting and Risk Register	May-14	Managed and monitored through the risk register		see Datix for information	SAFE There are sufficient capnography to meet the service needs within the Trust (outcome 11)	Trust are aware that sufficient equipment is in place to rectify and omit the risk	Medical Equipment group
CS4.3	CQC Should point 2, summary action 18	Access to equipment is an issue within the Trust (there were no emergency call alarms in the anaesthetic rooms or operating theatres in the main theatres suite which does not comply with the NHS Estate Health Building Note 26 (HBN 26)	Undertake survey work to determine requirements.	DoF&CD	Charles Abolins	Caroline Corkerry	Action plan completed	Aug-14	This has been recognised as an issue and work is currently underway within the capital programme. To date anaesthetic rooms and PAR in Main, Manfield and Gynae theatres have had alarms installed and survey work is being undertaken in the remaining theatre areas to determine requirements.		4. Medical Equipment\CS4.3	SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 10)	Gaps are known & addressed	Medical Equipment group

5. Governance

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CS5.2	CQC Should point 1, Summary action 17	The management of serious incidents within the trust is not robust; the process of reporting is delayed, training in report writing is absent, monitoring of action plans is not consistent or timely. Organisational learning is limited if not absent. However there was evidence of learning in the area where the incident occurred.	Ensure incidents which fulfil the criteria of a serious incident are reported as per the national framework timescales	MD	Chris Ainsworth	Caroline Corkerry	Process for identification of incidents which fulfil the classification of an SI Quarterly report to IHGC demonstrating compliance with the National Framework for Reporting & Investigating Serious Incidents	Apr-14	The Serious Incident Group now meet weekly to expedite the agreement & external notification of Serious Incidents (SI). A process flow chart has been developed to support identification, confirmation and external reporting of Serious Incidents in a timely manner to meet external reporting requirements Compliance with timescales is reported quarterly to CQEG and IHGC		5. Governance\C5.2\Incident Approval Process.docx 5. Governance\C5.2\IHGC_SI_April2014.doc	SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16)	SI process meets the National Guidance	CQEG
			Provision of training for staff in root cause analysis				Training programme Attendance log	Sep-14	External training provider being sourced - planned for July 2014 and now being rescheduled due to sickness of identified external trainer. Consultant Governance Leads and Band 8a and above identified to attend Risk Manager and Senior Quality, Risk & Litigation Manager provide support for SI leads and quality assure all serious incident investigation reports prior to submission. In addition an inhouse training package for RCA and incident investigation is under development		5. Governance\C5.2\SI Investigator training.msg 5. Governance\C5.2\Trust Board SI for March2014.doc		Identified staff will receive RCA training	
			Develop a clear pathway which demonstrates the dissemination of lessons learnt at individual directorate, department, care group, trust wide and the wider health economy				Revised pathway demonstrating process Trust Board Report / Minutes CQEG Report / Minutes IHGC Report / Minutes Care Group Governance Minutes Directorate Minutes	Feb-14	A clear pathway has been developed to demonstrate the dissemination of lessons learnt at individual; Directorate/Department; Care Group; Trust wide and the wider health economy levels (see attached). The pathway commenced roll out in February 2014.		5. Governance\C5.2\SI flowchart_lessons learnt.docx			
			Serious Incident Group Liaise with Patient Safety Academy to implement simulation training based on learning from serious incidents				Simulation training plan Attendance logs	May-14	The Governance Team are working with the Patient Safety Academy to implement Simulation Training Sessions based on learning from Serious Incidents Add simulation suite training info		5. Governance\C5.2\Simulation Centre learning			
			Development of quarterly staff newsletter 'Quality Street' to include lessons learnt				Copies of Quality Street	May-14	All Trust Governance leads and managers have been emailed to request submission of articles The Governance Team have written articles on Datix upgrade; Duty of Candour; lessons learnt from incidents, serious incidents Photographs of team taken by Medical Illustrations to improve profile of Governance Team Medical Illustrations to publish first publication end Published copy June 2014 for Quarterly publication		5. Governance\C5.2\Quality Street final June 2014.pdf			
			Development of a Standard Operating Procedure to ensure lessons learnt are disseminated to ward level	DoN	Bill Wood / Natalie Green / Anne Thomas	Chris Ainsworth	Copy of SOP Ward minutes to demonstrate discussion	01/05/2014 revised date 01/08/2014	This is included in the Nursing & Midwifery Quality Agenda and the development of Standard Operating Procedures (SOP). A standard template was developed by the Head Nursing & Midwifery, Professional, Practice Development. Although evidence reflects compliance concerns were raised as part of the CEAC review and this has been Corporate Lead nurses meeting. Further discussion regarding the SOP and standing agenda will take place at NMB and Matrons and Sisters meeting		5. Governance\C5.2\SOP - 10 Standing Agenda.doc			

5. Governance

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CS5.3	CQC Should point 8 , summary action 24	Staff reported that learning from incidents and feedback when they reported incidents was not always given	Upgrade Datix reporting system to ensure full feedback capability of system. Development of a user guide to ensure staff are aware of whose responsibility it is to feedback to the reporter of the incident	MD & DoN	Chris Ainsworth	Caroline Corkerry / Chris Ainsworth	User guide Evidence of roll out / dissemination Ward Minutes Directorate Governance Group Minutes	May-14	Upgrade of Datix completed by Company March 2014. Gap analysis and redesigning of incident report forms by Governance team has taken place. Discussed at Governance meeting on 25 April 2014 and redesigned form agreed - minutes of meetings awaited User guide in process of development		5. Governance\C5.3\Screensaver - 14th April 2014.pdf 5. Governance\C5.3\April 2014 Away Day Agenda.docx	SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16)		Nursing & Midwifery Board
			A standard operating procedure for ward meetings has been launched which includes standing agenda items these include the months incidents		Bill Wood / Natalie Green / Anne Thomas		Standard Operating Procedure Minutes of meetings	May-14	The Ward Meeting SOP was developed by a ward sister and shared with their peers. It sets out a standard of each ward holding monthly ward meetings with a set agenda template that includes sharing of a patient story and learning from complaints and incidents.		5. Governance\C5.2\SOP - 10 Ward Meetings.doc			
			Minutes of the ward meeting will be generated and a sign off sheet to say staff have read them if they were not present at the meeting Evidence of standard agenda's for ward/ dept meetings , minutes from meetings to demonstrate discussions / feedback &copy of the SOP required.		Bill Wood / Natalie Green / Anne Thomas		Minutes of meetings Sign off sheet	May-14	The SOP also includes a standard template for the minutes and a sign off form providing evidence that staff have read the minutes. It is monitored through the Nursing & Midwifery Quality Dashboard and QuEST. We are reviewing the performance criteria of this SOP to reflect completion of the standard templates.		5. Governance\C5.2\Ward Meeting Sign sheet.docx			
CS5.4	CQC Should point 3, summary action 19	Actions following a complaint are realised and logged. However there are considerable delays in initiating actions; some action from complaints remain outstanding after three months after the action shave been agreed and the complaint has been responded to.	Develop a robust process for the review and follow up of action plans	DoN	Lisa Cooper	Chris Ainsworth	HealthAssure process plan Dissemination to Care Groups / Directorates CQEG reports Directorate Governance Reports	Sep-14	The Governance IT Facilitator and Complaints Manager have met to discuss the process. Agreed to adopt the same process as Serious Incident Action plans SI Action Plan assurance pathway to be adapted and distributed to care Groups/Directorates All Complaints action plans from 1st April 2014 in the process of being uploaded to HealthAssure Q1 data to be presented to CQEG / Care Groups / Directorates - Sept 2014		5. Governance\C5.4	CARING- Learning and improvements in care have occurred as a result of answering complaints - (outcome 17)	Learning and improvements in care have occurred as a result of answering complaints Action plans are evaluated to see if risks are addressed and improvements made.	CQEG
			Progress of all action plans monitored on HealthAssure											
			Ensure all action plans are signed off by the accountable committee in a timely manner											

6. End of Life Care

NGH Priority	Other Ref.	Observation	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C6.1	summary outcome 27	Four patient records reviewed with regard to the care plan relating to end of life needs found that the completion of the records was not consistent and that there were gaps in all four of the records that we looked at. For example, there were gaps in the daily charts which recorded the repositioning of patients at high risk of pressure ulcers and their daily nutrition and fluid intake for two of the patients and one patient had not had a pain assessment completed. In addition to this, one patient did not have a care plan for their end of life care at all.	To increase visibility on the wards enabling clinicians to provide high quality End of Life Care incorporating the five key enablers outlined in the National End of Life Transformation programme. To lead the implementation of the National Principles replacing the Liverpool Care Pathway. Promote best practice and support to clinicians to enable them to identify patients approaching the End of Life ensuring a patient centred plan of care is put in place and reviewed regularly. Provide ward based education in relation to DNAR and TEP with respect to End of Life care planning. Support clinicians to identify patients with unmet needs, ensuring they are referred to the Specialist Palliative Care Team.	DoS&P	Liz Summers	Sue Cross	Audit of records Clarification around Liverpool Care Pathway or the National Principles	May-14	End of life opiate audit is being undertaken by Karin Start		6. End of Life\C6.1\6.1.1 Audit of records		
								Jun-14	End of Life Care questions: Named Consultant / Senior Nurse Huddle is to be rolled out in May 2014		6. End of Life\C6.1\6.1.2 Ward Huddle EOL questions		
								Jun-14	Transforming End of Life Care Improving Quality info for all Acute Trusts reviewed regularly		6. End of Life\C6.1\Transforming End of Life Care Improving Quality info		
									Rolling quarterly agenda item to the End Of Life Risk Strategy Group to ensure compliance is monitored after quarterly submission		6. End of Life\C6.1\6.1.5 End of Life Steering Group agenda		
									Development of initial training compliance by ward On going local database kept to show training		6. End of Life\C6.1\6.1.3 Training compliance		
									TNA developed and being rolled out		6. End of Life\C6.1\6.1.3 Training compliance\6.1.3 a Training Needs Analysis for gaining competency in end of life.doc		
								Sep-14	Work with L&D to establish the registration of Core compliance of training can be evidenced on OLM/ESR. Discussions have taken place with Maggie Coe within the education and training strategy and further confirmation is required about moving this process forward				
								Jun-14	Additional training available to Clinical staff		6. End of Life\C6.1\6.1.3 Training compliance\6.1.3 Palliative and End of Life Care Training Prospectus 2014.doc		
											6. End of Life\C6.1\6.1.3 Training compliance\FW Booking form and Poster - EOLC.msg		
								Sep-14	An end of Life competency workbook has been developed Progress on education and training compliance will be monitored through the End of Life Steering Group The Team will work with Band 7s to complete their workbooks and then implement the process down to the lower bands.		6. End of Life\C6.1\6.1.3 Training compliance\6.1 End of Life Competencies		

6. End of Life Care

NGH Priority	Other Ref.	Observation	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C6.1 continued			Increased visibility on the wards of the End of Life Care Facilitator				End of Life Care Facilitator role reviewed to include daily visits to the ward where End of Life care patients have been identified to ensure an End of Life care		End of Life Care Facilitator attending daily "huddle" meeting, in her absence a member if the SPCT.		6. End of Life\C6.1\6.1.4 Clinical safety huddles		
							Screening tool post safety huddles	June 2014	Screening tool completed by EOL team post safety huddles and ensure relevant information is updated on "work space"		6. End of Life\C6.1\6.1.4 Clinical safety huddles\Mac Spec Palliative care end of life post safety huddle assessment forms (June 2014).pdf		
								Sep-14	New "work space" information to be used for end of life "Amber" to identify patients in last 8 weeks of their life. IT have started the role out and the approach for EOL wad discussed at July EOLSG. Awaiting confirmation from IT about how quickly implementation could be		6. End of Life\C6.1\6.1.4 Clinical safety huddles\Mac Spec Palliative care end of life post safety huddle assessment forms		

6. End of Life Care

NGH Priority	Other Ref.	Observation	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C6.2	summary outcome 27	The lack of a named consultant for palliative care within the trust meant that there was a lack of overall co-ordination and governance of this care pathway	Identify funding for a full time consultant in Palliative Medicine who will act at the End of Life Care Lead for the Trust.	DoS&P	Liz Summers	Sue Cross	Business Case Job description and Job Plan	Dec-14	Dr David Riley, Consultant in Palliative Medicine provides 3.5 clinical PAs to the Trust and acts as the named Consultant for the Specialist Palliative Care Team. Dr Christine Elwell, Consultant Clinical Oncologist acts as the Trust End of Life Care Lead and will be part of the Operational Group delivering the CQC action plan. Business Case submitted to CCG for identification of funding. CCG funding has been approve. An application to the East Midlands is being made for a years funding. A job description has now been developed		6. End of Life\C6.2\6.2.2 EOL Strat Group 6th May 2014.docx 6. End of Life\C6.2\6.2.2 Consultant in Palliative Medicine.docx 6. End of Life\C6.2\6.2.3 SPC business case FINAL 06 11 13.doc		End of life Strategy Group / IHCG
			Actions to address gap at present needs to be added				Annual Work Programme		Annual Work programme has been shared		6. End of Life\C6.2\6.2.1 EOL Annual Work Programme 2014-15.doc		
C6.3	summary outcome 27	Ensure provision of training for staff regarding end of life care	Identify a specific team of individual whose responsibility it is for delivering EoLC leadership. This could fall within existing senior nurse roles or be a dedicated team (which would require 3 additional WTE Band 7 SPC Nurse Specialists) To enable seven day a week face to face contact in line with National Directives. To provide out of hours telephone advice to clinical teams in line with National Directives. Respond to End of Life patients identified with unmet needs. Facilitate education and training related to Palliative and End of Life care. To lead the implementation of QELCA across the Trust. To develop a robust link nurse system across the Trust. To lead the development and support the implementation and assessment of competencies across the Trust. Competencies in providing high quality End of Life Care will be assessed during the appraisal process. To lead audits in relation to Palliative Care.	DoS&P	Liz Summers	Sue Cross	Business case	Jun-14	To produce a business case for funding for additional Band 7 WTE Specialist Palliative Care Nurses to comply with the National Standards relating to Specialist Palliative Care		6. End of Life\C6.2\6.2.2 EOL Strat Group 6th May 2014.docx 6. End of Life\C6.3\6.3.1 SPC CNS Band 7\6.3.1 Business case for SPC CNS Version 2.doc		End of life Strategy Group / IHCG
							Job plan and description for Speculative Palliative Care Nurse Appraisal documentation		A job description has been developed and is waiting now on the outcome of the business case		6. End of Life\C6.3\6.3.1 SPC CNS Band 7		
							Time table of audits built in to the clinical audit programme across the Trust		Care of the dying audit report		6. End of Life\C6.3\6.3.2 Northampton General Hospital NHS Trust report, NCDA4.pdf		
							Minutes of meetings where this has been discussed		Minutes of meetings CQEG reporting to be bi monthly from July 2014 and will be escalated to IHGC Newsletters circulated twice a year Macmillan meetings monthly		6. End of Life\C6.3\6.3 High level meetings 6. End of Life\C6.3\6.3 Newsletters		
									Presentation to Matrons and Sisters in June 2014 including minutes		6. End of Life\C6.3\6.3 High level meetings\6.3.4 Sisters & matron mtgs		

6. End of Life Care

NGH Priority	Other Ref.	Observation	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C6.4	summary outcome 27	Ensure the Trust has clear leadership with regard to the provision of end of life care.	To redefine the End of Life Care Strategy Group ensuring TOR is updated to reflect core membership and clarification of roles and responsibilities	DoS&P	Wendy Smith	Sue Cross	Terms of Reference	Apr-14	TOR developed		6. End of Life\C6.4\C6.4.1 EOL Strategy TOR		End of life Strategy Group / IHCG
									Strategy Group meets monthly		6. End of Life\End of Life Strategy Group		
			Provide a formal report to CQEG/IHGC				Minutes of meetings where this has been discussed	Jul-14	First CQEG paper will be presented at July meeting and any concerns will be escalated to IHGC		6. End of Life\C6.4\C6.4.2 High level meeting minutes		
			Develop annual plan				Work Programme		Annual Work plan developed and will be monitored at End of Life Strategy group in line with the End of Life Strategy. Draft end of Life Strategy been past to Procedural document group for final approval		6. End of Life\C6.4\C6.4.3 EOL Annual Work plan		
C6.5	summary outcome 27	Ensure there is clear guidance for staff regarding the pathway for end of life care	Communicate the End of Life Care principles across the Trust	DoS&P	Liz Summers	Sue Cross	Increase in the use of the LCP in May and June		Review and follow information from Transforming End of Life Care Improving Quality info		6. End of Life\C6.5\Transforming End of Life Care Improving Quality info 129 Northampto		End of life Strategy Group / IHCG
									Amber care pathway Heat Map and now will be introduced through Teleogic and monitoring will then be through that system		6. End of Life\C6.5\Amber Care Bundle- Final Report- v11 (2).pdf		
									The improvements in communication of LCP is monitored through EOLSG, NMB through the Quest audit results and also audit of LCP taken by the specialist palliative care team		6. End of Life\C6.3\6.3 Newsletters		
			Liaise with the Countywide group to develop guidelines based on the National Principles for End of Life Care				County wide guidelines for Care of the Dying	Oct-14	reflection around the Trust of current process		6. End of Life\C6.5\6.5.1 Northampton General Hospital NHS Trust report, NCDA4.pdf		
									Learning and development of Junior Doctors and Registrars understanding of the End of Life process. Escalated to EOLSG in July 2014. Email being sent to all CDs and consultants. Linking in with Governance Managers to spread the information through Care Group M&M, Governance and M&M meetings. Attending Grand Round in Sept 2014.		6. End of Life\C6.5\C6.5 FW EOL Grand Round for Docs.msg		
							Local EOL process developed	Jul-14	Local tool developed for use after 14th July onwards - Risk Assessment of withdrawal of national tool completed Communication has now ben circulated and training sessions on awareness of the new process have been set up		6. End of Life\C6.5\6.5 End of Life Competencies Band 7.doc		
									Task and finish group developed for new process and information on that group was in the June EOLSG minutes		6. End of Life\C6.2\6.2.2 EOL Strat Group 6th May		
									Monitoring of the personalised care plan for the dying pilot is taking place through reviews of the register - this is monitored at EOLSG		6. End of Life\C6.5\Copy of Expected deaths - June 2014		

6. End of Life Care

NGH Priority	Other Ref.	Observation	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C6.5 cont.	summary outcome 27	Continued .... Ensure there is clear guidance for staff regarding the pathway for end of life care	Embed the principles into Clinical Practice by End of Life Care team.				Audit of End of Life care built into the clinical audit programme across the Trust	Sep-14	End of life Advance care planning NHFT booklet		6. End of Life\C6.5\ACP booklet. App 7.pdf		Group / IHCG
									Monitoring the LCP pathway		6. End of Life\C6.5\Copy of LCPMonthlyReport 2013-WS March		
									Embed the new local pathway and launch including the ward manager involvement in compliance and activity of their teams Action plan developed		6. End of Life\C6.5\Relacement document for LCP email		
											6. End of Life\C6.5\6.5 Personalised Care new care plan for		
											6. End of Life\C6.5\6.5 Personalised Care new care plan for		
									The Audit is an on going monthly collection of information and is on the Trusts Audit schedule for 2014.15 as an on going audit		\\srv-filer-001\Governance-CQEGS\J. AUDIT\Audit		
									Further Audit Information		6. End of Life\C6.5\6.5 End of Life Audit information		
									Audit results are monitored through EOLSG		6. End of Life\C6.5\Copy of Expected deaths - June 2014 emailed 2.7.2014.xls		
			Review Trust policy to ensure it reflects current practice				Six monthly real time audit built into the Clinical Audit Programme across the Trust	Sep-14	New End of Life Strategy is with the Trust Procedural Documents Group for ratification to incorporate the update of current practice etc.		6. End of Life\C6.5\End of Life Strategy Review		
								Sep-14	EOL Policy to be updated to reflect the new local care tool that is being developed. This is scheduled for Aug 2014		6. End of Life\C6.5\6.5 End of Life operational policy		
								Sep-14	Trust Clinical audit review will take place in Sept 2014				
C6.6	summary outcome 27	Discuss the provision of formalised arrangement for out of hours telephone support to clinical teams as per peer review requirement.	Liaise with the Service Manager at CSH to formalise an SLA to provide out of hours telephone support until the full complement of the Palliative Care Team is established.	DoS&P	Liz Summers	Sue Cross	Written Agreement	Jul-14	Discussions have taken place with Dr Riley however no formal SLA as no funding available. This is currently a courtesy agreement. Correspondence is on going. Latest correspondence confirmed the agreement for the out of hours telephone support		6. End of Life\C6.6\C6.6 01.07.2014 FW Out of hours telephone advice.msg		End of life Strategy Group / IHCG
							Process for communicating advice back to the Specialist Palliative Care Team at NGH	Jun-14	Correspondence to Specialist Palliative Care Team at NGH is an informal process but does continue. This takes place via phone and is on specific patients with some information on the Summerset system		no specific evidence is available		

6. End of Life Care

NGH Priority	Other Ref.	Observation	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C6.7	summary outcome 27	Ensure there is a robust process whereby staff on the wards and in the palliative care team are able to articulate how many patients there are who are receiving end of life care.	Incorporate the identification of End of Life patients onto the "Ward Work Space"	DoS&P	Liz Summers	Sue Cross	Register of end of life patients by wards	May-14	A weekly register is now collated		6. End of Life\C6.7\C6.7 End of Life Patient Register Deaths & Discharges		End of life Strategy Group / IHCG
							Audit of identification of End of Life patients built into the clinical audit programme across the Trust	Jan-15	Bid for end of life register with CCG & Hospice. The EOL register is now in place. Audits are monitored daily		Register on a PC within the department		
			Develop an electronic system to alert the End of Life Care team about patients approaching the End of Life using ICE				Monitor the movement of patients approaching End of Life	Jan-15	New "work space" information to be used for end of life "Amber" to identify patients in last 8 weeks of their life. IT have started the role out and the approach for EOL wad discussed at July EOLSG. Awaiting confirmation from IT about how quickly implementation could be. Information is being shared through the CQEG report to the directorates on the new process.		6. End of Life\C6.7\Worksp ace Telelogic system		
			Prevent the movement of patients at End of Life unless in their best interest						Ward huddles information and movement - awaiting further assurance of info from Wendy Smith when meeting		6. End of Life\C6.7\Ward Huddles		
									Risk Assessments are now completed for all patient moved. EOL team will request from the risk assessments be faxed for them to review the assessments the next day to ensure the patients daily to ensure transfers are kept to a minimum or investigated if that is not the case				
C6.8	summary outcome 27	Patients on the end of life pathway should have palliative opioids prescribed and all doses should be administered within the two hour 'window' as advised by National guidance	Development and ratification of Palliative opioid administration guidance	DoS&P	Liz Summers	Sue Cross	Six monthly real time audit built into the Clinical Audit Programme across the Trust	Jan-15	Guidance has been reviewed and minuted at NMB 29..1.2014. This has now been approved by NMC and is now with MOC (meeting cancelled in June). Appendix 3 of the Trust Board paper reflects the draft guidance		6. End of Life\C6.8\C6.8.1 Adult Acute Chronic Surg and Non Surg Pain Mgt Guideline		End of life Strategy Group / IHCG
			Dissemination of initiation and prescription guidance						Karin Start (Pharmacy) is the key contact information still to be provided. A discussion has taken place at NMB. Discussions will now be taking place with Medicine Management on how to support the Team to role out the new guidance and other information.		6. End of Life\C6.8\C6.8.2 Dissemination of initiation and prescription guidance		
			Develop Opioid Leaflet for palliative patients						Opioid Leaflet for palliative patients has been developed, approved by Trust Board and approval has now been provided by MOC and the final copy is being past to PIG & Med Illustrations.		6. End of Life\Personalised Care Plan for the Dying Trust Board report June 2014.pdf		
			Review the possibility of incorporating strong opioids on the critical medicine list in the Medicines Management Policy and recorded on the drug chart						Medicines Management Policy is being updated by MOC and evidence of recorded on the drug chart is being investigated including incorporating within the teaching				

7. Mandatory Training & Appraisal

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
C7.1		Mandatory Training	Reach a target of 80% by October 2014 & 85% by March 2015	DoW&T	Sandra Wright	Sue Cross	Example of monthly reports. Papers & Minutes Directorates; Wards and Managers Papers of IHGC; Trust Board & Minutes	Mar-15	Examples shared with Managers in June 2014		7. Mandatory Training & Appraisal\7.1\C7.1	WELL-LED People who use services are safe and their health and welfare needs are met by competent staff and ensure that staff are properly trained, supervised and appraised. (outcome 14)	Information to be available to all staff	CQEG
							Provide data for individual staff members. Monitor the accuracy of the data		McKesson are currently looking into the data issues and working with the L&D dept		7. Mandatory Training & Appraisal\7.1\7.1 Committee Assurance Papers			
C7.2		Role Specific Training	Reach a target of 80% by October 2014 & 85% by March 2015	DoW&T	Sandra Wright	Sue Cross	Example of monthly reports. Papers & Minutes Directorates; Wards and Managers Papers of IHGC; Trust Board & Minutes	Mar-15	Examples shared with Managers in June 2014.		7. Mandatory Training & Appraisal\7.2	WELL-LED People who use services are safe and their health and welfare needs are met by competent staff and ensure that staff are properly trained, supervised and appraised. (outcome 14)	Patients are protected from risk of harm	CQEG
							Provide data for individual staff members. Monitor the accuracy of the data		Role Specific identification of Job roles has been completed by T&D. McKesson who will do the mass upload. Timing of this is important as McKesson will remove current competency requirements from our system and put the new information in so this needs to be done between reports etc. L&D are reviewing the risk register to highlight the data issues which McKesson are working with currently. This is being highlighted to IHGC & CQEG in June 2014		7. Mandatory Training & Appraisal\7.2			
C7.3		Staff Appraisals	Reach a target of 80% by October 2014 & 85% by March 2015	DoW&T	Sandra Wright	Sue Cross	Example of monthly reports. Papers & Minutes Directorates; Wards and Managers Papers of IHGC; Trust Board & Minutes	Mar-15	Examples shared with Managers in June 2014		7. Mandatory Training & Appraisal\7.3	WELL-LED People who use services are safe and their health and welfare needs are met by competent staff and ensure that staff are properly trained, supervised and appraised. (outcome 14)	The organisation are aware of which staff have had not had appraisals There is robust monitoring in place for the staff appraisals and Managers and Trust are aware of compliance levels against Trust target At least 85% of staff will have had an appraisal by March 2015	CQEG

8. COMPLIANCE Record Keeping and Mgmt

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Governance Support	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CS8.1	CQC Should point 4, summary action 20	Records were not available when required and were not always accurately completed with information regarding patients specific needs	Print off the batch lists for all records sent to specific outpatient clinics.	DoS&P	Tracey Harris	Sue Cross	Gap analysis	Apr-14	Spreadsheet documenting number of records requested for clinic and number available. Ongoing data collection from within medical records using batch list and clinic lists. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability. Appendix 2		8. Record Keeping and Mgmt\CS8.1\CS8.1.1 Examples of Printed off Batch Lists	SAFE - Store records in a secure, accessible way that allows them to be located quickly. (outcome 21)	SAFE Notes are available in a timely manner	Health Records Committee
			Audit list against clinic list tracked to the department / outpatient clinic		Tracey Harris		Audit results Minutes of meetings where results are discussed	Apr-14			8. Record Keeping and Mgmt\CS8.1\CS8.1.2 example of tracking report		SAFE Action plans are monitored to ensure actions are implemented	Health Records Committee
			Print off batch list for all medical records sent to a clinic including the 7 & 2 day changes. Audit those records that were requested from other departments / offices for availability at the clinic		Tracey Harris		Copy of audit results as evidence Monitoring	May-14	Ongoing data collection from within medical records using batch list and clinic lists. The audit is now taking place and the information is to be provided as evidence. Discussions are taking place with IT to get some smarter reports to address this in a more roust manner. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability. Appendix 2		8. Record Keeping and Mgmt\CS8.1\CS8.1.3 2 day notice audit		SAFE Notes are available in a timely manner	Health Records Committee
			Book OPAs prior to the 2 day cut-off within medical records. Review utilising Info view report		Tracey Harris		Exception report	Aug-14	Data/Graphs on number of records tracked out of medical records and into a specified clinic. Appendix 2 & 4 provide evidence of numbers tracked out of medical records, the tracking in clinics and availability. Further evidence will be captured through improvements in the patient document tracking universe. (review booked 2 days; on day and after clinic information) OPA booking will be discussed at the Health Records Group (HRG) and data sent out to service managers to action.		8. Record Keeping and Mgmt\CS8.1\draft 09 05 14 HRG Minutes.docx			Health Records Committee
			Ensure all departments email additions to the medical records clerks to enable pulling to be completed in a timely manner		Tracey Harris		Exception report	Sep-14	This process already takes place however a more robust process is being looked into currently. Provide a report on a monthly basis to the Service Managers review the reports and issues are discussed at Governance and or operational meetings					Health Records Committee
			Training staff who require access to medical records to ensure they understand how to track records in and out of areas		Tracey Harris		Training records and attendance logs	Sep-14	Examples of training logs are provided. Discussions are to take place with T&D & IT to review the training including looking at the possibility of making tracking notes a role specific training requirement for A&C staff. Increase profile of tracking etc. - Screensavers to be created to remind people that training is provided. Email has been sent to all admin managers to request all relevant staff have tracking training Email to T&D has been instigated A Risk Assessment or audit of the clinics where records are reported as missing against Med Records department info should be looked into		8. Record Keeping and Mgmt\CS8.1\CS8.1.6 Tracking training log\CS8.1.6 Tracking Training email 19.5.2014.msg 8. Record Keeping and Mgmt\CS8.1\CS8.1.6 Tracking training log\CS 8.1.6 T&D training role specific 19.5.2014.msg 8. Record Keeping and Mgmt\CS8.1\CS8.1.6 Tracking training log\CS8.1.6 Appendix 1 Training Log.tif			Health Records Committee

D

8. COMPLIANCE Record Keeping and Mgmt

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Governance Support	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	Overarching outcome	outcome or anticipated outcome	Accountable committee
CS8.1 continued		Continued ..Records were not available when required and were not always accurately completed with information regarding patients specific needs	Improve portering and filing services to ensure more records are held within the library rather than in offices / storage areas in clinics		Tracey Harris		Monitoring Evidence	Sep-14	Reduced number of records awaiting collection in departments. Proposal to be developed and submitted to the HRG for approval. An increase of the portering staffing has taken place in the afternoons. Porters are working with all departments to track records in on delivery. Changes in med rec processes to enable a seamless service of records being returned to the department and take out for delivery.		8. Record Keeping and Mgmt\CS8.1\Medical Record Group bi-annual report June 2014.doc			Health Records Committee
									Update intranet page to give help on how to track, other user information and how to access the training. PR campaign on reminder for tracking notes.		8. Record Keeping and Mgmt\CS8.1\draft 09 05 14 HRG Minutes.docx			
			Stronger monitoring of Datixs by undertaking RCAs and reporting back to all concerned		Tracey Harris		Process for Medical Records to monitor Datix Reports / Minutes	Sep-14	Datix's are now monitored and a log is available for review. The process is discussed at the Health records Group meetings and is also followed up with the specific department at the time. Some further challenge is required where secretaries and other departments have the notes where the tracking has not taken place		8. Record Keeping and Mgmt\CS8.1\CS8.1.8 HR Datix tracking			Health Records Committee
CS8.2	CQC Should point 7, summary action 23	Care record templates and audits were based on an acute hospital setting and not necessarily appropriate for a community hospital service	As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT Completed	n/a	n/a	n/a	n/a	n/a	Handed to NHFT		n/a Handed to NHFT	Outcome: SAFE- (outcome 21)		n/a

9. COMPLIANCE Workforce & Leadership

NGH Priority	Other Ref.	Recommendations	Actions Required	Executive Owner	Action Owner	Governance Support	Assurance / Evidence	Target Date end of month	Progress/Milestones	Action Status	Hyperlink	outcome or anticipated outcome	Accountable committee
C9.1		Ensure safe levels of staffing to meet patients needs and dependency	Benchmark against national data for general wards and admission wards using the safer nursing care tool	DoN	Fiona Barnes / Bill Wood / Natalie Green	Chris Ainsworth	Hard Truths daily update now in place, monthly reporting process in place. The Trust receive monthly updated through the Trust Board Nursing Paper	Jun-14	Hard Truths data submitted by DON		9. Workforce. Leadership\C9.1\Hard Truths		IHCG
			Encourage use of the 'Enhanced Observation of Care' policy to assist with decision making about the requirement for additional staffing for those patients that are vulnerable or 'at risk'. This includes a risk assessment (attached in a separate email) with every patient being individually reviewed by the matron for the area. Ensure escalation of the requirement for additional staff to the Site Team				The Safe and Supportive Observation of Adult Patients (Enhanced Observation) NGH-PO-415 is currently being updated.	Sep-14	Policy is currnetly being rewritten and is out for consulation. Use of currnet policy is encouraged Monthly staffing incident report discussed at NMB which includes incidents were safeguarding has been highlighted.				
C9.2		Senior management (particularly Execs and Non Execs) need to increase their visibility throughout the Trust to ensure that there is a clear leadership focus	Develop visibility plan for senior nursing staff	DoN	Fiona Barnes / Bill Wood / Natalie Green	Chris Ainsworth	Visibility Plans Ward Visit Board	Sep-14	A visability plan has been implemented by all nursing team		9. Workforce. Leadership\C9.2\Head of Midwifery - visibility plan.docx 9. Workforce. Leadership\C9.2\Visibility Plan.doc 9. Workforce. Leadership\C9.2\Lead Nurse VISIBILITY PLAN.docx 9. Workforce. Leadership\C9.2\Lead Nurse VISIBILITY PLAN.25.03.14.docx		Nursing & Midwifery Board
			Develop visibility plan for Execs and Non Execs	COO	COO	Simon Hawes		Sep-14	The Board Completed Board to ward and also attend other ward visits. Quality Street has been disemninated which outlines the Governance Arrangements within the Trust		9. Workforce. Leadership\C9.2\TRUST BOARD VISIBILITY PLAN.docx 9. Workforce. Leadership\C9.2\ward visit boardv1.pptx		
C9.3		Review the provision of the Outreach service	Critical Care establishment review undertaken and is incorporated within 2014/15 Nursing & Midwifery staffing strategy which will minimise the number of shifts without cover.	DoN	Jo Dilley	Chris Ainsworth	NMB staffing Strategy	Jul-14	NMB staffing Strategy Nursing & Midwifery Staffing Strategy NGH-SY-803		9. Workforce. Leadership\C9.3\Nursing & Midwifery Staffing Strategy NGH-SY-803.pdf		Nursing & Midwifery Board
			A risk assessment to be undertaken by the Critical Care team when there has been a last minute reduction in staffing numbers to ensure all options are explored prior to diminishing the outreach team	COO		Simon Hawes	Risk Assessment	Aug-14	Risk assessment completed		9. Workforce. Leadership\C9.3\Risk Assessment for CCOT staff moves June 2014.docx		
C9.4		Annual review of Consultant cover for Labour Ward and benchmark against Towards Safer Childbirth recommendations	Complete annual review	MD	Anne Thomas / Clement VonWidekind,	Caroline Corkerry	Copy of the review with minutes	Sep-14	A review of the consultant cover has taken place by AT & CV and wil be shared				IHCG
			Business case to be developed to meet any shortfall identified					Sep-14					
			Annual consultant job plan to ensure 24 hour on call Consultant cover					Sep-14					

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Medical Director's Report**
Agenda item	8
Sponsoring Director	Dr Mike Wilkinson, Interim Medical Director
Author(s) of Report	Dr Natasha Robinson, Associate Medical Director Christine Ainsworth, Senior Quality, Risk & Litigation Manager
Purpose	Assurance

Executive Summary

- HSMR data relates to March 2014
- No new areas of concern have emerged
- Crude mortality remains one of the lowest in the region
- 50 note death review recently completed and will be available at the end of September
- 6 new serious incidents were reports
- 2 of the 6 Serious Incidents reported in June 2014 were classified as causing severe harm or death, this represents a reporting rate of 0.24%, which is below the national average of <1%
- 0% of Serious Incidents this month were reported on STEIS within 2 working days; compared to 66% in May 2014 and 60% in April 2014. The delays have predominantly been associated with the validation and notification of Grade 3 pressure ulcers.
- 9 Serious Incidents were submitted for closure. 1 report was submitted in breach of the 45 day timescale. The timescales for internal submission of Pressure Ulcer reports needs to be reviewed and closely monitored to ensure that the report is received in advance of the external submission date to allow for review and quality assurance checks by the Risk Management team and the Executive Lead
- The Governance team are continuing to develop the HealthAssure system. The team are currently working on producing an action plan dashboard which will be included in future reports. This will provide the Committee with further assurance that recommendations from Serious Incidents are acted upon and monitored until actions are complete.

Related strategic aim and corporate objective	Strategic Aim 1: Be a provider of quality care for all our patients Objective No 1 : Invest in enhanced quality including improvements in the environment in which we deliver care
Risk and assurance	Risks to patient safety if the Trust does not robustly investigate root causes identify remedial actions required and ensure cross Trust learning to prevent recurrence of SI.
Related Board Assurance Framework entries	BAF 1

E

Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (**N**)
Legal implications / regulatory requirements	Compliance with CQC regulations (patient safety) and commissioner requirements through mandatory contracts.

Actions required by the Trust Board

The Board is asked to:

- Note the content of the report, details of the serious incidents declared and identify any areas for which further assurance is sought.

Public Trust Board
31 July 2014

Medical Director's Report

1. Review of current mortality and safety data provided by Dr Foster

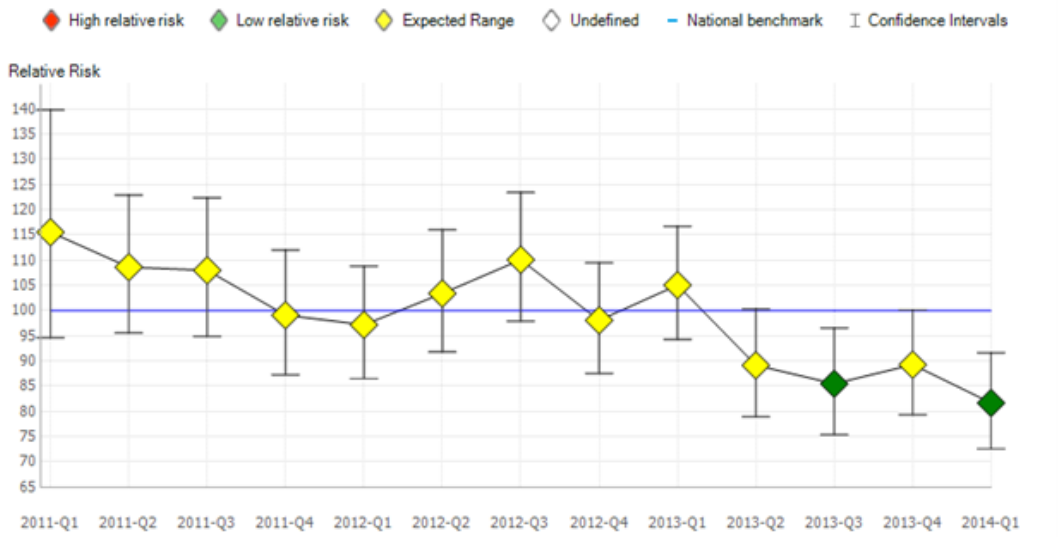
This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence to end March 2014 and SHMI (to September 2013). Overall improvement is sustained and there have been no new areas of significant concern to investigate. A programme to roll out specialty specific dashboards for use by clinicians and managers in each directorate is underway to enable improved local ownership of performance data. However this is slower than intended due to restrictions on the access to data by individual users within the organisation following the recent changes in licence terms between HSCIC and Dr Foster. This has also resulted in an additional month's delay in release of data, which is now 3 months in arrears [not two]. Lastly, due to perceived issues of patient confidentiality, the publication of 'small numbers' [<7] is no longer acceptable in the public domain, which means that certain sections of this report have been redacted.

2. Current Position HSMR (Hospital Standardised Mortality Ratio, Dr Foster Intelligence)

HSMR was developed as a tool to assist hospitals in monitoring mortality, and debate as to its appropriate use continues. It is based on mortality in 56 CCS (Clinical Classification Software) groups. These diagnosis groups account for 80% of hospital mortality and are recognised as having reliable predictive mortality. A further 200 much smaller CCS groups account for the remainder. They are not included in HSMR as predictive risk modelling for these small volume diagnoses is not as reliable. Due to continuous review of changing disease patterns and survival rates it is likely that there will be a revision of the tool in the near future.

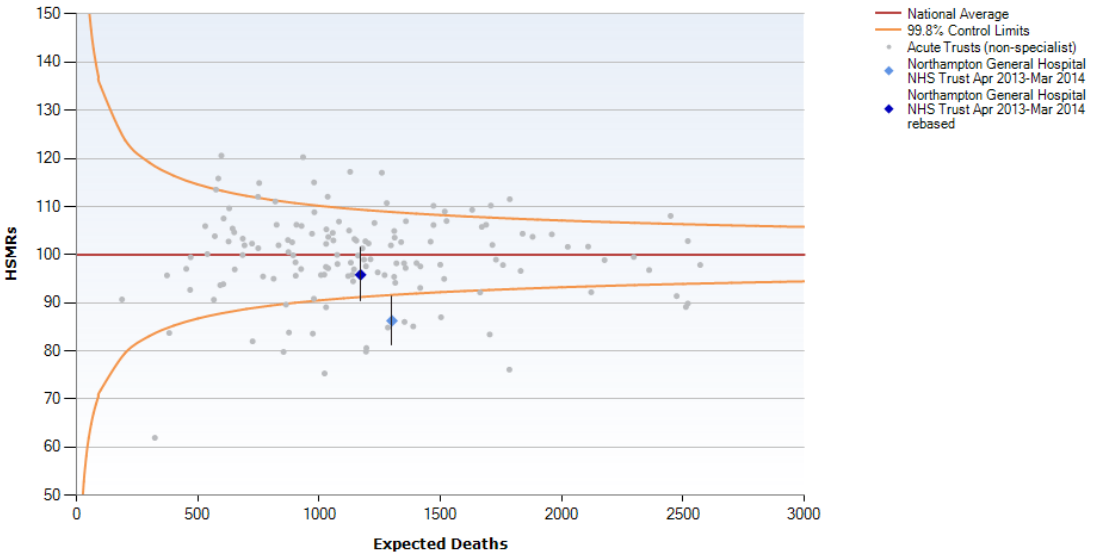
At NGH there is a detailed monitoring process which tracks HSMR and investigates individual diagnoses whose SMR (standardised mortality ratio) is persistently adverse. Where the term HSMR is used this refers to the previously defined group. Where all groups are included, the term HSMR 100 is used. The Trust systematically investigates all such areas of concern for both clinical care and data quality (including clinical coding). Where adverse performance is persistent detailed reviews of the information and individual cases are presented and discussed at Mortality & Coding Review Group, a multidisciplinary group chaired by the MD. The Board should note that the expected mortality for any given condition cannot take into account the severity of that condition in an individual patient at presentation, but is based on the diagnosis, age, presence of other conditions (comorbidities) and any surgical procedures carried out. Hospital mortality rates are also known to reflect local community and primary care provision. A high standard of care in the community may have a confounding effect on admissions, reducing numbers such that only the highest risk cases are admitted to hospital. Equally, lack of access to primary care may also mean that patients present late to hospital in a more serious condition. This is of particular relevance when considering differential survival rates in those admitted during the week and at weekends [see later] The model relies on accuracy of clinical coding, and as it is comparative, local performance may also reflect variation in coding practice in other organisations. Northampton General Hospital Trust has previously included 3 community sites until March 2014. Current data reflects this position, and historical data will continue to do so. However from August 2014 data will be released reflecting activity from April 2014 on NGH site only.

The following graph shows the sustained improvement in HSMR by quarter since 2011:

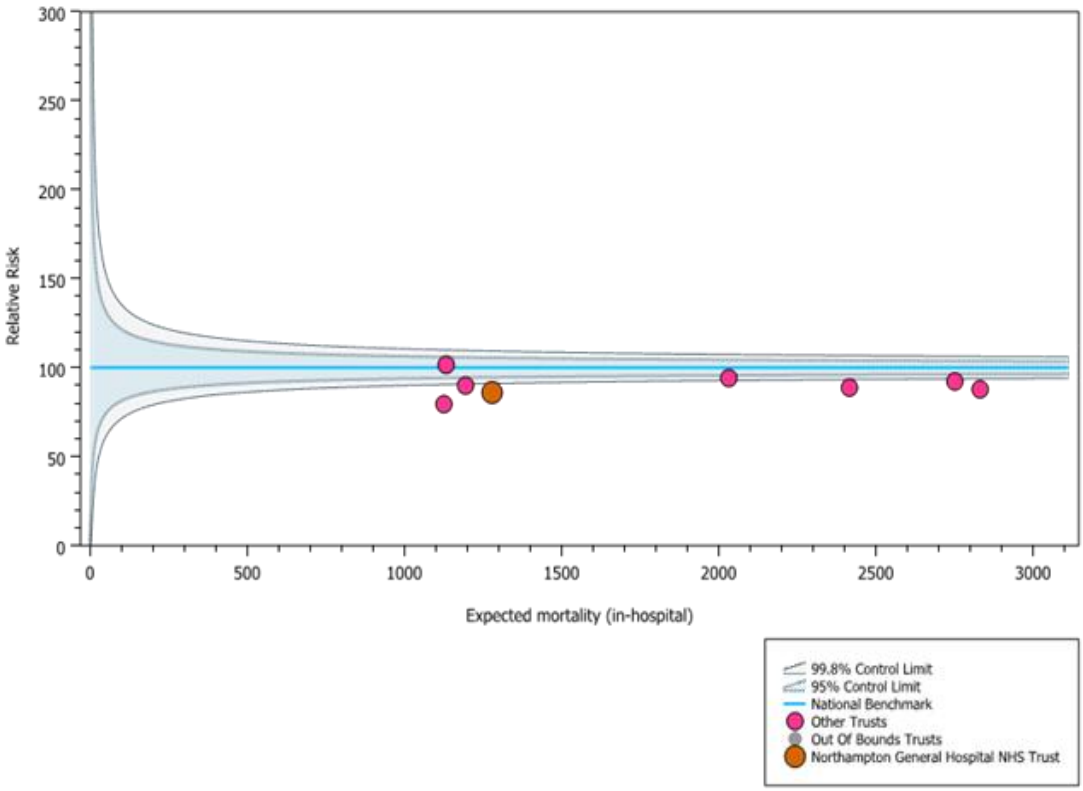


3. HSMR Comparison

The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture. This is especially important when death rates are falling nationally as is currently the case and the benchmark is continuously falling, as is currently the case. Dr Foster currently re-benchmarks annually in arrears, but will shortly change to real-time rebenchmarking. The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 9 points since 2012-3, following a winter of unexplained high mortality in 2012-3. NGH HSMR for 2013-4 is **86** (**96** when rebased).



The funnel plot below shows the current position in the East Midlands.

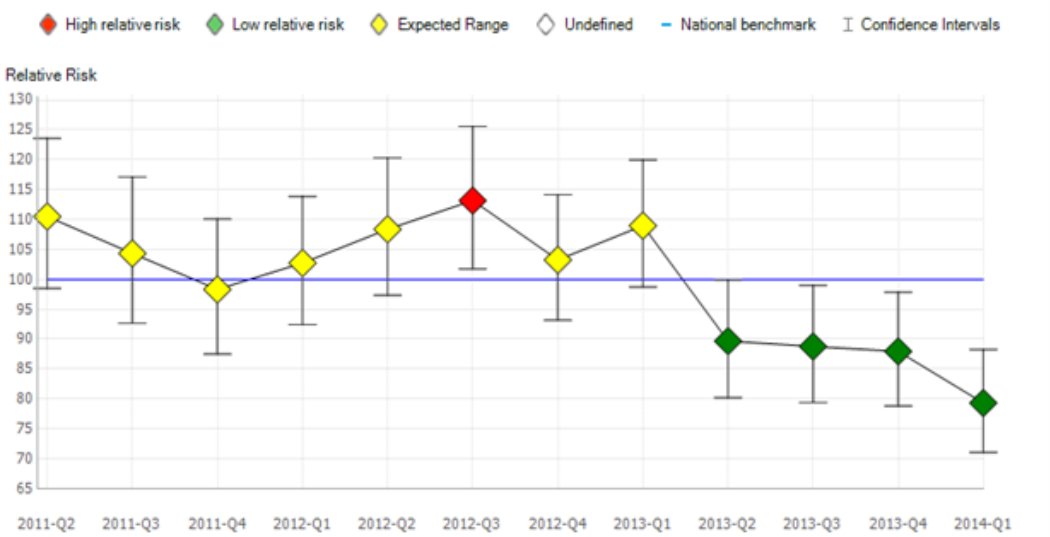


Crude mortality for 2013-4 remains 3.6%, showing sustained improvement as compared to 2012-3 (4.2%) and one of the 3 lowest in East Midlands. The current average for Trusts in East Midlands is 3.9% (range 3.4% - 4.9%).

4. Standardised Hospital Mortality Indicator (SHMI)

There has been no further SHMI data release since the last report to Board. The most recent data release (to end September 2013) shows SHMI for the rolling year to be at **110**, a noticeable fall from the previous **112.9** and no longer out with the 'expected' range. As previously, this is expected to fall in each of the successive 2 quarters so that the final value for 2013-2014 is **95-105**.

The graph below shows HSMR 100, which tracks SHMI but is not yet rebenchmarked.



E

5. Patient Safety Indicators

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups*	38,398	24	30.3	0.6	0.8	79
Decubitus Ulcer	9,631	299	326.3	31.0	33.9	92
Deaths after Surgery	368	46	49.2	125.0	133.6	94
Infections associated with central line*	16,009	****	****	****	****	93
Postoperative hip fracture*	25,079	****	****	****	****	257
Postoperative Haemorrhage or Haematoma	23,663	14	14.2	0.6	0.6	98
Postoperative Physiologic and Metabolic Derangement*	19,963	****	****	****	****	247
Postoperative respiratory failure	18,123	25	16.8	1.4	0.9	149
Postoperative pulmonary embolism or deep vein thrombosis	23,844	29	45.4	1.2	1.9	64
Postoperative sepsis	561	****	****	****	****	52
Postoperative wound dehiscence*	980	0	1.4	0.0	1.5	0
Accidental puncture or laceration	66,907	52	76.8	0.8	1.1	68
Obstetric trauma - vaginal delivery with instrument*	442	36	36.5	81.4	82.7	99
Obstetric trauma - vaginal delivery without instrument*	2,499	104	95.9	41.6	38.4	108
Obstetric trauma - caesarean delivery*	1,180	0	4.4	0.0	3.7	0

**** - cell contains <7

6. Reports on key areas for action or of importance

Aggregate mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is better than expected for 2013-4 at **75**.

7. Possible areas for concern under investigation

There have been no further alerts requiring investigation.

8. Crude Mortality

Unadjusted data using the crude numbers of deaths occurring in the Trust provided from internal information sources to the end of May 2014 continues to show that the crude number of deaths occurring has fallen in 2014-2015 as compared to 2013-2014. This may be partially attributable to the loss of the community hospital beds, but suggests that all composite mortality measures should remain within the expected range for Q1 2014-2015.

9. Areas of general relevance with respect to overall Trust performance

Mortality & Morbidity Reviews
A further 50 sets of deaths [December 2013] have now been reviewed by the multidisciplinary group who met weekly during June & July. The report will be available by the end of September to meet the local CQUIN requirements. A schedule of meetings for directorates to review their own cases during 2014-2015 has now been set up in all specialties.

New Serious Incidents
Since the last report to the Committee, and within the reporting period 1 – 30 June 2014, 6 new Serious Incidents have been reported. Serious incidents are graded in accordance with the National Patient Safety Agency (NPSA) Serious Incident Reporting and Learning Framework.

All 6 incidents identified during this reporting period were graded as 'Grade 1' which stipulates that these investigations must be completed and submitted to the Commissioners within a 45 working day timescale.

The following table illustrates the 'Grade 1' Serious Incidents by Datix category:

Category	Number	Comments
Implementation of care	4	4 x Hospital acquired Pressure Ulcers (1 which occurred in May)
Accident which may result in personal injury	1	Fractured neck of femur following fall (occurred in May)
Access, appointment, admission, transfer, discharge	1	Delay in transfer

Closed Serious Incidents
During the reporting period 9 incidents were submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure as follows:

6 Grade 3 Pressure Ulcers deemed to be avoidable
1 Grade 3 Pressure Ulcer. The investigation found that the pressure ulcer was incorrectly validated as a pressure ulcer and have therefore requested that the incident be downgraded
1 #NOF
1 Staff injury (needlestick)

Active Serious Incidents
As at 30 June 2014 there were 26 on-going Serious Incidents investigations underway.

STEIS Extension Submission Requests
During the reporting period the Trust applied to the Commissioners for 1 extension to the 45 day timescale. The reasons for the requests were:

- 2014/13476 – Maternity, unplanned admission to ITU. Due to the fact that this patient remains in hospital and has had a further admission to ITU, it has been difficult to obtain the medical records for a complex investigation which involves 3 specialities. The Trust requested the investigation be put 'outwith'; however the CCG refused this request and a 20 working day extension was granted.

E

- 2014/12684 – Grade 3 Pressure Ulcer was submitted in breach of the 45 day timescale. This was due to the fact that the report required amendments to ensure that all learning had been identified.

Serious Incident Reporting Rate

There were 823 patient safety incidents reported in June 2014, 6 of which were declared and investigated as a Serious Incident. Only Serious Incidents which result in severe harm or death are counted in the National Reporting & Learning Service national data. 2 of the 6 Serious Incidents reported in June 2014 were classified as causing severe harm, this represents a reporting rate of 0.24%, which is below the national average of <1%.

Report To	**Public Trust Board**
Date of Meeting	**31 July 2014**

Title of the Report	**Director of Nursing & Midwifery Care Report**
Agenda item	9
Sponsoring Director	Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Senior Nursing & Midwifery Team
Purpose	Assurance & Information

Executive summary

This report provides a detailed update on a number of clinical projects and improvement strategies within the Director of Nursing, Midwifery & Patient Services portfolio. A shortened version of this report, providing an overview of the key quality standards, will be shared on the Trusts website as part of the Open & Honest Care report. The report includes Trusts Safe Staffing, 'Hard Truths' commitment for July.

Key points from this report:

- N&M Quality Dashboard (QuEST) shows a slight improvement of 79% compliance against last month 77%.
- Hard Truths staffing data was prior to the national submission date, this is detailed in a separate Trust Board paper and illustrates 54% of wards (14) were staffed at equal to or above 98% of their funded establishment during June.
- Safety Thermometer – achieved 92.85 % this month against a ceiling of 93%. CRUTI are within the national average.
- There has been a slight decrease in the number of new hospital acquired pressure ulcers in June (24) against May (28)
- There have been seven C. Difficile cases this year; this is above our monthly internal stretch target but within our national annual ceiling of 35.
- The number of moderate falls this month was 3 and the completion of paperwork associated with the re-assessment and on-going care of patients at risk of falling improved this month to 74% from 47%.
- The Nutritional Update summarises the key work streams currently in place and acknowledges the week on week improvement in compliance of Weigh Day Wednesday to 98%.
- The Trust has achieved the Friends & Family Test for June and for the first quarter of the year
- The Patient Safety Academy has launched its second campaign which will support the development of a Flagship Ward.
- The Trust is fully prepared to discontinue the Liverpool Care Pathway and implement individualised plan of care for patients who are is dying, in line with guidelines from the Leadership Alliance

F

- During Q2 there is an improvement with “Making Every Contact Count” assessment of patients’ alcohol & smoking habits from 96% to 98% and the provision of brief opportunistic interventions for those patients who require support from 50% to 83%.
- The Trust has achieved the Safeguarding Childrens Improvement Board and the Quality Schedule target for Common Assessment Framework in quarter 1.
- Maternity Update includes a summary of the new Birth Centre and the positive FFT results that the service has received (94-100%). There is also a summary of the Caesarean section rate which is not being sustained at below 25%.

Related strategic aim and corporate objective	To be able to provide a quality care to all our patients
Risk and assurance	The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF – 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?No
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - No

Actions required by the Trust Board

The Trust Board is asked to discuss and where appropriate challenge the content of this report and to support the work moving forward.

The Trust Board is asked to support the on-going publication of the Open & Honest Care Report on to the Trusts website which will include safety, staffing and improvement data.

Public Trust Board
31 July 2014

Northampton General Hospital NHS
NHS Trust

Director of Nursing and Midwifery Care Report

1. Introduction

The Report presents highlights from across the Nursing, Midwifery and Patient Services portfolio during the month of June.

Key quality and safety standards will be drawn from this monthly report to share with the public on our web site as part of a 'Open & Honest' Care report. This new report aims to support the Trust to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture. The 'Open & Honest Care' report will also include the key monthly data from our Safe Staffing data 'Hard Truths' update.

2. Body of Report

2.1 Nursing and Midwifery Quality Dashboard

The Nursing and Midwifery Quality Dashboard presents the findings from the monthly QuEST audit. The QuEST data is 'aggregated' onto the Dashboard, which is triangulated with a wealth of information from other data sets and audits. The corporate nursing team have reviewed the N&M Quality Dashboard and the QuEST audit tool. The outcome of this review is that the N&M Quality dashboard has been refined to focus on key quality metrics. The QuEST audit tool will continue to incorporate the 15 Steps and will continue to be undertaken on a monthly basis by the Matrons. The revised QuEST audit tool will be in place in September. The Trust will continue to undertake a quarterly review of the clinical standards of care which will be expanded to cover more of the CQC standards and reflect the Trusts original Clinical Governance Review Scheme and will complement QuEST.

2.2 Nursing & Midwifery QuEST – Summary

The QuEST summary demonstrates an overall score of 79% for the wards. This is slightly improved compared to the previous month (77%).

- Currently Allebone ward are on improvement measures; a month on month improvement since February is acknowledged.
- Cedar, Abington & Brampton have completed their Improvement Measures and will continue to be monitored on a monthly basis.
- Dryden is being closely monitored and will be placed on Improvement Measures if improvements are not seen next month. The Ward Sister is currently meeting on a weekly basis with their Matron.
- Victoria Ward is on Improvement Measures and there are weekly meetings with Matron, Lead Nurse with the Service Manager.

3. Nurse Staffing – Hard Truths Commitment

Earlier this year NHS England and the CQC launched 'Hard Truths Commitment'. This work complimented the National Quality Board guidance to optimise nursing, midwifery and care staffing capacity and capability. The data submitted demonstrated the planned versus actual number of staff on each shift for each day of the month across our in-patient areas.

Each month Hard Truths data will be available on the Trust website & NHS Choices for the public to see. The data will be presented in a format that is user/public 'friendly' and be supported by a narrative to enable understanding of the information provided. The narrative will include the rationale for there being more or less staff on each shift in comparison to the planned staffing numbers.

F

As part of the Trusts on-going review of the nursing skill mix on the wards the Senior team have undertaken a Staffing Review in accordance with the Nurse Staffing Strategy and, more recently, the national guidance from NHS England as part of 'Hard Truths'.

A full report of our ward staffing data and the findings of the Staffing review will be provided as part of the 'Hard Truths Commitment' Trust Board paper.

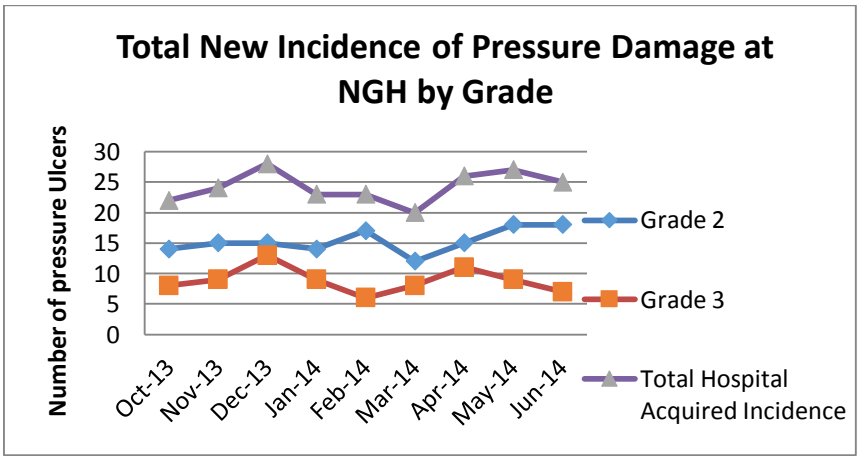
4. Safety Thermometer

The Safety Thermometer looks at four harms: pressure ulcers, falls, blood clots and urine infections for those patients who have a urinary catheter (CRUTI) in place. In June 92.85% patients experienced harm free care in this Trust which is just below the national average of 93%.

5. Pressure Ulcer Prevention

In June 24 new hospital acquired pressure ulcers (HAPU) were validated (figure 1). Of these 17 were validated as Grade 2 and 7 Grade 3/Grade 3 unclassified. This is a slight down ward trend from May's data of 28 HAPU.

Figure 1



Of the 24 pressure ulcer reported, 9 have been identified as Device Related Pressure ulcers (DRPU), 2 of which occurred in critical care. In May one of the ulcers reported was attributed to anti-embolism stockings and June's data suggest they accounted for 3 DRUP's. This is an area the TV team will be addressing.

The Confirm & Challenge meeting with the Ward Sister, Lead Nurses and Lead Tissue Viability Nurse now takes place twice a month. This will continue until the number of hospital acquired pressure ulcers reduces. The Tissue Viability Team, in conjunction with the medical equipment library has redeveloped mattress ordering request on ICE which includes a prompt for staff on how to order out of hours which has been identified as a theme on some root cause analysis as to why patient not placed on appropriate support surface.

6. Health Care Associated Infections (HCAIs)

The table below shows the number of infections we have had this month and the previous month, plus the improvement target and results for the year to date.

	C.Difficile	MRSA
Number of infections this month	1	0
Number of infections last month	5	0
Improvement target for year to-date	35	0
Actual to-date	7	0

There is a mandatory requirement for all NHS acute trusts to report Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia. There is no target set as this is for information only. NGH have not had a post MSSA bacteraemia since December 2013.

Carbapenemase-producing Enterobacteriaceae (CPE) - The action plan produced for the early detection, management and control of Carbapenemase-producing Enterobacteriaceae (CPE) was submitted to the Trust Development Authority (TDA). This shows the progress and gives assurance that the Trust has responded to the national guidance that asked for a plan in the management of CPE. A presentation regarding CPE will be presented at the August Integrated Healthcare Governance Committee meeting to update members.

7. Falls Prevention

During June we reported 3 falls that caused at least 'moderate' harm. There is one additional fall which is currently under investigation.

Severity	Number of falls
Moderate	2
Severe	1
Death	0

8. Nutritional Update

8.1 Fasting guidelines

The pre-elective fasting guidelines have been revised and ratified by the Trust guideline group, and are now available on the intranet.

8.2 Malnutrition Universal Scale Tool (MUST) Training

MUST Training has continued by the Dieticians & the Practice Development Team. Information folders have now been distributed across all the wards. The roll-out of MUST on Vital Pac is planned in the autumn.

8.3 Weigh Day Wednesday

All in-patients across the trust are now weighed on a Wednesday. This commenced in May 2014 and a week on week improvement of compliance can be seen, we are now 98% compliant.

8.4 Protected Mealtimes

An analysis of the QuEST data has revealed non-compliance in regard to drug rounds and doctor's rounds taking place during the mealtime period. A plan has been devised to work with 2 wards over a 2 week period, commencing 14 July to find ways to address these issues. The ward team will be involved with identifying ward specific issues and finding ways to resolve them. QuEST data can then be reviewed in August to see if improvement is sustained, and if so, the programme continued on other wards.

9. Friends & Family Test

In June In-patient adult wards achieve a response rate of 34.4% against a target of 25%. Maternity services achieved 36.9% against 20% target, and Paediatrics achieved 53.6% against a target 25%. This month A&E has improved to achieve 18.5% against a 15% target. The only areas not to achieve the target this month were the Day Case Units who scored 19.27% against a target of 25%, the care group has been informed and implemented an improvement plan.

All areas achieved their internal Net Promoter Score the in patients adult wards have improved from 57 last month to 65 this month. Over all for this quarter CQUIN was achieved.

10. Patient Safety Academy - Flagship Ward

The second Patient Safety Academy campaign has now launched. This is an exciting opportunity for a ward to be supported and developed to be a 'Flagship ward'. The four focused treatments will be around environment; communication; patient care and patient experience. The phases will include:

- Expression of interest – time for wards to discuss the concept with the Academy Manager and gain the necessary support from their team and named Consultant
- Application – wards that apply will be required to come and informally present why their ward should be chosen
- Observation phase – this will involve the Academy leads observing the ward to see how it works and reformulate the treatment plan as required
- Formulate a working group which will consist of the Academy leads & Manager & members of the ward team. This group will meet regularly to review the treatments throughout the campaign
- Make required ergonomic changes to the environment & commence the project

Regular updates will be provided through this report.

11. Update on Care for the Dying Patient

In March 2014 the Leadership Alliance published its interim statement confirming that there will be no national replacement of the Liverpool Care Pathway (LCP). Since then the Trust has been working on an extensive programme to ensure that the care that our dying patients receive reflect the 5 key priorities that form the basis of support as recommended by the Alliance.

The Trust has set up a Care for the Dying Steering Group which is a multi-professional group that have developed a detailed action plan to ensure the Trust is prepared for the removal of the LCP.

Part of the on-going work of the Group has been:

- The development of a multi-disciplinary individualised care plan for patients who are dying (and families) which reflects the 5 key priorities, with a pilot on two of our wards. There are two documents that include the assessment of the patients and the on-going daily evaluation of care
- The provision of teaching session since June 2014 including individual, group & 'drop-in' sessions and 'Train the Trainer'
- The updating of staff through presentations to many multi-professional forums across the Trust over the last 6 weeks including the End of Life Steering group, Trust Board (Public), Patient Safety Board.
- The implementation of a Communications Plan – including screen savers, Trust bullet-in and email updates
- The development of an audit tool used for the national Care of the Dying Audit that reflects the recent changes which will be used for future audits.

By July, in accordance with national guidance, the LCP will no longer be used within the Trust. The Steering group will continue to ensure that the implementations of the agreed actions are completed.

12 Safeguarding Update

12.1 Serious Case Review (SCR) Action Plans

A number of serious case reviews have been contributed to over the past year, of those that are published, there are minimal outstanding recommendations; of those that are awaiting publication, actions are ongoing but within timescales. The recommendation with most significant risk attached related to the apparent lack of seamless provision, and relative parity between acute providers, of skeletal survey for children with suspected non-accidental injury out of hours. This has generated significant professional, clinical and operational discussion and it was soon identified that the proposed recommendation from the SCR required a more sophisticated

solution than had originally been envisaged. This issue is being actively managed and taken forward by senior clinicians, in partnership with the wider health economy.

13. Midwifery Update

13.1 Barratt Birth Centre

Since the opening of the birth centre on 2 December 2013, women who are assessed as having low risk pregnancy have the choice of using the Birth Centre. The number of women using the Birth Centre to birth their babies is 352. The births over the past 3 months are shown in Table 1. The annual projection for 2014 is 700 births; the aim is for the Birth Centre to birth 1,000 women annually. Following recruitment, the projection is for the midwifery establishment to be achieved by September 2014. From a patient experience perspective, the Birth Centre has given women more choice and women who have birthed are reported as having a positive birth experience and this is captured in their feedback. The FFT net promoter scores for the Birth Centre are consistently high at 94 -100%

13.2 Caesarean Sections

Work continues to monitor the caesarean sections performed at NGH. Initiatives such as Birth after Caesarean (BAC) clinic and the development of the Birth Centre have supported a reduction in the overall caesarean section rate; however, this is not being sustained month on month. The emergency caesarean sections have shown a slight increase and the obstetric Team are auditing the reasons and timings of decisions; the report is being presented at the Obstetric Governance Group meeting in September. The target on the dash board is <25%, Red rated at >26%.

Table 1 - Caesarean Section rates

	April	May	June
Total %	27	27.9	25.8
Emerg CS %	16.4	14.2	14.2
Elec. CS %	10.9	13.7	11.6

The Maternity Governance Group will continue to monitor progress on a monthly basis. Audit of compliance to NICE guidelines will continue on a quarterly basis.

14. Recommendations

The Trust Board is asked to note the content of the report, support the mitigating actions required to address the risks presented and continue to provide appropriate challenge.

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 July 2014**

Title of the Report	**Hard Truths Commitments and Nurse Staffing Review Update**
Agenda item	10
Sponsoring Director	Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Fiona Barnes, Deputy Director of Nursing Kate Terrell-Gray, Support Analyst
Purpose	The purpose of this paper is to update the Trust Board on the monthly Hard Truth Commitment data and recent skill review of the general wards and specialist areas.

Executive summary

This report provides a summary of the Hard Truths data for the month of June that will be prepared for publication on the Trusts website. The results of the monthly data collection exercise illustrated that 54% of wards (14) were staffed at equal or over 90% of their funded establishment across day and night shifts for their registered and support staff groups during June 2014; this is against May ward staffing data of 58% of wards (15) were staffed at equal or over 90%.

Latterly the report updates the Trust Board on the second year of the Nurse Staffing Strategy investment, as agreed by Trust Board In April 2014. A total of 61.27wte registered nurses and 35.9wte un registered staff have been approved.

As part of the agreed Nurse Staffing Strategy a bi-annual skill mix on the general wards and a staffing review on the Specialist areas should be undertaken. This is part of the capacity & capability review and is an expectation of NHS England & CQC 'Hard Truths Commitment' This report provides a comparison between established staffing figures and recommended figures following the audit.
In summary when comparing the Trusts ward establishment against the Safer Nursing Care Tool (SNCT) the findings suggest that the Trust has an under establishment in the registered workforce by 19.8 wte, and an over establishment of the unregistered workforce by 33.5 wte. Consideration is given to the next stage of the review findings.

An overview of the recruitment plans is provided and the Director of Nursings' approach to workforce development.

The SNCT will be repeated in September and will be compared with professional judgement of the ward sisters as part of the annual budget setting process with the Director of Finance and the Director of Nursing.

Related strategic aim and corporate objective	Strategic Aim 1: Focus on Quality and Safety. To be an organisation focused on quality outcomes, effectiveness and safety.

Risk and assurance	The report aims to provide assurance to the Trust regarding the recent Nurse Staffing Review
Related Board Assurance Framework entries	BAF 4 and 6
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? N Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? N
Legal implications / regulatory requirements	Compliance with 'Hard Truths Commitment'

Actions required by the Trust Board

The Board is asked to:

- Support the continued reporting of the Hard Truths data on the Trust website & NHS Choices website
- Note that the Director of Nursing and senior team have reviewed the SNCT findings and will review the use of 'Specials' as part of the overall 'Temporary Staffing Review'
- Note that a further SNCT audit in September is planned which will include the Confirm & Challenge meeting with the Ward Sisters, Director of Nursing & Director of Finance ready for November budget setting.
- Support the on-going recruitment of the increased establishment that the Trust Board supported in April 2014.
- Support the Workforce Development work streams lead by the Director of Nursing.

Public Trust Board
31 July 2014

Hard Truths Commitments and Nurse Staffing Review Update

1. Introduction
On a monthly basis the Trust will submit the staffing levels for the 'Hard Truths commitment' as part of the NHS England and CQC expectations. This report will provide a summary of the data submitted for June and the data presented on the trust website (appendix 1). Latterly the report provides a summary of the Nurse Staffing Review and the findings of the audit undertaken appendix 2.

2. Body of the Report
The results of the monthly 'Hard Truths' data collection exercise illustrated that 54% of wards (14) were staffed at equal or over 90% of their funded establishment across day and night shifts for their registered and support staff groups during June 2014; this is against May ward staffing data of 58% of wards (15) were staffed at equal or over 90%.

27% of wards (7) had one shift type under established for one grade type i.e. either registered or support staff, not both. 15% of wards (4) had 2 shortfalls on 2 shifts for either registered or support staff, with only 1 ward showing shortfalls on all shifts for its support workers (ITU is discussed within section 2.2)
Two wards had a staffing shortfall for one shift type for both registered and support staff – Maternity unit (late shift / registered midwife plus night shift shortfall for both midwives and support workers) and Rowan (late shift shortfall / Registered Nurse (RN`s) plus night shift shortfall / Healthcare Assistants (HCAs)).

Supernumerary nursing staff included EU and trainee nurses awaiting Professional Identification Numbers (PINs). Many wards had supernumerary staff working between 1 and 3 days in June. Hawthorn, Abington and Willow employed supernumerary staff for 13 to 17 days of the month. Supernumerary status is currently excluded from the Hard Truths staffing data.

2.1 Wards – over establishment in June
Across inpatient areas there was consistent use of additional HCAs to fulfil a number of roles including specialling vulnerable patients, escalation area resourcing and supporting growth in patient acuity and dependency.

Day shifts
Wards showing over 150% established HCA staffing included Althorp, Dryden, Spencer (all escalation areas in addition to specialling requirements), Allebone, EAU, Finedon (primarily specials to support complex patients with increased dependency) and Head & Neck (in-ward Treatment Room staffing).

There was an average Trust wide rise in day shift HCA staffing of approximately 11% from May to June 2014.

Night shifts
HCA establishment for night shifts increased to 150% and 263% for 7 medical wards; Allebone (215%), Compton (170%), Dryden (237%), Finedon (167%), Holcot (162%), Talbot Butler (158%), Victoria (263%), plus 2 surgical wards; Althorp (234%) and Spencer (190%). It should be noted that Dryden, Althorp and Spencer wards were the requesting wards for escalation areas and that 6 out of the 9 wards shown have a night shift establishment of just 1 HCA, hence any staffing uplift elevates the figures substantially and disproportionally.

There was an average Trust wide increase in night shift staffing (HCA) of approximately 12% from May to June 2014.

6 wards employed RNs over establishment
at night.

2.2 Wards – Support Staffing: shortfalls in June
Staffing shortfalls recorded fewer than 90% affected RNs rather than HCAs. Total average RN day shift staffing (early plus late shifts combined) remained virtually static from May to June 2014.

Generally, staffing shortfalls were a consequence of outstanding established vacancies and short term sickness which were requested from bank / agency but which remained unfilled.

In these instances, Matrons and Ward Sisters collaborate to maintain safe staffing levels by implementing internal staff re-assignments. Currently substantive staff re-assignment is not captured on the Health roster system as staff are 'borrowed' for a shift.

A Risk Assessment for staff reassignment has been introduced and is planned to be reviewed and refined in August.

Notably, for combined day shifts, 8 wards showed between 83% and 89% under establishment for RN/RMs as opposed to 4 wards in May.

Midwifery staffing for both midwives and MSWs, illustrated slightly lower levels than in May with a 6% decrease in midwives but 5.5% increase in support workers over day shifts.

The combined maternity workforce move flexibly accordingly to patient acuity and activity. During June, Maternity staff had an unpredictable rise in short term sickness during June, coupled with unfilled established vacancies – recruitment is in progress.

Talbot Butler showed a shortfall of RNs with staffing levels for day and night shifts showing at 83-4%. This resulted predominantly from unfilled bank/agency requests to cover established vacancies and unpredictable short term and long term sick leave. Extensive recruitment is underway.

ITU showed a decrease of 26% in its HCAs on combined day shifts with a 63% staffing level for June. However, the ITU HCA establishment is 2, and a decrease to 1 HCA across 47% of shifts may be balanced by fewer patient beds and RN levels.

2.3 Shift Staffing in June – Overview

EARLY	RN: Across the month, 81% of the funded established RN staff levels were either achieved or above establishment on the early shift (21 out of 26 inpatient areas). 4 wards worked between 84% and 87%. One outlier, Talbot Butler worked on average at 75% establishment due to: • 30 requests for staff to cover established vacancies, of which 13 remained unfilled. • 5 requests for long term sick leave cover, of which 3 were unfilled. • 11 requests for short term sick leave cover of which 6 were unfilled. HCA / SUPPORT: Across the month, 92% of support staff (HCA & MSW) established levels were either achieved or above establishment on the early shift (24 out of 26 inpatient areas). There was one outlier; ITU achieved 65% staff established levels due to 13 unfilled bank/agency requests including cover for established vacancies, internal ward staff shift changes. HCA recruitment is now complete and staff start work in July.

LATE	RN: Across the month, 58% (15 out of 26 inpatient areas) of the funded established RN staff levels were above 93% or over. The remaining 11 wards were staffed at an average fill of 85%, with no wards falling below 80% staffing. HCA / SUPPORT: Across the month, 92% of support staff (HCA & MSW) established levels were either achieved or above establishment on the late shift (24 out of 26 inpatient areas). There was one outlier; ITU achieved 60% staff established levels due in part to unfilled bank/agency requests including cover for established vacancies, internal ward staff changes. HCA recruitment is now complete and staff start work in July.
NIGHT	RN: Across the month, 92% of the funded established RN staff levels were over 90% establishment on the night shift (24 out of 26 inpatient areas). Talbot Butler worked at 83% of establishment due to 22 unfilled bank/agency requests relating to escalation area and long term sick leave cover. The combined maternity unit worked at 84% of establishment due in part to short term sickness and internal staff shift changes. HCA / SUPPORT: Across the month, 88% of support staff (HCA & MSW) established levels were either achieved or above establishment on the late shift (23 out of 26 inpatient areas). 3 ward areas worked at between 83% and 88% of their establishment – ITU, the combined maternity unit and Rowan, all due to unfilled bank/agency requests short term sickness, internal staff shift changes plus HCA and MSW established vacancies. Recruitment is in progress on Rowan and the maternity unit. ITU have successfully recruited with new support staff planned to commence in July.

3. Assessment of Risk

Full engagement form the Ward Sisters to update Health-roster is fundamental to the accuracy and process for the Hard Truths data collection, which continues to be a focus.
To reduce the risk of inaccuracy and to reduce the extensive 'labour intensive' nature of the current process the Trust is reviewing a software staffing that links with the Health roster system and will allow daily management of staffing levels based on acuity & dependency needs across the Trust. The Trust is planning to pilot the tool with 3 wards to fully understand the benefits and functionality.

3.1 Next Steps

Next Steps / July	Status
1) Engage staff & encourage accurate, timely data entry in Healthroster (Workforce)	Workforce has been communicating with ward sisters although no significant change in staff data entry behaviour has been noted yet. Ongoing / work in progress
2) Organise demonstration of Safe Care staffing bolt-on to Healthroster and develop pilot project (Nursing management team)	Demonstration held on Friday 11 July Pilot project development TBA
3) Bank and agency Confirm and Challenge meetings with Ward Managers	Commence in July DoN and Finance
4) Commence Ward Sister leadership programme in July	Cohort 1 & 2 in progress, cohort 3 & 4 due to start in August
5) Bank and Agency workshops	In progress DoN and HR
6) Review Workforce plans and broaden current recruitment programme Ward managers to recruit and manage ward vacancies	In progress with DoN and HR

Next Steps / July	Status
7) Review extra support for overseas nurses recently recruited to NGH	In progress with DoN

3.2 Next Steps for August
Reporting
Prepare ward staffing data for NHSE August return and continue to refine the interim data collection, analysis and reporting tool to enable NGH to broaden the scope of the report to include ward administrators and supernumerary staff.

Health roster / Staffing Systems

- Ward Sisters – engagement with monthly staff data entry – continue communication and education, including adherence to standard Trust process.
- Safe Care Module –identify pilot project wards & shape pilot project.
- Health roster refinement / system development: Investigate whether the system can accommodate internal staff re-assignments and long day shift recording. Discuss potential for data cleansing exercise as a pre-cursor to Safe Care implementation.

3.3 Workforce Recruitment
To improve the staffing establishment the recruitment of staff, both registered and unregistered, is fundamental to improving the quality of the patients experience, improve the staffing morale on the wards and to reduce the financial expenditure on the temporary workforce.

Working closely with the HR and Finance teams the Bank & Agency group are working on:

- A Marketing strategy: this incorporates the proactive planning of attendance at events, conferences, Job fairs, to recruit relevant staff
- A Recruitment Campaign: radio campaigns and consideration for overseas recruitment.
- The Recruitment pipeline: provides the up-to-date information for the Lead Nurses & matrons with the recruitment 'process'
- Local recruitment ownership: Ward Sisters more involved and accountable for the staff they recruit. This will involve developing shared working between HR and the Ward Sister.

4. Nurse Staffing Review

4.1 Introduction
In 2012 the Trust agreed the Nurse Staffing Strategy, which is a four year strategy, to improve the nurse staffing levels across the Trust. As part of that strategy, and in line with national guidance, a bi-annual review of the nursing skill mix using an appropriate methodology and tool a skill mix review should be undertaken.

In April & May of 2014 the Trust undertook a skill mix review across the general wards using the Safer Nursing Care Tool (SNCT). The key findings of this audit are presented with recommendations.

The report also updates the Board on staffing reviews undertaken within Specialty services and the investment supported by the Trust in the second year of the Nurse Staffing Strategy.

4.2 Background
In line with the recommendations from the 'Francis Report' Independent Inquiry into the care provided by Mid Staffordshire NHS FT the Trust has reviewed its nurse staffing capacity during that past 3 years. More recently the NSH England & CQC paper 'Hard Truths Commitment' has clear expectations for organisations to undertake a six monthly review of staffing capacity.

4.3 Nurse Staffing Strategy
In year two of the strategy additional funding was agreed to commence in April 2014. A total of 61.27wte registered nurses and 35.9wte unregistered support staff was funded (see appendix 2).

4.4 Nursing Review Methodology
The Royal College of Nursing (RCN) policy on evidence-based nurse staffing levels (December 2010) recommends that any staffing review is systematic, has staff involvement and is triangulated with benchmark data from other comparators and is led by professional judgement.

The RCN also recommends adequate 'up-lift' within the establishment budget. The up-lift' refers to the percentage of the budget that is required to cover annual, sickness, study leave. Across the Trust the wards uplift is 22%, the RCN recommend an uplift of 25%.

The skill mix of a ward establishment refers to the number of registered nurses to unregistered nurses. It is often presented as a percentage i.e. 70:30% this suggests that 70% of the establishment are registered nurses and 30% are unregister. The RCN benchmark on general hospital wards is 65:35%.

In April & May 2014 the Trust undertook an audit of the skill mix across the general wards. The tool used for the review was the Safer Nursing care Tool (SNCT). This tool has been modified over the last year as a number of national bodies (National Institute of Clinical Excellence – NICE) have started to review the evidence based tools available in this country to measure the skill mix within a ward, department and community services.

On a daily basis Ward Sisters were asked to review the acuity & dependency of their patients and record their 'level' of care required. Validation by the Lead Nurses and Deputy Director of Nursing took place, where possible, on a daily basis.

5. Presentation of Findings

The findings of the SNCT audit are presented in a summary table appendix 3. It should be noted that our 'Specialist wards' have not undertaken an audit due to the limitations of the SNCT but have undertaken a local review of their own staffing against speciality national guidance/best practice, which is presented in section 6.

The summary table presents the funded establishment for 2014/15 (including the up-lift from the second year of the Nurse Staffing review) the SNCT recommended establishment and the difference between the two. Both data sets are presented as numbers of qualified and unqualified staff. The Trusts current establishment supports the Ward Sister role working 2 days 'clinically' and 3 days 'supervisory' and a coordinator on the 'early shift', which has been included in the SNCT data.

For some wards the funded establishment includes additional clinic, for example on Beckett ward there are additional registered nurses & HCA's to support the Chest Clinic. Therefore this has been added to the SNCT to ensure there is an equitable comparison.

5.1 Key / Analysis of Findings
For 14 of the 22 wards the Trust established registered workforce is below the SNCT suggested establishment signifying a number of the wards are under established. However, for unregistered staff (HCA) the SNCT is suggesting that the wards are above establishment and therefore over established. Further comments on each ward are in appendix 3.

The SNCT findings suggest that the current budget establishment of Registered Nurses is under established by 19.5 wte. This could be for a number of reasons. Over recent years the Trust has undertaken a variety of skill mix reviews it has been noted that many of the wards have a low skill mix, i.e. ratio of registered nurses to unregistered staff. The RCN recommends 65RN:35HCA, however in some specialities it is recognised that a higher ratio of

registered nurses is required, i.e. Becket Ward (respiratory Medicine), and in other areas, Elderly Care a skill mix of 60:40 is acceptable if the numbers of staff to patients is 1:8.

Consideration needs to be given that the acuity & dependency of the wards has increased yet staff, tend to increase their unregistered workforce as part of their budget setting process rather than registered staff. Through the skill mix reviews there has been an increase in ratio of registered nurses but on some wards this is still below guidelines.

The wards endeavour to identify a co-ordinator on the ward on the early shift to facilitate the smooth running of the ward and this has historically been part of the budget. This role does not take a patient workload due to the increased nature of the role which is covering the ward rounds, breaks, supporting with acute patients, liaising with discharge teams, Bed Management and ensuring patient care is optimised. However, this reduces the number of registered staff available to provide and implement 'hands-on care', and proactively manage the patients pathway. Therefore this may also affect the number of registered staff required.

The SNCT findings suggest that the current budget establishment for unregistered staff is over established by 33.5wte. It is recognised that there continues to be a reliance on 'Specials' across the wards. ('Specials / Specialling' refers to the use of a HCA to provide additional supervision and care to a patient who due to chronic or acute clinical condition is at risk of falling or has increased confusion or dementia and is unsafe to be left unsupervised.) This is potentially because the acuity and dependency has increased over the years, also the availability of unregistered staff make it easier to recruit than registered nurses.

Previous skill mix models have identified that there is a national increase in the number of unregistered staff used to 'special' a patient. However, within the SNCT there is currently no identified provision, this should have been considered as part of the patients 'dependency' score on a daily basis. Having reviewed the individual ward 'score sheets' this was not consistently monitored throughout the recording period. The use of 'Specials' is part of a focused piece of work for the B&A group. The work will include understanding the implementation of the recent national guidance on Deprivation of Liberty within an acute Trust setting, review of the Trust Enhanced Observations of Care policy, risk assessment and the Trusts current restraint and Ligature guidelines. This work is due to be completed within 4 months.

It should also be noted that the SNCT will be updated in the pending months as part of the NICE guidance that is shortly due for publication, hopefully in time for the repeat skill mix review planned for September.

As part of the national discussion regarding the SNCT it is also recognised that the SNCT is not always appropriated for smaller wards (below 18 beds) due to the need for a minimum of two staff on each shift. Of particular note is Eleanor, Spencer & Head & Neck.

General Medicine
Most of the medical wards are showing below the suggested SNCT establishment for registered staff, in particular, Brampton, Compton and Victoria Ward. It is noted that the acuity and nature of the patients on Compton & Victoria has changed over the year so this will be reviewed as part of the next skill mix review. The SNCT suggests that Dryden is over established which would not be supported by the senior nursing team as the ward has a varied number of CCU beds, sometimes requiring increase ratio of registered staff to care for cardiac patients in side rooms.

Benham as an assessment unit is particularly below the SNCT establishment for both registered and unregistered staff.

General Surgery
Rowan is currently establishment for 6 level 1 beds but only open to 3 level 1 beds and isn't fully recruited so there is a rationale for the difference between the trust and SNCT establishments. Head & Neck is showing an over establishment which to some extent can be due to the small ward (14 beds) but also during the period of monitoring there were less level 1 patient that the ward is currently budgeted for.

The SNCT is suggesting that number of the surgical wards are over established with unregistered staff, however, on a daily basis most fo these wards have more than half their patients requiring basic nursing care to wash, dress and feed which is provided by unregistered staff.

Oncology Services
Talbot Butler is showing under establishment on unregistered staff which reflects the complex dependency of the patient group.

6. Specialist Services

Accident & Emergency
As part of this year's Nurse Staffing Strategy A&E have increased their budget to national guidance and their recruitment will focus on paediatric training staff. No further review is required until budget setting.

Finedon
In 2010 the Renal Association updated their guidelines for nurse to bed ratios. The ward increased it establishment in accordance to the 1.4wte/bed ratio. Currently the Unit is 1.6/bed with a skill mix of 74%:26%. Over the last year the dialysis service/activity has changed and is now 7 days a week. Therefore staffing will be reviewed to reflect the increase in activity. The proposal is to develop high dependency beds on Finedon over the next 2-3 years and the guidelines will be used as part of the business case

Critical Care Units (Intensive Care & High Dependency Unit)
ITU & HDU have increased their establishment in line with national guidance from the Intensive Care Society as part of the Nursing Strategy. The recommendation is 1:1 ratio for level 3 patients and 1:2 for level 2 patients, registered nurses. The increased establishment will support the co-ordinator role which is recommended. The recruitment for these posts is currently in progress.

Childrens' Services
It is anticipated that a full nursing and skills review will be undertaken in 2015 following any decision regarding the community tender and any design changes within the ward areas regarding defined age group areas or pathway considerations.

Maternity Services
Birth-rate Plus (BR+) is a Midwifery Workforce Planning system based upon the principles of providing one to one care during labour and delivery to all women with additional midwife hours for women in the higher clinical needs categories. The 2008 NICE guidance for antenatal care led to a change in midwifery workload and this had been reflected in the staffing profile for BR+ nationally. As a result the national ratio of 28 births per wte midwife was recommended and a ratio of 35 births per wte midwife for home births.
Currently within the midwifery Service we have the following ratios:

Midwife: Birth ratio 1:28
Midwife : Birth ratio (excluding specialist midwives) 1:30

Supervisor of Midwives (SoM) ratio: 1:21 (target is 1:15 with an aim to reach 1:12)
The ratio has increased within the service due to midwives leaving the role due to retirement or needing a break and choosing to cease their SoM role. Succession planning is in place involving the training of new recruits, these are Midwives working for the Trust who are nominated by their peers to become SoM. They undertake the training following a robust interview and once qualified (6 month course) they apply to the LSA for appointment as a SoM. The Trust is currently supporting 3 midwives to undertake training in 2014/15.

July 2014 – 2 midwives are awaiting appointment – 1:17
March 2015 - 2 midwives will qualify – 1:15
July 2015 – 1 midwife will qualify – 1:14

7. Summary of the Nurse Staffing Review
When undertaking a staffing review using the SNCT there are still some anomalies against our current establishment. However, the professional judgement of the senior nursing team would not, in general, want to alter the current establishment. For those areas where there appears to be significant under/over establishment further review will be required.

It is proposed that another review will be undertaken in September of this year. As part of the September review there will be a Confirm & Challenge meeting with the Director of Nursing, Director of Finance, Ward Sister, Matron and Lead Nurse to review the findings from the SNCT. Part of this meeting will also include the professional judgement of the Ward Sister which collectively will form part of the Budget setting process for 2015/16.

8. Quality Standards & Staffing Skill Mix
It is clearly recognised that having the correct skill mix for a ward, department or unit is fundamental to improving the patient's safety, quality of experience and outcome for the patient. As part of this skill mix review seven quality metrics have been compared with the staffing levels from the month of May 2014 (appendix 3). The Quality standards are the summative QuEST data and the Harm Free care is from the Safety Thermometer data. There is some correlation between the under establishment of registered nurses and reduced outcomes for patients (Benham, Brampton, Compton, Knightley and Victoria). However, the senior nursing staff recognise that this is a 'snap-shot' and needs to be considered against previous N&M Quality dashboard and professional judgement before changes to the establishment are recommended.

9. Next Steps
To complement the Hard Truths Commitment, Nurse Staffing Review, and Recruitment Campaign the Director of Nursing is leading a number of fundamental changes to workforce development across the nursing & midwifery teams.

- Bank & Agency Group – this is now lead by the Director of Nursing with support from Assistant Director of Finance and senior HR leads. The group will be concentrating on the recruitment of staff and reducing the use of temporary staff, in partiuclar Agency staff.
- Set up a 'Specials' bank of HCA's who have the relevant training and skills to care for those patients who require 1:1 care. Part of this initiative will include the consideration of using mental health trained staff who may be able to 'special' more than one patient at a time due to their skill set.
- Performance Meetings – the Director of Nursing is leading 1:1 meetings with the 15 ward Sisters/Charge nurses whose current ward expenditure is over budget. These meetings will be supported by the Finance team. Each Sister/Charge Nurse will have a financial trajectory to achieve in a given time frame with regular meetings to review progress.
- Back to Basics – Band 7 Development programme. All band 7 (Ward Sisters/Charge Nurses) have to attend a four day development programme focusing on the fundamental aspects of their role. The programme is providing clear expectations, roles, responsibilities and accountability of the Sister/Charge Nurse role.

- Back to Basics Review Meetings– The Director of Nursing with the Deputy Director of Nursing will be holding a weekly meeting to challenge the Sisters & Charge Nurses on Quality Metrics. KPI will be set for the individuals to ahcieve in a planned time frame.

Updates on the progress of these work streams will be presented as part of future Board papers but it is believed that a firm but fair approach to managing performance is required by the senior nursing & midwifery team.

10. Recommendations

The Board is asked to:

- Support the continued reporting of the Hard Truths data on the Trust website & NHS Choices website
- Note that the Director of Nursing and senior team have reviewed the SNCT findings and will review the use of 'Specials' as part of the overall 'Temporary Staffing Review'
- Note that a further SNCT audit in September is planned which will include the Confirm & Challenge meeting with the Ward Sisters, Director of Nursing & Director of Finance ready for November budget setting.
- Support the on-going recruitment of the increased establishment that the Trust Board supported in April 2014.
- Support the Workforce Development work streams lead by the Director of Nursing.

ABINGTON WARD: Trauma & Orthopaedics / Neck of Femur

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	5	4	3
Support Planned Staff	4	4	3

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇩	⇩
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Numbers slightly under establishment (90%+ for day and night). Supernumerary nurses worked approximately half the month in addition to staff recorded below - they await their professional PIN numbers. Other factors included assignment to escalation areas and staff vacancies.
HCA: Numbers over establishment especially at night due to additional specials deployed to care for complex patients with increased dependency / clinical needs / cognitive impairment.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	4	3	5	3	2	5	4	3	5	4	3	4	3	3	5	4	4	6	3	3	5	4	2	5	3	2	5	4	3
HCA	4	4	4	4	4	4	4	4	4	4	3	5	4	3	4	4	3	3	4	4	3	5	3	2	4	4	4	3	4	5

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	4	2	5	3	2	4	3	3	5	4	3	4	4	3	4	3	3	4	4	3	5	4	2	5	4	2	5	3	2
HCA	4	4	4	5	4	5	5	4	5	5	5	5	4	4	4	4	5	4	5	5	4	4	4	5	4	5	6	5	5	6

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	3	2	4	4	3	5	4	3	4	4	3	4	3	3	5	2	3	4	3	3	4	4	3	3	4	3	6	3	3
HCA	5	4	5	5	4	5	5	5	5	6	5	5	5	7	4	5	6	4	6	4	4	6	3	5	6	6	6	6	5	4

ALLEBONE WARD: Acute Medicine

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	5	4	3
Support Planned Staff	3	3	2

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇧	⇧
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Numbers over establishment (104%+ for day and night). More nurses deployed to care for complex patients with increased dependency / clinical needs / cognitive impairment.
HCA: Numbers considerably over establishment especially at night due to additional specials deployed to care for complex patients with increased dependency / clinical needs / cognitive impairment.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	4	3	6	5	3	6	4	3	4	5	3	5	6	3	6	4	4	4	4	4	4	5	3	5	3	4	5	6	4
HCA	3	4	4	4	6	4	4	5	3	6	5	3	5	5	4	6	5	2	7	5	5	5	3	3	4	5	3	5	3	4

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	6	3	4	5	4	4	6	4	4	4	4	3	6	4	3	5	5	3	4	6	3	6	4	3	6	4	4	4	3	3
HCA	5	5	4	5	5	4	4	5	5	5	4	5	6	5	5	5	5	4	4	5	4	6	6	5	6	5	5	6	4	5

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	6	3	3	5	4	2	5	4	3	3	5	3	5	4	4	6	4	2	5	5	4	4	4	5	5	4	5	5	5	2
HCA	5	4	5	5	5	6	7	3	3	5	5	4	5	6	4	4	6	5	6	5	5	6	7	6	5	5	4	5	3	6

ALTHORP WARD: Elective Trauma & Orthopaedics

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	3	2	2
RGN W'end	2	2	2
Support Planned Staff	3	2	1
Support W'end	2	1	1

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇧	⇧
	HCA	⇩	⇧

JUNE - STAFFING OVERVIEW:

RGN + HCA: Althorp is used as the 'requesting ward' for an escalation area which opened in response to a growth in inpatients. This equates to approximately 1additional RGN +1 HCA at night.
HCA: Daytime numbers were down due to a mix of re-assignment to another ward on request. Additional specials were required to care for complex patients with increased dependency / cognitive impairment at night.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	2	2	2	4	2	2	4	2	2	4	3	2	4	2	2	4	3	2	3	2	2	2	2	3	4	3	3	3	2	3
HCA	3	1	1	3	2	2	3	3	1	3	3	2	3	3	2	3	2	1	2	1	2	2	1	2	2	2	3	2	1	3

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	3	3	4	3	3	4	3	2	2	2	2	3	2	2	4	2	2	5	2	2	3	3	2	3	3	4	3	3	4
HCA	2	1	3	2	2	3	2	1	2	1	1	0	1	1	1	1	3	2	1	3	2	3	2	2	1	1	3	1	0	2

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	2	1	3	3	3	3	3	3	3	3	3	3	4	3	4	3	3	2	3	3	2	3	3	3	2	3	2	4	3	3
HCA	3	3	2	3	1	1	2	2	2	1	3	2	2	1	2	2	2	3	1	1	2	0	2	1	2	1	0	2	3	1

BECKET WARD: Respiratory + Level 1 (more acutely unwell patients)

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	6	5	4
RGN W'end	5	4	4
Support Planned Staff	4	4	2

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇩	⇩
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Numbers slightly down due to unpredictable sickness - if there are fewer Level 1 patients the nursing team can work below establishment if they assess their patients' acuity plus the nursing team's skill mix then confirm that they are working at a greed safe levels.
HCA: Day and night numbers rose due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	5	3	6	5	3	5	4	4	6	6	4	5	3	4	5	2	4	4	4	4	5	4	4	6	4	4	6	4	4
HCA	5	4	2	3	3	3	4	4	3	4	2	2	7	4	3	5	5	4	4	4	4	4	4	2	5	5	2	4	4	2

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	5	4	5	3	4	6	4	4	4	2	4	4	4	4	6	4	4	4	4	4	6	4	4	7	4	5	5	4	4
HCA	4	4	2	5	5	2	4	4	3	6	6	3	4	4	2	4	4	3	6	4	3	5	4	2	4	4	2	4	4	3

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	4	3	4	5	3	5	4	3	6	4	3	5	4	4	6	5	4	6	4	3	4	4	3	5	4	3	6	5	5
HCA	3	3	3	4	4	3	3	4	4	4	4	2	4	4	2	4	4	3	4	4	4	5	5	4	5	5	4	5	5	4

BENHAM WARD: Male Assessment Unit

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	5	5	4
Support Planned Staff	2	2	2

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇩	⇧
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers slightly down due to unpredictable sick/carer leave + uncovered vacancy. Night numbers up slightly due to complex patients with increased dependency / clinical needs.
HCA: Additional specials were deployed to care for complex patients with increased dependency / cognitive impairment at night.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	5	4	4	5	4	4	5	4	5	5	5	5	5	4	5	5	4	4	5	5	5	5	3	5	5	4	5	5	4
HCA	3	3	2	2	2	2	2	2	3	3	2	4	1	3	4	3	3	2	2	2	3	3	2	3	3	2	2	2	2	4

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	5	3	5	5	5	5	5	4	5	5	4	4	4	4	4	4	4	5	5	4	4	4	5	5	5	4	4	4	5
HCA	3	3	3	3	2	3	2	2	3	4	2	3	4	2	2	2	3	2	2	2	4	2	3	3	3	4	4	4	2	3

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	4	6	5	5	4	5	4	4	5	4	4	5	4	4	4	5	4	5	4	4	4	5	4	4	5	4	4	3	5
HCA	5	2	2	3	1	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2	3	2	2	2

BRAMPTON WARD: Elderly Short Stay

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	4	3	2
Support Planned Staff	3	3	2

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇩	⇧
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers just under establishment (97%) - slightly down due to unpredictable sick leave.
HCA: Additional specials were deployed to care for complex patients with increased dependency / cognitive impairment, particularly at night.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	3	4	3	4	3	2	4	3	2	4	3	2	4	3	2	4	3	2	3	3	2	3	3	2	4	3	2	4	3	2
HCA	4	4	3	2	3	3	6	5	4	4	5	4	5	4	4	4	4	4	4	4	3	5	4	3	3	3	3	5	3	3

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	3	2	4	3	2	4	3	2	4	3	3	3	3	2	4	3	2	4	3	2	4	3	2	3	3	2	4	3	2
HCA	5	3	4	4	2	4	4	4	4	4	4	2	4	3	2	3	3	3	3	2	2	3	3	3	3	1	3	3	2	3

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	3	3	2	3	3	2	4	3	2	4	3	2	4	3	2	4	3	2	4	3	2	3	3	2	4	3	2	4	3	2
HCA	3	2	3	4	4	2	4	3	2	4	3	2	4	3	2	3	3	2	3	2	3	3	3	3	3	3	2	3	3	2

CEDAR WARD: Trauma & Orthopaedics - Trauma

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	5	4	3
Support Planned Staff	5	4	3

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇩	⇧
	HCA	⇩	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down due to uncovered vacancies, maternity leave + unpredictable carer/sick leave and staff re-assignments to other wards by agreement. Night numbers were just over establishment in response to workload. There were nurses awaiting their professional PINs - they are not counted in the planned staff numbers until they are fully registered.
HCA: Day numbers slightly down due to maternity leave / staff vacancy. Night numbers up due to additional specials required to care for complex patients with increased dependency / cognitive impairment.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	2	2	6	3	3	5	3	4	5	3	3	6	4	3	6	3	4	5	3	3	5	3	3	5	4	3	5	3	4
HCA	5	4	3	4	4	3	5	4	3	5	4	3	3	3	3	4	3	4	4	3	3	3	3	3	5	2	3	4	4	2

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	2	3	4	4	4	5	3	4	3	3	3	3	3	3	5	4	3	5	4	3	5	3	3	5	3	3	5	4	3
HCA	5	5	3	6	3	2	5	5	3	6	4	3	6	4	3	5	3	4	4	5	4	5	4	3	5	4	3	5	4	4

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	3	3	4	3	3	5	4	3	5	3	3	4	4	3	4	4	4	5	1	3	4	3	3	4	3	3	4	4	3
HCA	4	4	4	5	4	4	6	4	3	5	5	3	6	4	3	6	4	3	4	5	3	5	4	3	5	4	3	6	4	3

CHILD HEALTH combined unit - Disney (Oncology), Gosset (Special Care Baby Unit) + Paddington (General Paediatrics)

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	19	18	13
Support Planned Staff	3	3	3

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇧	⇩
	HCA	⇩	⇔

JUNE - STAFFING OVERVIEW:

General note: Wards in the Child Health specialty work together as a combined unit to ensure safe staffing. The unit assesses its wards' requirements on a continuous basis, and deploys its staff between Disney, Gosset and Paddington as patient numbers and acuity levels fluctuate.

RGN: Day numbers up slightly due to workload. RGN night numbers down slightly across the month due to some uncovered, unfilled vacancies.
HCA: Day numbers down due to uncovered, unfilled vacancies and unpredictable sickness.
Recruitment is in progress and new staff are due to start in August 2014.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	13	13	12	21	15	12	22	19	12	22	17	13	22	17	12	23	19	10	14	13	12	15	14	12	25	18	12	22	21	12
HCA	2	1	2	3	3	1	3	3	2	1	2	2	2	2	1	1	2	4	1	1	2	3	3	2	4	4	3	2	2	4

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	27	17	13	24	19	11	20	17	11	16	15	11	18	17	12	25	20	13	25	20	14	24	16	12	24	21	13	20	18	11
HCA	4	4	1	3	3	5	3	3	2	2	2	2	1	1	2	3	3	1	4	4	2	2	2	3	2	2	2	3	3	1

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	17	15	13	17	16	13	25	18	11	26	20	13	25	18	13	23	20	13	21	17	14	17	15	15	17	17	14	24	18	12
HCA	1	1	1	2	2	1	2	2	2	3	3	2	5	5	3	2	2	1	3	3	1	3	3	1	2	2	2	3	3	2

COLLINGTREE WARD: Acute Medicine

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	7	6	4
RGN W'end	5	5	4
Support Planned Staff	5	4	3

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇩	⇩
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Numbers down on some day shifts due to unpredictable sick + carer leave. Numbers on night shifts were 98% of establishment.
HCA: Day and night numbers up - some additional specials deployed across the month to care for complex patients with increased dependency / cognitive impairment.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	4	4	6	4	4	6	4	4	6	5	4	6	5	4	6	5	4	4	3	4	5	5	4	6	4	4	6	4	4
HCA	5	6	3	5	4	3	5	4	3	6	5	3	5	5	3	6	5	3	6	6	3	5	4	4	5	5	3	4	5	4

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	7	6	4	6	4	4	7	6	4	4	5	4	5	4	4	5	5	4	6	5	4	8	6	4	6	4	4	5	5	4
HCA	5	4	3	6	5	3	5	4	3	5	4	4	5	4	4	5	6	4	6	3	4	5	4	5	7	6	5	6	4	3

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	5	4	4	5	4	4	6	5	4	6	5	3	6	4	3	7	6	3	7	6	4	5	5	6	3	4	4	7	6	3
HCA	5	4	4	5	5	5	6	5	3	7	6	5	7	6	5	5	5	5	5	4	4	5	4	4	8	5	4	4	4	5

COMPTON WARD: Medical Rehabilitation

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	3	2	2
Support Planned Staff	2	2	1

ABOVE or BELOW planned	JUNE	DAY	NIGHT
	RGN	⇧	⇩
	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day and night numbers around 2% under/over establishment.
HCA: Day + night numbers up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	01-Jun-14	01-Jun-14	01-Jun-14	02-Jun-14	02-Jun-14	02-Jun-14	03-Jun-14	03-Jun-14	03-Jun-14	04-Jun-14	04-Jun-14	04-Jun-14	05-Jun-14	05-Jun-14	05-Jun-14	06-Jun-14	06-Jun-14	06-Jun-14	07-Jun-14	07-Jun-14	07-Jun-14	08-Jun-14	08-Jun-14	08-Jun-14	09-Jun-14	09-Jun-14	09-Jun-14	10-Jun-14	10-Jun-14	10-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	2	3	2	3	1	2	3	2	2	3	2	2	4	2	2	3	2	2	3	2	2	3	2	2	4	2	2	4	2	2
HCA	2	1	1	2	2	1	2	2	1	2	2	2	2	2	1	2	2	1	3	1	2	2	1	2	4	2	2	3	4	2

DATE	11-Jun-14	11-Jun-14	11-Jun-14	12-Jun-14	12-Jun-14	12-Jun-14	13-Jun-14	13-Jun-14	13-Jun-14	14-Jun-14	14-Jun-14	14-Jun-14	15-Jun-14	15-Jun-14	15-Jun-14	16-Jun-14	16-Jun-14	16-Jun-14	17-Jun-14	17-Jun-14	17-Jun-14	18-Jun-14	18-Jun-14	18-Jun-14	19-Jun-14	19-Jun-14	19-Jun-14	20-Jun-14	20-Jun-14	20-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	4	2	2	3	2	2	4	2	2	2	2	2	3	2	2	4	2	2	3	2	2	3	2	2	3	2	1	4	2	2
HCA	3	2	2	3	1	2	3	3	2	3	3	2	2	1	2	3	2	2	3	2	2	3	4	3	4	3	2	4	1	2

DATE	21-Jun-14	21-Jun-14	21-Jun-14	22-Jun-14	22-Jun-14	22-Jun-14	23-Jun-14	23-Jun-14	23-Jun-14	24-Jun-14	24-Jun-14	24-Jun-14	25-Jun-14	25-Jun-14	25-Jun-14	26-Jun-14	26-Jun-14	26-Jun-14	27-Jun-14	27-Jun-14	27-Jun-14	28-Jun-14	28-Jun-14	28-Jun-14	29-Jun-14	29-Jun-14	29-Jun-14	30-Jun-14	30-Jun-14	30-Jun-14
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
RN	3	2	2	3	2	2	3	2	2	3	2	2	3	2	2	3	2	2	4	2	2	3	2	2	3	2	2	2	2	2
HCA	3	3	2	3	3	2	3	2	1	2	2	2	3	3	2	3	2	2	2	1	1	2	1	1	1	2	1	3	1	1

CREATON WARD: Acute Medicine

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT	ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN Planned Staff	5	4	3	RGN	⇩	⇩
Support Planned Staff	4	4	2	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down slightly due to unpredictable sick leave + staff re-deployment to escalation areas. Night numbers just under establishment.
HCA: Day numbers around establishment, with nights up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment in both the main ward + escalation area.

DATE	SHIFT	RN	HCA
01-Jun-14	E	4	4
01-Jun-14	L	4	3
01-Jun-14	N	3	3
02-Jun-14	E	5	4
02-Jun-14	L	4	3
02-Jun-14	N	3	3
03-Jun-14	E	5	3
03-Jun-14	L	4	3
03-Jun-14	N	3	4
04-Jun-14	E	5	5
04-Jun-14	L	3	5
04-Jun-14	N	3	2
05-Jun-14	E	5	5
05-Jun-14	L	4	3
05-Jun-14	N	3	3
06-Jun-14	E	5	5
06-Jun-14	L	4	3
06-Jun-14	N	3	3
07-Jun-14	E	4	4
07-Jun-14	L	4	4
07-Jun-14	N	3	3
08-Jun-14	E	4	4
08-Jun-14	L	4	4
08-Jun-14	N	3	3
09-Jun-14	E	5	5
09-Jun-14	L	4	4
09-Jun-14	N	3	3
10-Jun-14	E	5	5
10-Jun-14	L	7	4
10-Jun-14	N	3	3
11-Jun-14	E	6	4
11-Jun-14	L	3	2
11-Jun-14	N	2	4
12-Jun-14	E	6	4
12-Jun-14	L	3	4
12-Jun-14	N	3	3
13-Jun-14	E	5	4
13-Jun-14	L	4	4
13-Jun-14	N	3	1
14-Jun-14	E	3	4
14-Jun-14	L	4	3
14-Jun-14	N	3	2
15-Jun-14	E	4	4
15-Jun-14	L	3	2
15-Jun-14	N	3	3
16-Jun-14	E	4	5
16-Jun-14	L	4	4
16-Jun-14	N	2	3
17-Jun-14	E	5	4
17-Jun-14	L	4	4
17-Jun-14	N	3	3
18-Jun-14	E	5	5
18-Jun-14	L	4	3
18-Jun-14	N	3	3
19-Jun-14	E	5	5
19-Jun-14	L	4	5
19-Jun-14	N	3	3
20-Jun-14	E	5	5
20-Jun-14	L	4	4
20-Jun-14	N	3	3
21-Jun-14	E	3	5
21-Jun-14	L	4	4
21-Jun-14	N	3	3
22-Jun-14	E	4	3
22-Jun-14	L	4	4
22-Jun-14	N	3	2
23-Jun-14	E	5	2
23-Jun-14	L	3	6
23-Jun-14	N	3	3
24-Jun-14	E	5	5
24-Jun-14	L	5	4
24-Jun-14	N	3	3
25-Jun-14	E	5	6
25-Jun-14	L	5	3
25-Jun-14	N	3	3
26-Jun-14	E	6	3
26-Jun-14	L	3	5
26-Jun-14	N	3	4
27-Jun-14	E	4	6
27-Jun-14	L	4	4
27-Jun-14	N	3	4
28-Jun-14	E	3	4
28-Jun-14	L	3	5
28-Jun-14	N	3	4
29-Jun-14	E	4	4
29-Jun-14	L	3	4
29-Jun-14	N	3	3
30-Jun-14	E	5	4
30-Jun-14	L	4	4
30-Jun-14	N	3	3

DRYDEN WARD: Cardiac + Heart Centre (Escalation Area)

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT	ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN Planned Staff	5	5	4	RGN	⇩	⇧
Support Planned Staff	2	1	1	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down slightly due to unpredictable sick leave + staff re-deployment to escalation areas. Night numbers rose due to additional staff requirements for escalation area.
HCA: Day + night numbers up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment in both the main ward + escalation area.

DATE	SHIFT	RN	HCA
01-Jun-14	E	5	3
01-Jun-14	L	4	2
01-Jun-14	N	6	2
02-Jun-14	E	4	4
02-Jun-14	L	4	2
02-Jun-14	N	5	2
03-Jun-14	E	5	3
03-Jun-14	L	5	2
03-Jun-14	N	7	2
04-Jun-14	E	5	3
04-Jun-14	L	5	2
04-Jun-14	N	6	2
05-Jun-14	E	6	3
05-Jun-14	L	5	2
05-Jun-14	N	6	3
06-Jun-14	E	5	3
06-Jun-14	L	5	1
06-Jun-14	N	4	2
07-Jun-14	E	4	2
07-Jun-14	L	5	2
07-Jun-14	N	4	2
08-Jun-14	E	4	3
08-Jun-14	L	5	2
08-Jun-14	N	6	2
09-Jun-14	E	5	3
09-Jun-14	L	4	2
09-Jun-14	N	6	2
10-Jun-14	E	5	2
10-Jun-14	L	6	1
10-Jun-14	N	6	3
11-Jun-14	E	5	1
11-Jun-14	L	5	1
11-Jun-14	N	6	3
12-Jun-14	E	5	3
12-Jun-14	L	5	2
12-Jun-14	N	4	3
13-Jun-14	E	5	3
13-Jun-14	L	5	3
13-Jun-14	N	5	3
14-Jun-14	E	5	3
14-Jun-14	L	5	3
14-Jun-14	N	5	3
15-Jun-14	E	5	3
15-Jun-14	L	5	3
15-Jun-14	N	4	3
16-Jun-14	E	4	2
16-Jun-14	L	5	4
16-Jun-14	N	5	3
17-Jun-14	E	5	5
17-Jun-14	L	5	4
17-Jun-14	N	6	3
18-Jun-14	E	5	5
18-Jun-14	L	4	5
18-Jun-14	N	5	2
19-Jun-14	E	4	3
19-Jun-14	L	3	2
19-Jun-14	N	4	3
20-Jun-14	E	5	3
20-Jun-14	L	4	2
20-Jun-14	N	4	2
21-Jun-14	E	5	4
21-Jun-14	L	5	4
21-Jun-14	N	6	2
22-Jun-14	E	6	3
22-Jun-14	L	7	2
22-Jun-14	N	5	3
23-Jun-14	E	5	3
23-Jun-14	L	4	3
23-Jun-14	N	6	2
24-Jun-14	E	3	5
24-Jun-14	L	4	4
24-Jun-14	N	6	2
25-Jun-14	E	5	3
25-Jun-14	L	4	3
25-Jun-14	N	4	2
26-Jun-14	E	5	2
26-Jun-14	L	5	2
26-Jun-14	N	4	2
27-Jun-14	E	5	3
27-Jun-14	L	4	3
27-Jun-14	N	4	2
28-Jun-14	E	4	3
28-Jun-14	L	5	2
28-Jun-14	N	4	2
29-Jun-14	E	5	3
29-Jun-14	L	4	2
29-Jun-14	N	4	2
30-Jun-14	E	4	1
30-Jun-14	L	4	1
30-Jun-14	N	4	2

EAU WARD: Female Assessment Unit

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT	ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN Planned Staff	6	6	5	RGN	⇩	⇩
Support Planned Staff	3	3	3	HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down on a few shifts due to uncovered unpredictable sick leave, vacancy/mat leave + staff re-deployment. Night numbers slightly under establishment (97%).
HCA: Day + night numbers up due to additional specials deployed o care for complex patients with increased dependency / cognitive impairment.

DATE	SHIFT	RN	HCA
01-Jun-14	E	6	2
01-Jun-14	L	5	3
01-Jun-14	N	5	4
02-Jun-14	E	6	3
02-Jun-14	L	6	1
02-Jun-14	N	5	2
03-Jun-14	E	6	3
03-Jun-14	L	6	3
03-Jun-14	N	5	3
04-Jun-14	E	6	4
04-Jun-14	L	6	4
04-Jun-14	N	5	4
05-Jun-14	E	5	5
05-Jun-14	L	5	5
05-Jun-14	N	5	4
06-Jun-14	E	5	4
06-Jun-14	L	5	5
06-Jun-14	N	5	4
07-Jun-14	E	6	4
07-Jun-14	L	6	3
07-Jun-14	N	6	3
08-Jun-14	E	5	6
08-Jun-14	L	5	5
08-Jun-14	N	4	3
09-Jun-14	E	6	3
09-Jun-14	L	6	3
09-Jun-14	N	5	4
10-Jun-14	E	5	5
10-Jun-14	L	5	5
10-Jun-14	N	5	4
11-Jun-14	E	6	6
11-Jun-14	L	5	4
11-Jun-14	N	5	3
12-Jun-14	E	4	4
12-Jun-14	L	4	4
12-Jun-14	N	7	4
13-Jun-14	E	5	4
13-Jun-14	L	5	3
13-Jun-14	N	6	5
14-Jun-14	E	5	6
14-Jun-14	L	5	4
14-Jun-14	N	5	3
15-Jun-14	E	5	5
15-Jun-14	L	5	6
15-Jun-14	N	5	4
16-Jun-14	E	5	6
16-Jun-14	L	5	5
16-Jun-14	N	5	4
17-Jun-14	E	5	5
17-Jun-14	L	4	5
17-Jun-14	N	5	5
18-Jun-14	E	6	7
18-Jun-14	L	6	6
18-Jun-14	N	5	5
19-Jun-14	E	5	6
19-Jun-14	L	5	4
19-Jun-14	N	4	6
20-Jun-14	E	4	7
20-Jun-14	L	4	6
20-Jun-14	N	4	8
21-Jun-14	E	6	5
21-Jun-14	L	6	4
21-Jun-14	N	5	6
22-Jun-14	E	6	5
22-Jun-14	L	6	5
22-Jun-14	N	3	6
23-Jun-14	E	5	3
23-Jun-14	L	5	4
23-Jun-14	N	5	5
24-Jun-14	E	4	6
24-Jun-14	L	4	5
24-Jun-14	N	5	4
25-Jun-14	E	5	6
25-Jun-14	L	5	6
25-Jun-14	N	5	4
26-Jun-14	E	5	6
26-Jun-14	L	5	6
26-Jun-14	N	4	5
27-Jun-14	E	5	4
27-Jun-14	L	5	5
27-Jun-14	N	4	6
28-Jun-14	E	3	6
28-Jun-14	L	3	6
28-Jun-14	N	3	5
29-Jun-14	E	5	6
29-Jun-14	L	5	6
29-Jun-14	N	5	6
30-Jun-14	E	4	5
30-Jun-14	L	4	3
30-Jun-14	N	5	3

ELEANOR WARD: Hyper Acute Stroke Unit

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT	ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN Planned Staff	3	3	2			
RGN W'end	3	2	2	RGN	⇧	⇔
Support Planned Staff	2	1	1	HCA	⇩	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers up in response to patient acuity - night numbers at establishment.
HCA: Day numbers slightly under establishment and night numbers up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	SHIFT	RN	HCA
01-Jun-14	E	4	2
01-Jun-14	L	3	1
01-Jun-14	N	2	1
02-Jun-14	E	3	2
02-Jun-14	L	3	1
02-Jun-14	N	2	1
03-Jun-14	E	4	2
03-Jun-14	L	3	1
03-Jun-14	N	2	1
04-Jun-14	E	4	2
04-Jun-14	L	3	1
04-Jun-14	N	2	1
05-Jun-14	E	3	2
05-Jun-14	L	3	1
05-Jun-14	N	2	1
06-Jun-14	E	3	2
06-Jun-14	L	2	2
06-Jun-14	N	2	1
07-Jun-14	E	3	2
07-Jun-14	L	3	1
07-Jun-14	N	2	1
08-Jun-14	E	3	2
08-Jun-14	L	3	0
08-Jun-14	N	2	2
09-Jun-14	E	4	2
09-Jun-14	L	3	1
09-Jun-14	N	2	1
10-Jun-14	E	4	2
10-Jun-14	L	3	1
10-Jun-14	N	2	1
11-Jun-14	E	4	2
11-Jun-14	L	4	1
11-Jun-14	N	2	1
12-Jun-14	E	3	2
12-Jun-14	L	3	1
12-Jun-14	N	1	1
13-Jun-14	E	4	2
13-Jun-14	L	2	1
13-Jun-14	N	2	1
14-Jun-14	E	4	2
14-Jun-14	L	2	1
14-Jun-14	N	2	1
15-Jun-14	E	3	2
15-Jun-14	L	1	1
15-Jun-14	N	2	1
16-Jun-14	E	3	2
16-Jun-14	L	4	1
16-Jun-14	N	2	1
17-Jun-14	E	4	2
17-Jun-14	L	3	1
17-Jun-14	N	2	1
18-Jun-14	E	5	2
18-Jun-14	L	3	1
18-Jun-14	N	2	1
19-Jun-14	E	4	2
19-Jun-14	L	4	1
19-Jun-14	N	3	1
20-Jun-14	E	5	2
20-Jun-14	L	3	1
20-Jun-14	N	2	1
21-Jun-14	E	4	2
21-Jun-14	L	2	0

DATE	SHIFT	RN	HCA
01-Jun-14	E	4	2
01-Jun-14	L	3	1
01-Jun-14	N	2	1
02-Jun-14	E	3	2
02-Jun-14	L	3	1
02-Jun-14	N	2	1
03-Jun-14	E	4	2
03-Jun-14	L	3	1
03-Jun-14	N	2	1
04-Jun-14	E	4	2
04-Jun-14	L	3	1
04-Jun-14	N	2	1
05-Jun-14	E	3	2
05-Jun-14	L	3	1
05-Jun-14	N	2	1
06-Jun-14	E	3	2
06-Jun-14	L	2	2
06-Jun-14	N	2	1
07-Jun-14	E	3	2
07-Jun-14	L	3	1
07-Jun-14	N	2	1
08-Jun-14	E	3	2
08-Jun-14	L	3	0
08-Jun-14	N	2	2
09-Jun-14	E	4	2
09-Jun-14	L	3	1
09-Jun-14	N	2	1
	E	4	2

FINEDON WARD: Renal

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	6	6	3
RGN W'end	4	4	3
Support Planned Staff	1	1	1

ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN	⇩	⇩
HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day and night numbers down due to unfilled unpredictable sick leave + uncovered vacancies.
HCA: Day numbers significantly up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	3	3	3	2	2	2
02-Jun-14	6	4	3	3	2	1
03-Jun-14	6	6	3	2	2	2
04-Jun-14	6	5	3	2	1	2
05-Jun-14	6	5	3	4	3	2
06-Jun-14	4	3	3	4	3	2
07-Jun-14	4	4	3	2	2	2
08-Jun-14	4	4	3	2	2	2
09-Jun-14	4	4	3	4	3	2
10-Jun-14	5	5	3	3	2	2
11-Jun-14	5	5	3	4	3	2
12-Jun-14	6	6	3	3	2	2
13-Jun-14	5	5	3	4	3	2
14-Jun-14	4	4	3	2	2	2
15-Jun-14	4	4	3	2	2	2
16-Jun-14	7	5	3	2	2	1
17-Jun-14	5	5	3	2	2	2
18-Jun-14	5	5	3	1	1	1
19-Jun-14	7	6	3	2	1	1
20-Jun-14	6	5	3	1	1	1
21-Jun-14	4	4	3	1	1	1
22-Jun-14	4	4	3	1	1	1
23-Jun-14	7	5	3	0	0	1
24-Jun-14	6	5	3	1	2	1
25-Jun-14	5	5	3	1	1	1
26-Jun-14	6	6	2	2	2	1
27-Jun-14	7	6	2	1	1	2
28-Jun-14	4	4	1	2	1	3
29-Jun-14	4	4	2	2	2	3
30-Jun-14	7	4	3	1	1	1

HAWTHORN WARD: Surgical Assessment Unit

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	6	5	3
RGN W'end	5	4	3
Support Planned Staff	3	3	3

ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN	⇩	⇩
HCA	⇧	⇔

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down due to uncovered to unpredictable leave, vacancy + staff re-deployment as well as internal ward staff changes. Supernumerary nursing staff worked with established staff over approximately 13 days of the month. Night numbers slightly under establishment. Recruitment is in progress.
HCA: Day numbers slightly above establishment and night numbers at establishment.

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	5	4	3	3	3	3
02-Jun-14	5	4	3	3	4	3
03-Jun-14	5	4	3	4	4	3
04-Jun-14	6	5	3	3	3	3
05-Jun-14	5	3	3	2	3	3
06-Jun-14	4	3	3	4	3	3
07-Jun-14	5	3	4	3	3	2
08-Jun-14	5	3	3	4	3	2
09-Jun-14	5	4	3	4	3	3
10-Jun-14	4	3	3	3	4	3
11-Jun-14	6	3	3	3	4	3
12-Jun-14	4	2	3	2	4	4
13-Jun-14	5	3	3	4	3	3
14-Jun-14	4	4	3	3	3	2
15-Jun-14	5	4	3	3	3	2
16-Jun-14	4	4	3	2	3	3
17-Jun-14	6	4	3	3	1	3
18-Jun-14	5	4	3	3	3	4
19-Jun-14	6	4	2	2	3	3
20-Jun-14	6	5	2	3	2	4
21-Jun-14	4	3	2	2	3	4
22-Jun-14	4	4	2	3	2	3
23-Jun-14	6	6	3	2	2	3
24-Jun-14	6	4	3	3	4	4
25-Jun-14	5	5	3	4	4	4
26-Jun-14	5	4	3	4	4	4
27-Jun-14	5	3	3	4	3	2
28-Jun-14	4	4	3	3	3	1
29-Jun-14	4	4	3	4	3	2
30-Jun-14	5	4	3	5	2	3

HEAD & NECK WARD: Head + Neck / Treatment Room

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	3	3	3
RGN W'end	3	2	2
Support Planned Staff	1	1	1

ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN	⇧	⇩
HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers just over establishment and night numbers down slightly due to uncovered vacancies.
HCA: Day + night numbers up due to additional HCAs deployed to staff the in-ward Treatment Room, as well as additional specials required to care for complex patients with increased dependency / cognitive impairment

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	3	1	2	1	3	1
02-Jun-14	3	2	2	0	2	1
03-Jun-14	4	3	2	1	2	1
04-Jun-14	3	3	3	2	1	1
05-Jun-14	3	3	3	2	1	1
06-Jun-14	3	3	3	2	1	1
07-Jun-14	3	3	3	0	2	1
08-Jun-14	3	2	3	2	2	1
09-Jun-14	3	3	2	1	1	1
10-Jun-14	4	2	2	1	3	1
11-Jun-14	4	3	3	1	2	1
12-Jun-14	4	3	2	1	2	1
13-Jun-14	3	3	2	1	1	1
14-Jun-14	3	2	3	1	1	1
15-Jun-14	3	3	2	1	1	1
16-Jun-14	4	2	2	2	1	1
17-Jun-14	3	2	2	1	3	1
18-Jun-14	4	2	3	1	2	1
19-Jun-14	4	2	2	2	2	2
20-Jun-14	4	3	2	2	2	2
21-Jun-14	2	3	2	1	2	2
22-Jun-14	3	2	2	2	2	2
23-Jun-14	4	2	2	1	2	2
24-Jun-14	4	3	3	2	1	2
25-Jun-14	4	3	3	2	2	2
26-Jun-14	4	3	2	2	2	2
27-Jun-14	4	2	2	2	3	2
28-Jun-14	3	2	3	1	1	1
29-Jun-14	3	2	2	1	1	2
30-Jun-14	4	3	2	2	1	2

HOLCOT WARD: Stroke Rehabilitation

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	5	3	3
Support Planned Staff	3	3	2

ABOVE or BELOW planned	JUNE DAY	NIGHT
RGN	⇩	⇔
HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down slightly due to uncovered unpredictable sick leave, professional leave and some internal ward staff changes. Night numbers at establishment.
HCA: Day and night numbers (significantly for nights) up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	4	3	3	3	2	3
02-Jun-14	5	2	3	5	3	3
03-Jun-14	3	3	3	6	2	3
04-Jun-14	5	3	3	4	3	3
05-Jun-14	4	3	3	5	4	3
06-Jun-14	4	3	3	6	3	4
07-Jun-14	2	2	3	4	4	5
08-Jun-14	3	5	3	5	4	4
09-Jun-14	5	3	3	4	3	4
10-Jun-14	5	4	3	3	3	4
11-Jun-14	4	4	3	4	3	4
12-Jun-14	4	3	3	4	2	4
13-Jun-14	6	2	3	3	3	4
14-Jun-14	4	3	3	3	3	4
15-Jun-14	2	2	3	4	4	3
16-Jun-14	4	3	3	3	3	4
17-Jun-14	4	4	3	5	3	4
18-Jun-14	5	4	3	4	3	3
19-Jun-14	5	3	3	6	2	2
20-Jun-14	6	3	3	5	3	2
21-Jun-14	5	3	3	4	2	2
22-Jun-14	3	3	3	5	4	2
23-Jun-14	5	3	3	5	2	2
24-Jun-14	5	3	2	5	3	4
25-Jun-14	6	3	3	4	3	3
26-Jun-14	5	3	3	6	3	2
27-Jun-14	5	3	3	5	2	3
28-Jun-14	4	4	3	4	3	3
29-Jun-14	5	4	3	4	4	3
30-Jun-14	4	4	3	6	2	3

ITU + HDU WARD: Critical Care

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	13	13	12
Support Planned Staff	2	2	2

ABOVE or BELOW planned: JUNE	DAY	NIGHT
RGN	⇩	⇧
HCA	⇩	⇩

JUNE - STAFFING OVERVIEW:

Critical care staffing is assessed on a shift by shift basis, balanced with the number /acuity of patients. Activity in ITU particularly, fluctuates and is unpredictable, so although staff are planned to work on a 1:1 basis, this is not always required as beds are not necessarily filled.

RGN: Day + night numbers just below/above establishment. Supernumerary nursing staff worked with established staff over 22 days of the month.
HCA: Day + night numbers down due to unpredictable sick leave + uncovered vacancies. 2 HCAs have been recruited and should be starting in July.

DATE	SHIFT	RN	HCA
01-Jun-14	E	12	1
01-Jun-14	L	11	2
01-Jun-14	N	12	1
02-Jun-14	E	13	1
02-Jun-14	L	12	2
02-Jun-14	N	13	2
03-Jun-14	E	13	1
03-Jun-14	L	13	1
03-Jun-14	N	14	2
04-Jun-14	E	14	2
04-Jun-14	L	13	1
04-Jun-14	N	13	2
05-Jun-14	E	14	1
05-Jun-14	L	13	1
05-Jun-14	N	13	2
06-Jun-14	E	11	1
06-Jun-14	L	12	2
06-Jun-14	N	13	2
07-Jun-14	E	13	2
07-Jun-14	L	12	2
07-Jun-14	N	13	1
08-Jun-14	E	15	1
08-Jun-14	L	12	1
08-Jun-14	N	12	1
09-Jun-14	E	14	0
09-Jun-14	L	13	0
09-Jun-14	N	12	2
10-Jun-14	E	16	1
10-Jun-14	L	13	1
10-Jun-14	N	11	1
11-Jun-14	E	14	2
11-Jun-14	L	13	1
11-Jun-14	N	13	1
12-Jun-14	E	13	0
12-Jun-14	L	13	0
12-Jun-14	N	12	2
13-Jun-14	E	14	2
13-Jun-14	L	13	1
13-Jun-14	N	13	2
14-Jun-14	E	12	2
14-Jun-14	L	12	0
14-Jun-14	N	11	1
15-Jun-14	E	13	2
15-Jun-14	L	13	2
15-Jun-14	N	11	1
16-Jun-14	E	11	0
16-Jun-14	L	11	0
16-Jun-14	N	12	2
17-Jun-14	E	14	1
17-Jun-14	L	13	1
17-Jun-14	N	13	3
18-Jun-14	E	15	2
18-Jun-14	L	13	2
18-Jun-14	N	13	2
19-Jun-14	E	14	0
19-Jun-14	L	13	1
19-Jun-14	N	13	4
20-Jun-14	E	10	3
20-Jun-14	L	10	2
20-Jun-14	N	16	3
21-Jun-14	E	14	2
21-Jun-14	L	14	2
21-Jun-14	N	14	4
22-Jun-14	E	15	2
22-Jun-14	L	13	2
22-Jun-14	N	11	4
23-Jun-14	E	12	1
23-Jun-14	L	11	1
23-Jun-14	N	14	2
24-Jun-14	E	15	2
24-Jun-14	L	13	1
24-Jun-14	N	13	1
25-Jun-14	E	15	0
25-Jun-14	L	12	1
25-Jun-14	N	13	0
26-Jun-14	E	12	1
26-Jun-14	L	11	1
26-Jun-14	N	14	0
27-Jun-14	E	14	2
27-Jun-14	L	11	1
27-Jun-14	N	13	1
28-Jun-14	E	12	2
28-Jun-14	L	12	2
28-Jun-14	N	12	2
29-Jun-14	E	12	2
29-Jun-14	L	12	2
29-Jun-14	N	13	1
30-Jun-14	E	13	0
30-Jun-14	L	11	0
30-Jun-14	N	13	1

KNIGHTLEY WARD: Acute Medicine

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	3	2	2
Support Planned Staff	3	2	1

ABOVE or BELOW planned: JUNE	DAY	NIGHT
RGN	⇩	⇔
HCA	⇧	⇧

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down slightly due to some uncovered unpredictable sick leave. Night numbers at establishment.
HCA: Day numbers up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	SHIFT	RN	HCA
01-Jun-14	E	2	3
01-Jun-14	L	1	3
01-Jun-14	N	2	2
02-Jun-14	E	3	3
02-Jun-14	L	1	3
02-Jun-14	N	2	2
03-Jun-14	E	2	4
03-Jun-14	L	1	3
03-Jun-14	N	2	2
04-Jun-14	E	2	4
04-Jun-14	L	1	3
04-Jun-14	N	2	2
05-Jun-14	E	3	2
05-Jun-14	L	2	2
05-Jun-14	N	2	1
06-Jun-14	E	3	3
06-Jun-14	L	1	3
06-Jun-14	N	2	1
07-Jun-14	E	3	3
07-Jun-14	L	2	1
07-Jun-14	N	2	1
08-Jun-14	E	2	4
08-Jun-14	L	1	3
08-Jun-14	N	2	1
09-Jun-14	E	4	2
09-Jun-14	L	2	3
09-Jun-14	N	2	1
10-Jun-14	E	2	5
10-Jun-14	L	1	3
10-Jun-14	N	2	1
11-Jun-14	E	1	5
11-Jun-14	L	3	3
11-Jun-14	N	2	1
12-Jun-14	E	3	4
12-Jun-14	L	3	3
12-Jun-14	N	2	1
13-Jun-14	E	4	4
13-Jun-14	L	2	3
13-Jun-14	N	2	2
14-Jun-14	E	3	4
14-Jun-14	L	1	3
14-Jun-14	N	2	2
15-Jun-14	E	3	3
15-Jun-14	L	2	3
15-Jun-14	N	2	1
16-Jun-14	E	2	4
16-Jun-14	L	2	1
16-Jun-14	N	2	1
17-Jun-14	E	4	4
17-Jun-14	L	2	2
17-Jun-14	N	2	1
18-Jun-14	E	3	3
18-Jun-14	L	2	2
18-Jun-14	N	2	1
19-Jun-14	E	4	3
19-Jun-14	L	2	2
19-Jun-14	N	2	2
20-Jun-14	E	4	4
20-Jun-14	L	2	3
20-Jun-14	N	2	2
21-Jun-14	E	3	3
21-Jun-14	L	1	4
21-Jun-14	N	2	1
22-Jun-14	E	2	4
22-Jun-14	L	2	3
22-Jun-14	N	2	1
23-Jun-14	E	3	4
23-Jun-14	L	2	2
23-Jun-14	N	2	1
24-Jun-14	E	2	4
24-Jun-14	L	2	3
24-Jun-14	N	2	1
25-Jun-14	E	4	2
25-Jun-14	L	2	2
25-Jun-14	N	2	1
26-Jun-14	E	2	5
26-Jun-14	L	2	3
26-Jun-14	N	2	1
27-Jun-14	E	3	4
27-Jun-14	L	1	3
27-Jun-14	N	2	2
28-Jun-14	E	4	2
28-Jun-14	L	2	1
28-Jun-14	N	2	1
29-Jun-14	E	3	2
29-Jun-14	L	2	3
29-Jun-14	N	2	2
30-Jun-14	E	4	2
30-Jun-14	L	2	3
30-Jun-14	N	2	1

MATERNITY SPECIALTY - Combined wards: Balmoral & Birth Centre, Maternity Observation Ward, Robert Watson, Sturtridge

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RM Planned Staff	17	16	16
RM W'end	16	16	16
MSW Planned	9	8	8
MSW W'end	8	8	8

ABOVE or BELOW planned: JUNE	DAY	NIGHT
RGN	⇩	⇩
HCA	⇩	⇩

JUNE - STAFFING OVERVIEW:

This presents a combined picture of all maternity wards at NGH. At times, some wards are not at 100% capacity (beds free / fewer or less sick patients). Therefore staffing numbers fluctuate + can be below the planned staffing levels shown here, while still maintaining safe care for all our mothers + babies.
Midwives: Day + night numbers down due to some uncovered unpredictable sick leave + vacancies, in addition to varied and non-standard shift patterns which can result in the resource management system showing some unfilled hours - this will be addressed when shifts are standardised.
Maternity Support Workers: Day + night numbers down due to uncovered unpredictable sick leave + vacancies, in addition to non-standard shift patterns and resulting system anomalies, as above.
Recruitment is in progress.

DATE	SHIFT	RN	HCA
01-Jun-14	E	13	10
01-Jun-14	L	13	9
01-Jun-14	N	10	3
02-Jun-14	E	14	9
02-Jun-14	L	15	7
02-Jun-14	N	10	9
03-Jun-14	E	25	4
03-Jun-14	L	21	1
03-Jun-14	N	7	16
04-Jun-14	E	14	7
04-Jun-14	L	14	7
04-Jun-14	N	12	7
05-Jun-14	E	10	13
05-Jun-14	L	15	10
05-Jun-14	N	13	6
06-Jun-14	E	15	9
06-Jun-14	L	12	9
06-Jun-14	N	13	6
07-Jun-14	E	11	10
07-Jun-14	L	16	5
07-Jun-14	N	10	4
08-Jun-14	E	10	6
08-Jun-14	L	11	6
08-Jun-14	N	19	9
09-Jun-14	E	16	8
09-Jun-14	L	14	6
09-Jun-14	N	13	12
10-Jun-14	E	19	10
10-Jun-14	L	19	3
10-Jun-14	N	12	7
11-Jun-14	E	20	5
11-Jun-14	L	14	6
11-Jun-14	N	8	11
12-Jun-14	E	18	8
12-Jun-14	L	13	8
12-Jun-14	N	10	9
13-Jun-14	E	10	11
13-Jun-14	L	13	7
13-Jun-14	N	12	5
14-Jun-14	E	15	10
14-Jun-14	L	11	8
14-Jun-14	N	13	5
15-Jun-14	E	16	5
15-Jun-14	L	12	9
15-Jun-14	N	12	4
16-Jun-14	E	14	13
16-Jun-14	L	16	5
16-Jun-14	N	16	7
17-Jun-14	E	13	14
17-Jun-14	L	7	19
17-Jun-14	N	17	3
18-Jun-14	E	19	10
18-Jun-14	L	19	7
18-Jun-14	N	10	9
19-Jun-14	E	17	4
19-Jun-14	L	17	1
19-Jun-14	N	13	7
20-Jun-14	E	15	7
20-Jun-14	L	8	10
20-Jun-14	N	19	7
21-Jun-14	E	12	9
21-Jun-14	L	8	12
21-Jun-14	N	18	2
22-Jun-14	E	11	12
22-Jun-14	L	10	10
22-Jun-14	N	17	2
23-Jun-14	E	15	9
23-Jun-14	L	9	11
23-Jun-14	N	17	3
24-Jun-14	E	15	8
24-Jun-14	L	9	10
24-Jun-14	N	15	6
25-Jun-14	E	20	6
25-Jun-14	L	18	6
25-Jun-14	N	13	6
26-Jun-14	E	20	6
26-Jun-14	L	21	5
26-Jun-14	N	11	9
27-Jun-14	E	13	10
27-Jun-14	L	13	8
27-Jun-14	N	22	4
28-Jun-14	E	14	8
28-Jun-14	L	12	10
28-Jun-14	N	16	3
29-Jun-14	E	15	7
29-Jun-14	L	17	4
29-Jun-14	N	8	8
30-Jun-14	E	13	6
30-Jun-14	L	9	8
30-Jun-14	N	17	9

ROWAN WARD: Gastrointestinal + 3 x Level One beds

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	6	5	4
Support Planned Staff	3	3	3

ABOVE or BELOW planned: JUNE	DAY	NIGHT
RGN	⇩	⇩
HCA	⇧	⇩

JUNE - STAFFING OVERVIEW:

RGN: Day + night numbers down due to some uncovered unpredictable sick / maternity leave + vacancies as well as staff re-deployment. RGN staff are assessed daily and depending on the team's skill mix, Level 1 beds and patient acuity, the nursing team may work below establishment, but at agreed safe staffing capacity.
HCA: Day numbers up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment. Night numbers down due to uncovered vacancy/maternity leave + staff re-deployment. Recruitment in progress.

DATE	SHIFT	RN	HCA
01-Jun-14	E	6	3
01-Jun-14	L	4	2
01-Jun-14	N	3	2
02-Jun-14	E	6	6
02-Jun-14	L	6	3
02-Jun-14	N	4	2
03-Jun-14	E	5	6
03-Jun-14	L	4	3
03-Jun-14	N	4	3
04-Jun-14	E	6	4
04-Jun-14	L	4	3
04-Jun-14	N	3	4
05-Jun-14	E	7	3
05-Jun-14	L	4	4
05-Jun-14	N	3	3
06-Jun-14	E	8	2
06-Jun-14	L	4	4
06-Jun-14	N	4	2
07-Jun-14	E	5	3
07-Jun-14	L	3	3
07-Jun-14	N	4	3
08-Jun-14	E	5	3
08-Jun-14	L	4	2
08-Jun-14	N	3	2
09-Jun-14	E	8	3
09-Jun-14	L	5	4
09-Jun-14	N	4	2
10-Jun-14	E	7	4
10-Jun-14	L	4	4
10-Jun-14	N	3	2
11-Jun-14	E	7	4
11-Jun-14	L	5	3
11-Jun-14	N	3	3
12-Jun-14	E	3	5
12-Jun-14	L	5	2
12-Jun-14	N	4	2
13-Jun-14	E	6	3
13-Jun-14	L	4	4
13-Jun-14	N	4	2
14-Jun-14	E	6	4
14-Jun-14	L	3	3
14-Jun-14	N	4	3
15-Jun-14	E	4	5
15-Jun-14	L	3	3
15-Jun-14	N	4	3
16-Jun-14	E	4	4
16-Jun-14	L	4	3
16-Jun-14	N	3	3
17-Jun-14	E	6	4
17-Jun-14	L	4	4
17-Jun-14	N	4	2
18-Jun-14	E	6	3
18-Jun-14	L	5	2
18-Jun-14	N	5	3
19-Jun-14	E	5	3
19-Jun-14	L	5	2
19-Jun-14	N	3	3
20-Jun-14	E	6	5
20-Jun-14	L	4	3
20-Jun-14	N	3	3
21-Jun-14	E	5	3
21-Jun-14	L	3	4
21-Jun-14	N	3	3
22-Jun-14	E	6	4
22-Jun-14	L	6	2
22-Jun-14	N	3	3
23-Jun-14	E	8	4
23-Jun-14	L	4	3
23-Jun-14	N	4	2
24-Jun-14	E	6	3
24-Jun-14	L	4	3
24-Jun-14	N	4	2
25-Jun-14	E	6	4
25-Jun-14	L	4	3
25-Jun-14	N	4	2
26-Jun-14	E	7	4
26-Jun-14	L	5	2
26-Jun-14	N	4	2
27-Jun-14	E	6	4
27-Jun-14	L	6	3
27-Jun-14	N	3	2
28-Jun-14	E	5	3
28-Jun-14	L	4	3
28-Jun-14	N	4	3
29-Jun-14	E	5	4
29-Jun-14	L	3	3
29-Jun-14	N	4	2
30-Jun-14	E	6	5
30-Jun-14	L	4	4
30-Jun-14	N	4	2

SPENCER WARD: Gynaecology + Gynae Day Care Unit (Escalation Area)

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	3	2	2
Support Planned Staff	1	1	1

ABOVE or BELOW planned (JUNE)	DAY	NIGHT
RGN	↓	↑
HCA	↑	↑

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down slightly due to staff re-deployment, and night numbers up due to escalation area requirements.
HCA: Day and night numbers up significantly due to escalation area deployment.

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	2	2	2	1	1	1
02-Jun-14	3	2	2	1	1	1
03-Jun-14	3	2	2	1	2	3
04-Jun-14	3	2	2	2	3	2
05-Jun-14	3	2	3	2	2	3
06-Jun-14	2	2	3	2	1	3
07-Jun-14	3	2	2	3	3	2
08-Jun-14	2	2	2	2	2	2
09-Jun-14	3	2	3	1	2	3
10-Jun-14	3	2	3	2	3	2
11-Jun-14	3	2	3	2	2	2
12-Jun-14	3	2	2	1	2	2
13-Jun-14	3	2	2	2	3	2
14-Jun-14	3	3	2	2	2	2
15-Jun-14	2	2	2	3	2	2
16-Jun-14	3	2	2	1	2	3
17-Jun-14	3	2	3	2	2	3
18-Jun-14	3	2	3	1	3	3
19-Jun-14	3	2	1	2	2	1
20-Jun-14	3	2	2	2	2	1
21-Jun-14	2	2	2	2	1	1
22-Jun-14	2	2	2	1	1	1
23-Jun-14	3	3	2	2	1	2
24-Jun-14	3	2	2	1	2	2
25-Jun-14	3	2	3	1	2	2
26-Jun-14	3	2	2	2	1	1
27-Jun-14	3	2	2	2	1	1
28-Jun-14	2	2	2	1	1	1
29-Jun-14	2	2	2	1	2	1
30-Jun-14	3	2	3	1	1	2

TALBOT BUTLER WARD: Haematology & Oncology

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	8	6	3
RGN W'end	7	5	3
Support Planned Staff	3	3	2
Support W'end	2	2	2

ABOVE or BELOW planned (JUNE)	DAY	NIGHT
RGN	↓	↓
HCA	↑	↑

JUNE - STAFFING OVERVIEW:

RGN: Day + night numbers down due to uncovered unpredictable sickness, escalation deployment + uncovered vacancy.
HCA: Day + night numbers up due to additional HCAs deployed for escalation area and complex patients with increased dependency / cognitive impairment .

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	4	4	3	4	3	2
02-Jun-14	3	5	3	5	3	2
03-Jun-14	6	5	2	4	3	3
04-Jun-14	6	4	3	3	4	4
05-Jun-14	5	5	1	5	3	5
06-Jun-14	6	5	1	4	3	4
07-Jun-14	5	5	2	4	4	6
08-Jun-14	5	4	2	4	5	3
09-Jun-14	5	4	2	3	4	4
10-Jun-14	4	4	3	6	5	2
11-Jun-14	4	4	2	5	4	4
12-Jun-14	6	5	3	3	3	2
13-Jun-14	5	3	3	4	5	3
14-Jun-14	4	4	2	4	2	3
15-Jun-14	4	4	3	4	2	3
16-Jun-14	5	5	2	3	2	3
17-Jun-14	6	5	3	2	3	3
18-Jun-14	5	4	3	2	2	3
19-Jun-14	5	5	3	3	3	3
20-Jun-14	6	5	3	2	3	3
21-Jun-14	5	5	3	3	1	3
22-Jun-14	5	4	2	3	2	3
23-Jun-14	5	5	2	3	3	3
24-Jun-14	5	5	3	3	3	3
25-Jun-14	5	5	3	3	3	3
26-Jun-14	5	5	3	3	3	3
27-Jun-14	6	6	2	3	2	3
28-Jun-14	5	4	3	1	3	3
29-Jun-14	5	4	2	3	3	3
30-Jun-14	5	5	3	3	3	3

VICTORIA WARD: General Medicine

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	4	3	2
Support Planned Staff	3	3	1

ABOVE or BELOW planned (JUNE)	DAY	NIGHT
RGN	↓	↓
HCA	↑	↑

JUNE - STAFFING OVERVIEW:

RGN: Day and night numbers down slightly due to some uncovered unpredictable sick leave and vacancy.
HCA: Day + night numbers up (night significantly) due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment.

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	3	3	2	4	4	3
02-Jun-14	4	4	2	4	4	3
03-Jun-14	4	3	2	5	6	3
04-Jun-14	4	3	2	4	4	2
05-Jun-14	4	3	2	4	4	2
06-Jun-14	4	3	2	4	4	3
07-Jun-14	3	3	2	4	4	2
08-Jun-14	3	3	2	4	2	3
09-Jun-14	4	3	2	4	4	2
10-Jun-14	4	3	2	3	2	2
11-Jun-14	4	3	2	2	4	2
12-Jun-14	4	3	2	4	4	2
13-Jun-14	4	3	2	3	4	3
14-Jun-14	3	2	2	4	4	2
15-Jun-14	3	3	2	4	4	3
16-Jun-14	4	3	1	3	4	2
17-Jun-14	4	3	2	4	4	2
18-Jun-14	4	3	2	4	4	3
19-Jun-14	5	3	2	4	4	2
20-Jun-14	4	3	2	4	4	3
21-Jun-14	3	3	2	5	4	3
22-Jun-14	3	3	2	5	5	3
23-Jun-14	3	3	1	5	4	3
24-Jun-14	4	3	2	4	5	3
25-Jun-14	4	3	2	5	5	3
26-Jun-14	4	3	2	5	4	3
27-Jun-14	4	3	2	5	5	3
28-Jun-14	3	2	2	5	5	3
29-Jun-14	4	3	2	4	4	3
30-Jun-14	4	3	2	5	4	3

WILLOW WARD: Vascular + 9 x Level One beds

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	7	6	5
Support Planned Staff	2	2	1

ABOVE or BELOW planned (JUNE)	DAY	NIGHT
RGN	↓	↔
HCA	↑	↑

JUNE - STAFFING OVERVIEW:

RGN: Day numbers down due to uncovered unpredictable sick leave which affected a number of staff on a rolling basis, long term sickness + vacancies. Night numbers at establishment. Supernumerary nursing staff worked with established staff across 17 days of the month.
HCA: Day + night numbers up due to additional specials deployed to care for complex patients with increased dependency / cognitive impairment. Supernumerary HCAs worked with established staff over approximately 8 days of the month.

DATE	RN E	RN L	RN N	HCA E	HCA L	HCA N
01-Jun-14	6	5	4	2	2	3
02-Jun-14	7	6	5	1	0	1
03-Jun-14	8	6	5	2	1	1
04-Jun-14	6	4	5	3	3	2
05-Jun-14	6	5	4	3	3	3
06-Jun-14	6	5	5	3	3	1
07-Jun-14	4	4	6	3	3	1
08-Jun-14	6	5	5	2	2	1
09-Jun-14	6	5	5	1	1	1
10-Jun-14	7	6	5	2	2	1
11-Jun-14	7	6	5	2	1	1
12-Jun-14	6	6	5	3	1	2
13-Jun-14	6	5	5	4	2	2
14-Jun-14	6	4	5	2	3	1
15-Jun-14	5	5	5	3	3	2
16-Jun-14	7	6	5	4	2	1
17-Jun-14	7	4	5	2	2	1
18-Jun-14	5	6	5	5	2	1
19-Jun-14	6	5	5	3	3	1
20-Jun-14	4	5	5	5	2	1
21-Jun-14	6	6	6	2	1	1
22-Jun-14	6	5	5	2	1	1
23-Jun-14	5	4	4	3	2	4
24-Jun-14	7	4	4	4	2	2
25-Jun-14	5	6	4	4	2	2
26-Jun-14	5	4	5	2	1	1
27-Jun-14	6	4	6	4	2	1
28-Jun-14	5	5	5	2	2	1
29-Jun-14	6	5	5	2	2	1
30-Jun-14	5	4	5	2	3	1

Appendix 2

Nurse Staffing Strategy – Year 2 investment, April 2014

Service	Registered Nurse	Support Worker	Total/WTE
Medical care group - general wards	37.68	15.05	52.73
Surgical care group - general wards	10.49	8.65	19.14
Critical Care	6.84		6.84
Midwifery Services		12.20	12.20
A&E	6.26		6.26
	61.27	35.9	**97.17**

Appendix 3
SNCT table & comments

Nursing Shift Pattern Analysis - NGH v SNCT

Ward	No. of Beds	Total (Mth 1 budget + 2014/14 uplift)		Combined Total	NGH Skill Mix	SNCT		Combined Total	SNCT Skill Mix	NGH v SNCT		Combined Total	*Quality Standards / %	*Harm Free Care/ %	*PU (G2,3 & 4)	*Falls (<Mod)	*HIA	*Incidents (no PU & #NoF)	*Complaints
		Qualified	UnQual		Qual/ Unqual	Qualified +Mgt.	UnQual		Qual/ Unqual	Qualified	UnQual								
Abington	28	23.9	21.4	45.3	53:47	23.9	16.2	40.1	60:40	0.0	5.2	5.2	79.0	89.3	2.0	0.0	0.0	0.0	0.0
Althorp	18	13.7	9.5	23.3	59:41	14.0	7.7	21.7	65:35	-0.3	1.8	1.6	87.0	100.0	1.0	0.0	0.0	0.0	0.0
Cedar	29	23.6	21.1	44.7	53:47	26.0	17.5	43.5	60:40	-2.4	3.6	1.2	84.0	96.7	0.0	0.0	0.0	0.0	0.0
Hawthorn	30	28.0	18.0	45.9	61:39	28.2	15.3	43.5	65:35	-0.2	2.7	2.4	81.0	100.0	0.0	0.0	0.0	0.0	2.0
Head & Neck	14	17.7	8.8	26.5	67:33	12.8	6.9	19.7	65:35	4.9	-0.7	4.2	91.0	100.0	0.0	0.0	0.0	1.0	0.0
Rowan	30	29.9	18.0	48.0	62:38	28.5	12.0	40.5	70:30	1.4	6.0	7.5	84.0	93.3	3.0	0.0	0.0	0.0	0.0
Spencer	14	14.1	7.9	21.9	64:36	12.8	6.9	19.7	65:35	0.3	0.0	0.2	83.0	100.0	0.0	0.0	0.0	0.0	1.0
Willow	28	32.8	14.5	47.3	69:31	32.6	11.0	43.6	75:25	0.2	3.5	3.7	72.0	80.8	4.0	0.0	0.0	0.0	1.0
Allebone	28	25.3	18.0	43.3	58:42	27.2	14.9	42.1	65:35	-1.9	3.1	1.2	73.0	92.3	2.0	0.0	0.0	0.0	2.0
Becket	26	27.6	17.4	45.0	61:39	27.8	12.0	39.8	70:30	-1.0	4.0	3.0	82.0	84.6	0.0	0.0	0.0	0.0	1.0
Benham	28	26.6	11.9	38.5	69:31	31.0	17.0	48	65:35	-4.4	-5.1	-9.6	68.0	100.0	0.0	1.0	1.0	0.0	0.0
Brampton	27	23.2	14.8	38.1	61:39	28.0	14.8	42.8	65:35	-4.8	0.0	-4.7	83.0	85.2	2.0	0.0	0.0	0.0	0.0
Collingtree	40	32.6	25.4	58.1	56:44	35.0	19.1	54.1	65:35	-2.4	6.3	4.0	72.0	92.5	6.0	0.0	0.0	0.0	0.0
Compton	18	15.1	10.1	25.1	60:40	20.8	11.3	32.1	65:35	-5.7	-1.3	-7.0	84.0	82.4	0.0	0.0	0.0	0.0	0.0
Creaton	28	26.5	19.9	46.4	57:43	27.5	14.5	42	65:35	-1.1	5.4	4.4	85.0	88.9	2.0	0.0	0.0	0.0	0.0
Dryden	22	32.1	9.5	41.5	77:23	29.5	10.0	39.5	75:25	2.6	-0.5	2.0	79.0	92.0	1.0	0.0	0.0	0.0	0.0
EAU	32	32.3	17.7	49.9	65:35	31.1	17.0	48.1	65:35	1.2	0.7	1.8	81.0	96.7	0.0	0.0	0.0	0.0	0.0
Eleanor	12	14.1	7.3	21.4	66:34	13.2	5.7	18.9	70:30	0.9	1.6	2.5	82.0	100.0	0.0	0.0	0.0	0.0	0.0
Holcot	27	27.6	15.7	43.3	64:36	28.5	15.5	44	65:35	-0.9	0.2	-0.7	78.0	96.3	6.0	0.0	0.0	0.0	0.0
Knightley	21	18.1	11.9	30.0	60:40	20.8	11.4	32.2	65:35	-2.7	0.5	-2.2	77.0	100.0	2.0	1.0	0.0	0.0	0.0
Talbot Butler	30	32.0	11.0	42.9	74:26	27.5	11.7	39.2	70:30	-0.1	-4.1	-4.3	80.0	92.6	2.0	0.0	0.0	1.0	0.0
Victoria	18	16.2	12.7	28.9	56:44	16.0	8.6	24.6	65:35	-3.2	0.7	-2.5	78.0	83.3	1.0	0.0	0.0	0.0	1.0
Total		**532.7**	**322.3**	**855.0**		**542.7**	**277.0**	**819.7**		**-19.8**	**33.5**	**13.7**	*May quality data						

Ward	Comments
Abington	High number of dementia/confused patients requiring HCA cover due to the nature of the patient injuries 75% of the ward will need assistance with their ADL's
Althorp	Ward size / registered workforce & due to ward geography especially the side rooms B2 increased
Cedar	High number of bed bound patients requiring assistance with ADL's gives an increased HCA wte
Hawthorn	The 'Hot Clinic' staffing is included in the ward establishment due to the layout of the ward staff are required to be in the bays for the assessment patients
Head & Neck	Budget includes Treatment Rm = B2 2.6wte + B7 has full supervisory due to clinics. Ward size and layout also effects the data + on call countywide OOH
Rowan	Establishment figures are for 6 level 1 patients at time of audit only 3 open
Spencer	Budget includes Emergency treatment area B5 =1.0 & B2 = 1.0. Ward size also effects the data
Willow	B2 increased this year due to high number of vascular dementia patients and the complexity of care needs
Allebone	High number of dementia/confused patients requiring HCA cover due to the nature of the patient injuries 75% of the ward will need assistance with their ADL's
Becket	Clinic Room B5 x 0.8wte and B2 - 2x 0.67 wte
Benham	Assessment area high number of patients requiring a 'special'. Patients at initial stage of hospital admissiona and acutely unwell/stable
Brampton	Now working as a short stay elderly with support from crisis hub leading to a change in casemix and length of stay activity on the ward
Collingtree	High number of confused patients due to alcohol issues requiring HCA cover. These patients are at risk of harm/injury to themselves and others.
Compton	Medical rehabilitation ward. Ward size and environment has an impact
Creaton	High number of dementia/confused patients requiring HCA cover due to the nature of the patient injuries 75% of the ward will need assistance with their ADL's
Dryden	Ability to flex number of level 2 CCU beds due to location of telemetry - this may be into siderooms.
EAU	Assesment area - high number of patients requiring a 'special' Patients at initial stage of hospital admissiona and acutely unwell/stable
Eleanor	Hyperacute stroke unit. Ward size also effects the data
Holcot	Stroke Unit with acutely unwell patients that are also dependent on HCA care.
Knightley	Increased acuity due to changes in other medical wards.
Talbot Butler	Budget includes staffing for the EAB which equates to RN x2.8 wte and HCA x 2.8 wte and the chemotherapy area Band 5 x 1wte on an early shift.
Victoria	Budget includes additional RN x 1wte and HCA x 1wte 7 days a week for the Discharge Lounge

Report To	**PUBLIC TUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Integrated Performance Report and Quality Scorecard**
Agenda item	11
Sponsoring Director	Deborah Needham, Chief Operating Officer Dr Mike Wilkinson, Medical Director (Interim) Jane Bradley, Director of Nursing, Midwifery and Patient Services (Interim)
Author(s) of Report	Deborah Needham, Chief Operating Officer
Purpose	The paper is presented for discussion and assurance

Executive summary

This revised Integrated Performance Report and Quality Scorecard provides a holistic and integrated set of metrics closely aligned between the TDA, Monitor and the CQC oversight measures used for identification and intervention.

The domains identified within are: Caring, Effective, Safe, Responsive and Well Led, many items within each area were provided within the TDA documentation with a further number of in-house metrics identified from our previous quality scorecard which were considered important to continue monitoring.

The scorecard includes exception reports provided for all measures which are Red, Amber or seen to be deteriorating over this period even if they are scored as green or grey (no target); identify possible issues before they become problems.

A detailed report on Urgent Care and Cancer Performance has been presented to Finance Committee

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and assurance	Risk of not delivering Urgent care and 62 day performance standards
Related Board Assurance Framework entries	BAF 11, 12 and 23

H

Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

The Trust Board is asked to review and scrutinise the exception report and note the positive achievements presented in the report.

Public Trust Board
31 July 2014

Trust Board Quality Scorecard

Revised quality scorecard for alignment with the Trust Development Authority's (TDA)

Delivering for patients:
the 2014/2015 Accountability Framework for NHS trust boards

This revised quality scorecard provides a holistic and integrated set of metrics closely aligned between the TDA, Monitor and the CQC oversight measures used for identification and intervention.

The domains identified within are: Caring, Effective, Safe, Responsive and Well Led, many items within each area were provided within the TDA documentation with a further number of in-house metrics identified from our previous quality scorecard which were considered important to continue monitoring.

A number of metrics are new, and as such will only contain one month's measure. It is important to understand that the performance presented is based on the month of availability rather than the stated month, i.e. Standardised Hospital Mortality Indicator (SHMI) which is a rolling year as available via Dr Foster or complaints which has a 40 day response timeframe.

The arrows within this report are used to identify the changes within the last 3 months reported, with exception reports provided for all measures which are Red, Amber or seen to be deteriorating over this period even if they are scored as green or grey (no target); identify possible issues before they become problems.

Northampton General Hospital NHS Trust Quality Scorecard 2014-15

Caring

Indicator	Target	Trend	Apr-14	May-14	Jun-14
Complaints rate per bed days	None	⇔	0.23%	0.24%	0.21%
Complaints responded to within agreed timescales	90%	⇩	76%	73%	67%
Friends & Family Test: Inpatient score	70	⇧	71	57	65
Friends & Family Test: A&E score	60	⇔	57	67	64
Friends & Family Test: Maternity score	70	⇧	80	68	82
Mixed Sex Accommodation	0	⇔	0	0	0
Patients in last days of life with a care plan in place	None	⇩	N/Avail	25.0%	10.8%
Transfers: All patients moved / transferred out of hours	None	⇔	30	31	31
Transfers: Patients moved with a risk assessment completed	None	⇔	15	23	23

Effective

Indicator	Target	Trend	Apr-14	May-14	Jun-14
Emergency re-admissions within 30 days (adult elective) *****	None	⇧	3.78%	3.72%	3.48%
Emergency re-admissions within 30 days (adult non - elective) *****	None	⇔	3.60%	3.83%	3.74%
Length of stay - All	None	⇔	4.84	4.57	4.66
Length of stay - Elective	None	⇔	2.78	2.97	2.78
Length of stay - Non Elective	None	⇔	5.18	4.85	5.0
Maternity: C Section Rates - Total	<25%	⇧	27.3%	27.9%	25.8%
Maternity: C Section Rates - Emergency	<14%	⇧	16.4%	14.2%	14.7%
Maternity: C Section Rates - Elective	<10%	⇧	10.9%	13.7%	11.6%
Mortality: SHMI*	Within expected range	⇔	109.8	109.8	109.8
Mortality: HSMR**		⇧	88	No Update on Dr Foster - SUS data withheld	86
Mortality: HSMR - Weekend**		⇧	88		86
Mortality: HSMR - Week day**		⇧	89		87
Mortality: Low risk conditions**		⇧	86		79
Mortality: Maternal Deaths	0	⇔	0	0	0
NICE compliance	80%	⇔	96.5%	96.6%	95.9%
Number of patients cared for in an escalation area	None	⇧	148	187	169
# NoF - Fit patients operated on within 36 hours	100%	⇔	92%	70.6%	81.0%
Percentage of patients cared for outside of specialty (General Medicine)	None	⇧	12.2%	11.0%	10.5%
Stroke patients spending at least 90% of their time on the stroke unit	80%	⇔	88.4%	83%	87%
Suspected stroke patients given a CT within 1 hour of arrival	50%	⇔	62%	58%	61%

Safe

Indicator	Target	Trend	Apr-14	May-14	Jun-14
C-Diff	Max 2.9 p/mth	⇔	1	5	1
Dementia: Case finding	90%	⇧	90.7%	91.0%	92.5%
Dementia: Initial diagnostic assessment	90%	⇔	100%	98.8%	100%
Dementia: Referral for specialist diagnosis/Follow-up	90%	⇔	95.2%	91.7%	100%
Falls per 1,000 occupied bed days	5.8	⇔	5.37	4.56	5.49
Harm Free Care (Safety Thermometer)	93%	⇔	90.4%	93.1%	92.9%
Medical Notes: Availability for clinics***	99%	⇔	N/A	100%	99%
Medical notes: Documentation - Doctors	95%	⇔	64.9%	67.8%	64.5%
Medical notes: Documentation - Nurses	95%	⇔	57.4%	59.2%	56.4%
Medical notes: Documentation - Allied Health	95%	⇧	69.5%	73.3%	74.2%
Medication errors (administration)	None	⇩	26	31	32
MRSA	0	⇔	0	0	0
Never event incidence	0	⇔	0	1	0
Pressure Ulcers: Total grade 3 & 4 hospital acquired (incidence)	None	⇧	10	9	1
Pressure Ulcers: Avoidable grade 3 & 4 (incidence) - verification of current month required prior to publishing	3	⇩	6	8	Awaiting verification
Pressure Ulcers: Avoidable grade 2 (incidence) - verification of current month required prior to publishing	7	⇔	11	11	
Open Serious Incidents Requiring Investigation (SIRI)	None	⇧	12	15	6
Open CAS alerts	0	⇔	0	0	0
TTO's sent by taxi	0	⇔	0	0	0
UTI with Catheters (Safety Thermometer-Percentage new)	0.4%	⇧	0.32%	0.64%	0.48%
VTE Risk Assessment	95%	⇔	97.4%	97.7%	97.0%

Responsive

Indicator	Target	Trend	Apr-14	May-14	Jun-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇩	92.3%	94.6%	92.8%
A&E: 4hr SitRep reporting	95%	⇩	90.86%	95.06%	92.3%
A&E: 12 hour trolley waits	0	⇔	0	0	0
Diagnostics: Number of patients waiting more than 6 weeks for a diagnostic test	0	⇔	0	0	0
Discharge: Number of medically fit patients awaiting discharge (at end of the month)	None	⇔	N/Avail	N/Avail	61
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	⇔	92.5%	95.3%	94.3%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	⇩	94.1%	93.8%	92.8%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	⇩	100.0%	100.0%	94.7%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇩	88.2%	80.0%	78.9%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇩	78.0%	78.0%	72.4%
Cancer: Percentage of patients treated within 31 days	96%	⇩	94.3%	97.1%	93.9%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	⇔	96.2%	100.0%	100.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	⇔	100.0%	100.0%	100.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	⇔	97.9%	98.9%	94.6%
Operations: Urgent Operations cancelled for a second time	0	⇔	0	0	0
Operations: Percentage of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	⇧	1	0	0
RTT for admitted pathways: Percentage within 18 weeks	90%	⇔	94.1%	95.1%	94.7%
RTT for non- admitted pathways: Percentage within 18 weeks	95%	⇔	98.6%	98.7%	98.4%
RTT waiting times incomplete pathways	92%	⇧	97.3%	97.5%	98.0%
RTT over 52 weeks	0	⇔	0	0	0

Well Led

`	Target	Trend	Apr-14	May-14	Jun-14
Friends & Family: NHS England Inpatient response rate	25%	⇧	33.3%	27.6%	34.3%
Friends & Family: NHS England A&E response rate	15%	⇧	16.6%	11.4%	18.5%
Friends & Family: NHS England Maternity response rate	20%	⇧	36.6%	34.9%	36.96%
Friends & Family: Net Promoter Score of staff that would recommend the trust as a place of work ****	None	Not applic.	-11		
Data quality of Trust returns to HSCIC (SUS)	None	⇧	89%	93%	N/Avail
Staff: Trust turnover rate	8%	⇧	11.5%	11.7%	8.7%
Staff: Trust level sickness rate	3.8%	⇔	4.3%	4.3%	4.3%
Staff: Trust level vacancy rate - Doctors		⇔	6.1%	7.4%	6.7%
Staff: Trust level vacancy rate - Nurses		⇩	9.3%	9.1%	8.8%
Staff: Trust level vacancy rate - Other		⇔	12.5%	12.5%	12.4%
Staff: Temporary costs & overtime as a % of total pay bill	None	⇔	12.3%	11.6%	11.7%
Staff: Percentage of staff with annual appraisal	85%	⇧	62.8%	64.3%	66.1%
Staff: Percentage of all trust staff with mandatory training compliance	85%	⇧	76.9%	78.1%	78.4%
Staff: Percentage of all trust staff with role specific training compliance	85%	⇧	63.7%	63.9%	65.4%

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	2	0	3	4	9
Effective	1	3	9	7	20
Safe	3	2	11	5	21
Responsive	6	0	13	1	20
Well-Led	4	1	3	6	14
Total	16	6	39	23	84

KEY	
⇧	Improving performance over 3 month period
⇩	Reducing performance over 3 month period
⇔	Stable performance delivery over 3 month period
⇔	Static underperformance delivery over 3 month period
⇧	No target but improving performance over 3 month period
⇩	No target but reducing performance over 3 month period
⇔	No target but stable performance delivery over 3 month period

* SHMI October 2012 to September 2013 (published April 2014)

** HSMR Rolling year April 2013 to March 2014

***Currently a manual audit until central reporting is in place - June 2014

**** Staff FFT is reported nationally for the 1st time for Q1 2014/15 and there is yet to be a target set. The net promoter score range is srom -100 to +100.

***** Readmissions - The figure provided is for the previous month to allow for the 30 day time lapse.

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Complaints response rate – **67%** (April 2014)	Report period:	June 2014

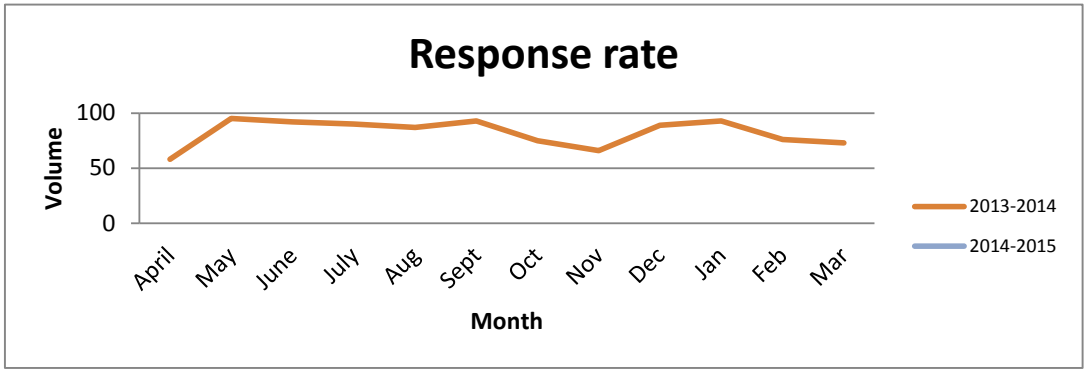
Driver for underperformance:	Actions to address the underperformance:
-A key member of staff left the Trust in early November 2013. The person was replaced but the new person has required training and has understandably worked at a slower pace. -The workload continues to grow due to the ever increasing complexity of complaints, which we report on yearly in the annual complaints report	-Temporary person was employed for 6 weeks to clear the backlog, which was complete but this has increased over time. -The additional 20 hour band 5 Complaints Officer commended in post on the 30th June 2014 – training ongoing at present -Head of Complaints is also completing responses to try to assist with the backlog. This focus will be on 'in time' complaints whilst the two officers continue to respond to 'out of time' complaints. It is hoped that this will gradually bring the response rate up. -Temporary person in post for 4-6 weeks as of the 7 July 2014 to help to clear the backlog of complaints
Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
October 2014	No Change
Lead for recovery:	Lead Director:
Lisa Cooper, Head of Complaints	Jane Bradley,

H

Historical Target Performance

% Response rate - Year on Year

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013-2014	58%	95%	92%	90 %	87 %	93%	75 %	66 %	89 %	93 %	76 %	73 %
2014-2015	67%											



NB: The table above only shows the response rate for 2013-14 as until May 2014's data is entered nothing will show on the graph.

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Friends and Family Test: Inpatient score	Report period:	June 2014

Driver for underperformance:	Actions to address the underperformance:
The Trust have implemented an in-house target Net Promoter Score (NPS) of 70 for Inpatient areas. The NPS dropped in May to 57 and although this has increased to 65 in June it is still 5 points below the target expected in the Trust.	• Comments will be analysed to identify any particular trends with regards to negative feedback and any improvements which can be made from the comments will be undertaken by the ward areas. • The areas that have achieved low NPS's have been notified and requests have been made for feedback as to what improvements will be made.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
October 2014	No change
Lead for recovery:	**Lead Director:**
Rachel Lovesy, Patient Experience Lead	Jane Bradley

Historical Target Performance

Indicator	Target	Trend	Apr-14	May-14	Jun-14
Friends & Family Test: Inpatient score	70	⇧	71	57	65

H

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Neck of Femur – Fit patients operated on within 36 hours	Report period:	June 2014

Driver for underperformance:	Actions to address the underperformance:
Excessive amount of trauma patients, particularly at weekends. Some patients with fracture neck of femur require Total Hip Replacement and may have to wait longer to ensure the appropriate surgeon is available to do the surgery. Every Tuesday it is an upper limb surgeon that does the trauma list. There are a number of patients weekly who require upper limb surgeon skills and this list is always pre booked/over booked.	The situation is highlighted every month (monthly Neck of Femur data report) to the Clinical Director and Directorate Manager. Additional Trauma list as required.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Lead for recovery:	**Lead Director:**
Mr Jason Auld	Rebecca Brown

Historical Target Performance

Indicator	Target	Trend	Apr-14	May-14	Jun-14
# NoF - Fit patients operated on within 36 hours	100%	⇔	92%	70.6%	81.0%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Healthcare Records Audit	Report period:	June 14

Driver for underperformance:	Actions to address the underperformance:
The audit findings are reported in the Quarterly Patient Safety and Clinical Quality & Governance Progress report and monthly whilst they remain as part of the Medical Directors exception report. It has been acknowledged that positive progress has been limited due to the operational challenges of the audit criteria and the meaningfulness and implications for operational staff. A revised set of questions were presented to the Medical Director as part of an options appraisal and has been discussed and approved at Strategic Management Board. With effect from **1 April 2014** the revised data set is used to audit Healthcare Records.	Improvements noted each month since inception of new data set. • Lead sends data to review monthly. • Lead has asked all Consultants and clinical directors (May 2014) to consider alternate ways of addressing this audit within their specialities and have requested that any discussions within their teams and actions are fed back to the Health Records Group. • This has been discussed at the healthcare records group meeting 11th July. • Continuous monitoring of all non-elective admission proformas is ongoing. • Discussion of the direct relevance of some of the continuously red areas, are many of these standards required?? This mainly pertains to deletions in notes, which do not often have any relevance to patient safety or compromise care.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Review at August's HRG	75.7% - maintain / slight trend increase
Lead for recovery:	**Lead Director:**
Dr Jonny Wilkinson	Mike Wilkinson

Historical Target Performance

Indicator	Target	Trend	Apr-14	May-14	Jun-14
Medical notes: Documentation - Doctors	95%	⇔	64.9%	67.8%	64.5%
Medical notes: Documentation - Nurses	95%	⇔	57.4%	59.2%	56.4%
Medical notes: Documentation - Allied Health	95%	⇑	69.5%	73.3%	74.2%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	A&E 4 hour target	Report period:	June 2014

Driver for underperformance:	Actions to address the underperformance:
Increased attendances in Emergency Dept Increased admissions Lack of flow through the Trust Number of clinically stable patients awaiting discharge with other health care providers Gaps in Staffing	Continued focus on the Urgent Care Programme Clinical Safety Huddles Senior leadership at patient tracking meetings and weekly meetings with commissioners to review capacity barriers Close working with the Urgent Care Working Group South including one, system wide, integrated action plan Improved ways of working across the Emergency Care Pathway.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
August 2014	94.5%
Lead for recovery:	**Lead Director:**
Work stream leads	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Apr-14	May-14	Jun-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇩	92.3%	94.6%	92.8%
A&E: 4hr SitRep reporting	95%	⇩	90.86%	95.06%	92.3%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Cancer Access Targets:- - *2 week GP referral to outpatient (**breast symptomatic**)* - *62 days of referral from hospital specialist* - *62 days urgent referral to treatment of all cancers* - *31 days*	Report period:	June 2014

Driver for underperformance:	Actions to address the underperformance:
• Breast capacity; New Patient clinic stopped and patients being booked at 14 days • Reallocation policy not agreed with KGH • Recruitment to oncology positions • Joint Clinic for prostate patients • Head & Neck (H&N) posts based solely at NGH for H&N cancer • Offer MRI/CT within 7 days of referral • Upper GI patients with a suspected cancer on OGD to have a CT within 2-3 days of OGD • Urology surgical capacity	• 2nd locum breast consultant in post as of 1 July to increase capacity • CCG to assist NGH in gaining agreement with KGH • Locum and permanent positions being advertised / recruited to. • Review job plan of oncologist • Rebecca Brown to lead on H&N surgical review • Review of radiology capacity • Discussions between cancer services and radiology, awaiting decision. • Reviewing allocated slots for cancer patients. Discussion with UHL 10 July •
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
We are aiming to deliver the 62 day standard for Q3 but in order to do this the Trust will only be able to tolerate 30 breaches on 201 treatments. We are aiming to deliver the 31 day standard for Q2 but this will not be achieved in Q1 The consultant upgrade is not a nationally set target and each individual patient is considered in line with our contract.	
Lead for recovery:	**Lead Director:**
Services Managers/Tracey Harris	Chris Pallot

H

Historical Target Performance

Indicator	Target	Trend	Apr-14	May-14	Jun-14
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	⇩	94.1%	93.8%	92.8%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇩	88.2%	80.0%	78.9%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇩	78.0%	78.0%	72.4%
Cancer: Percentage of patients treated within 31 days	96%	⇩	94.3%	97.1%	93.9%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Staff Sickness Rates	Report period:	Jun 2014

Driver for underperformance:	Actions to address the underperformance:
The financial year to date rate for sickness absence rose slightly to 4.25%. **In month Sickness Absence increased by 0.26% to 4.32% which is above the Trust target.** • Short term sickness absence increased from 2.06% to 2.43%. • Long term sickness absence decreased slightly by 0.11% to 1.89% which remains below Trust Target. • The total calendar days lost to sickness absence increased by 290 to 6205 days lost. The number of days lost per employee increased to 1.30 days.	• Increases in long-term sickness rates within areas are being actively managed resulting in some recent and forthcoming staff resignations. • All short term sickness absences are also actively managed with improvement notices issued as necessary. • HR Business Partners and Advisors work closely with managers to provide guidance & support in the management of sickness. • The current Industrial Action within Pathology may have an impact upon sickness rates in future months however once resolved there will be a re-integration programme to pro-actively manage the potential of staff absences.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
This is difficult to predict due to the current industrial action situation within Pathology which may have an impact upon future month's sickness rates.	It is anticipated that staff sickness rates may increase next month due to the current industrial action within Pathology.
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

H

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Staff: Trust level sickness rate	3.8%	⇔	4.2%	4.3%	4.3%

The Overall Trust Board Quality Scorecard
Exception Report

Target underperformed:	Appraisals	Target	85%	Report period:	Jun 2014
Performance: Trust compliance with exception of Medical Staff – 66.09%					
Driver for underperformance:		Actions to address the underperformance:			
Different appraisal processes in recent years have led to limited information being provided to the Learning & Development Department on in-date appraisals.		All staff should have an in-date appraisal and will need to have a further review aligned to incremental dates as per the new appraisal process.			
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:			
March 2015		67% (66.09% in June)			
Lead for recovery:		Lead Director:			
Sandra Wright		Janine Brennan			

Historical Target Performance

`	Target	Trend	Apr-14	May-14	Jun-14
Staff: Percentage of staff with annual appraisal	85%	⇧	62.8%	64.3%	66.1%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Mandatory & Role Specific Training Compliance Rates	Report period:	June 2014

Driver for underperformance:	Actions to address the underperformance:
Mandatory Training compliance rates have incrementally progressed over the last 3 years, however CQC felt that assurance was limited. Mandatory Training Review in 2013 reduced subjects and proposed target of compliance to be 75% which was achieved in March 2014 therefore target was increased to 80% to be achieved by October 2014 and 85% in March 2015 as per the Quality Schedule	New Appraisal process will encourage uptake of Mandatory training by requiring staff to have in-date training in order to incrementally progress. All subjects to have workbook, e-learning, face-to-face and Review of Knowledge sessions, thereby providing sufficient capacity. Encourage Admin & Clerical roles to access e-learning or workbook. Performance Wave refined to produce trajectories to Directors to enable challenge back to Senior Managers on progress against targets
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
March 2015	Mandatory Training 79.13% Role Specific Essential Training 67.57%
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance

`	Target	Trend	Apr-14	May-14	Jun-14
Staff: Percentage of all trust staff with mandatory training compliance	85%	⇧	76.9%	78.1%	78.4%
Staff: Percentage of all trust staff with role specific training compliance	85%	⇧	63.7%	63.9%	65.4%

H

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Finance Report Month 3**
Agenda item	12
Sponsoring Director	Simon Lazarus, Director of Finance
Author(s) of Report	Andrew Foster, Deputy Director of Finance
Purpose	To report the financial position for the period ended June 2014/15.

Executive summary

- The I&E position for Q1 is a £5.8m deficit with the forecast a projected deficit of £14.2m.
- The Trust has been unable to secure any agreement with NENE CCG in relation to the reinvestment of the excess MRET penalty above plan.
- NEL activity has performed above plan in June giving rise to a further increased provision for the associated MRET penalty.
- CIP delivery has improved but there remains significant forward risk in the CIP plan.
- A draft Financial Recovery Plan has been developed to address the projected deficit.
- The TDA have been informed of the increased projected deficit and have offered support in dealing with the excess MRET penalty. However, the TDA will continue to performance manage the Trust against the £7.8m plan submission.
- The forecast cashflow position gives rise to potential liquidity risk in H2 and a temporary borrowing application for £3m has been submitted to DH to cover the period September to November 2014.

Related strategic aim and corporate objective	Develop IBP which meets financial and operational targets.
Risk and assurance	There are a range of financial risks which pose a direct risk to delivery of the financial plan for 2014-15.
Related Board Assurance Framework entries	BAF 17, 18 and 19
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Board:

The Trust Board is asked to:

- note the NTDA's requirements in relation to the forecast I&E position.
- consider the recommendations of the report
- consider the approach and key elements required in developing a financial, recovery plan to address the emerging financial position at an early stage of the year.

Northampton General Hospital NHS
NHS Trust

Financial Position
Month 3 2014/15

Report to
Trust Board
July 2014

1. Performance against Statutory Duties & Key Issues

	YTD Actual	YTD TDA Plan	Variance	Forecast outturn	Full Year Plan	Variance
Statutory Financial Duties:	£'000	£'000	£'000	£'000	£'000	£'000
Delivering I&E Breakeven duty	-£5,781	-£2,610	£ 3,171 Adv	-£7,829	-£7,829	-
Achieving EFL (£000's)				£15,083	£15,083	£0
Achieving the Capital Resource Limit (£000's)	£1,407	£1,592	£ 185 Fav	£19,545	£19,545	£0
Better Payment Practice Code:						
Volume of Invoices	95.13%	95.00%	0.13% Fav	95.00%	95.00%	-
Value of Invoices	96.59%	95.00%	1.59% Fav	95.00%	95.00%	-

Financial Performance

- Financial performance for the period ended June 2014 is a normalised deficit of £5.8m (May £3.9m).
- NENE CCG have challenged all of the NEL over performance for M1 and 2 and will not currently reimburse the Trust for this activity which is now subject to a joint review process.
- The DoF has discussed the increased forecast deficit of £14m with the TDA and had submitted this change to the planned forecast in the Q1 finance return. The TDA have subsequently advised the Trust against this course of action and that achievement of the plan should remain a priority. The Q1 position will therefore be re-submitted with a forecast £7.8 deficit.
- A draft Financial Recovery Plan setting out the forecast position was discussed with the Board on 10th July. Further work is required to firm up the actions, assumptions and deliver the full year CIP plan if the revised forecast position is to be maintained.

Capital Expenditure

- Delivery of the full plan is contingent on the Trust making a successful application to the Independent Trust Financing Facility (ITFF) for £7.2m of new PDC loans in 14-15.

External Financing Limits (EFL) & Better Payment Practice Code (BPPC)

- The EFL for 14/15 stands at £15.1m(+ve) reflecting the planned new PDC loans required to fund the Radiology and Radiotherapy capital scheme.
- The Trust continues to improve performance against the BPPC target and has now achieved the 95% target to pay suppliers within 30 days in June.

Key issues

- The I&E position for Q1 is a £5.8m deficit with the forecast position a projected deficit of £14m.
- The overall expenditure run rate has remained static in Q1, despite a number of one off costs experienced in April. Agency nurse costs continue to increase.
- The Trust has been unable to secure any agreement with NENE CCG in relation to reinvestment of the MRET penalty above plan.
- NEL activity has performed above plan in June giving rise to a further increased provision for the associated MRET penalty.
- CIP delivery has improved in June and is now £0.4m ahead of plan. There remains forward risk in the CIP plan with high risk CIPs of £2.3m still to be identified.
- The forecast I&E position is for a projected deficit of £14m (£6.4m adverse to the plan submitted in May). This position assumes that all of the £12.7m CIP target is delivered by the financial year end (high risk).
- The TDA have been informed of the increased projected deficit and have offered support in dealing with the excess MRET penalty. However, the TDA will continue to performance manage the Trust against the £7.8m plan submission.
- The forecast cashflow position gives rise to potential liquidity risk in H2 and a temporary borrowing application for £3m has been submitted to DH to cover the period September to November 2014.
- A draft application for longer term revenue and capital cash support has also been submitted for TDA review prior to onward submission to the Independent Trust Financing Facility (ITFF) in September (earliest expected draw down date 27/10).

2.0 Financial Performance Dashboard

KPIs	Jun 14		May 14	April 14
Continuity of Service Risk Rating	2	Monitor CSR Rating 2.	2	3
EBITDA %	-2.9%	% Earnings Before Interest, Tax and Depreciation.	-2.6%	-4.5%
Liquidity (days cover)	-13	Liquidity days cover.	-11	3
Surplus Margin	-9.02%	% earnings after interest, tax and depreciation.	-9.32%	-10.47%
Pay / Income	69.9%	Total YTD Pay costs as % of YTD income.	69.6%	70.7%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position (YTD)	(5,731)	Deficit before impairment and donated asset adjustment.	(3,896)	(2,288)
Impairment and Donated Assets	(50)	Donations and donated asset depreciation adjustment.	(47)	46
Normalised Position (YTD)	(5,781)	I&E position (normalised and adjusted for donated assets).	(3,943)	(2,242)
TDA Plan (Year to date)	(2,610)	Year to date TDA Plan 14/15.	(2,023)	(1,137)
CCG SLA Income Variance	(1,201)	SLA income £1.2m adverse to plan.	(422)	(194)
Value of CCG Fines & Penalties	2,985	£2.9m provision for potential fines and penalties.	1,634	1,013
Forecast EOY I&E postion	(7,829)	Forecast to deliver £7.8m deficit plan for 14-15.	(7,829)	(7,829)
EBITDA Performance	**£000's**		**£000's**	**£000's**
Variance from plan	(3,269)	Adverse variance to planned EBITDA position	(1,779)	(1,104)
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	1,611	TDA plan for YTD	1,049	545
YTD Actual	2,060	Actual delivered for YTD	873	437
% Delivered	128%	% delivery of plan for year to date.	83%	80%
LTF	10,323	Most likely delivery FY14-15	8,927	12,387
Annual Plan	12,668	Annual CIP target.	12,668	12,668
LTF v. Plan	81%	Planned annual % delivery of plan.	70%	98%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	1,407	Capital expenditure for year to £185k behind plan.	854	265
% of annual plan Committed	28%	% of annual plan committed.	14%	8%
Annual Plan	19,851	Includes Radiology & Radiotherapy equipment replacement.	20,246	21,501
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	(447)	Decrease in non current assets.	(52)	(446)
Current assets	(1,247)	Decrease in cash balance.	(3,709)	1,833
Current Liabilities	410	Increase in accruals.	(2,404)	3,406
Cash	**£000's**		**£000's**	**£000's**
In month movement	(2,769)	In month Increase / (decrease) in cash balance.	990	(100)
In Year movement	(1,879)	YTD Increase / (decrease) in cash balance.	890	(100)
DH Temporary Loans	0	Working Capital facility of £8m requested for 14-15.	0	0
New PDC Capital	0	PDC capital required for Radiology / Radiotherapy scheme.	0	0
Debtors Balance > 90 days	1,749	CRIPPS centre, NCA and Overseas Patients.	1,030	948
Creditors % > 90 days	0.00%	No creditor balances over 90 days.	1.13%	2.84%
Cummalative BPPC (by volume) YTD	95.1%	BPPC improved in May but below 95% target.	94.1%	92.0%

Key issues

KPIs

- Continuity of Service Rating of 2 (**see Appendix 1**).

I&E Position

- I&E position adverse to plan by £3.17m (May £1.9m).
- Current forecast aims to deliver plan submitted to TDA in April but requires resolution to excess MRET position and access to CCG transformation funding.
- TDA require Trust to deliver to £7.8m deficit plan.
- YTD Pay / Income ratio increased to 70% in June.

Cost Improvement Programme

- CIP programme delivery is £2.060m, £0.4m favourable to plan for the period to June.
- Most likely case forecast delivery is £2.3m adverse to plan (requires recovery to achieve £14m forecast deficit).

Capital

- Full year capital expenditure plan stands at £19.8m (includes £306k assumption for donated assets).

Cash

- Cash balances reduced month on month due to creditor demand.
- £3m temporary borrowing facility to be requested to support operational and capital programme September to November.
- BPPC target achieved to 95% by volume (May 94%, April 92%) but contingent on maintaining working capital balance and temporary borrowing moving forward.

2.1 I&E Summary & Gross Forecast 14-15 (base M3+9)

	Annual Budget 2014/15 £000's	Gross Forecast 2014-15	YTD Actual £000's	YTG Value £000's	Action Plan (Most Likely) £000's	EOY Position £000's
SLA Clinical Income	237,701	232,499	38,793	193,705	2,421	234,919
Other Clinical Income	2,690	2,065	343	1,722	100	2,165
Other Income	24,056	25,208	3,676	21,532	7,951	33,159
Total Income	264,446	259,772	42,812	216,959	10,472	270,243
Pay Costs	(175,834)	(181,950)	(29,790)	(152,160)	3,783	(178,167)
Non-Pay Costs	(77,985)	(86,681)	(14,140)	(72,541)	2,675	(84,005)
Reserves & Provsions	(2,250)		-	-	1,000	1,000
Total Costs	(256,069)	(268,631)	(43,930)	(224,701)	7,458	(261,173)
EBITDA	8,377	(8,859)	(1,118)	(7,741)	17,930	9,071
Depreciation	(12,268)	(11,981)	(2,045)	(9,936)	503	(11,478)
Amortisation	(10)	(10)	(2)	(8)		(10)
Impairment of Fixed Assets	-	-	-	-		-
Net Interest	29	23	4	20		23
Dividend	(4,409)	(4,409)	(735)	(3,674)	50	(4,359)
Gross Surplus / (Deficit)	(8,281)	(25,235)	(3,896)	(21,340)	18,483	(6,753)
Donated Asset adj.	452	313	(47)	360		313
Surplus / (Deficit)	(7,829)	(24,922)	(3,943)	(20,980)	18,483	(6,440)

- TDA Support	(7,800)
Gross Fcst deficit	(14,240)

Key issues

- Gross forecast allowing for all known cost pressures is for a deficit of £25m if no action taken to reduce current run rate.
- A draft Financial; Recovery plan with £18.4m of actions reduces the forecast position to £14m.
- The actions noted above include an assumption that the TDA will provide system support funding of £7.8m in 14-15 (this cannot be guaranteed).
- The TDA have advised the Trust to assume that any MRET above plan is reinvested back to the Trust. This would reduce the £14m deficit by up to £4.6m.
- The Trust is targeting receipt of £1.4m of transformation funding from the CCG 2% Strategic Reserve primarily to cover existing costs incurred in the Urgent Care and Clinical Strategy reviews.
- A range of additional actions have been proposed which now need additional work up and implementation.
- Key to this is the delivery of the full CIP plan which carries significant risk and is a high priority area within the FRP.

3.0 YTD Income and Expenditure Position

I&E Summary	Annual Plan 2014/2015	YTD Actual	YTD Plan	Variance to Plan	Full Year Forecast
	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	237,701	57,886	59,087	(1,201)	237,701
Other Clinical Income	2,690	595	672	(77)	2,690
Other Income	24,024	5,623	5,945	(322)	24,024
Total Income	264,414	64,104	65,704	(1,600)	264,414
					0
Pay Costs	(175,834)	(44,789)	(44,037)	(753)	(175,834)
Non-Pay Costs	(77,953)	(21,167)	(20,262)	(906)	(77,953)
CIPs	0	0	0	(0)	0
Reserves/ Non-Rec	(2,250)	0	11	(11)	(2,250)
Total Costs	(256,037)	(65,957)	(64,288)	(1,669)	(256,037)
					0
EBITDA	8,377	(1,853)	1,416	(3,269)	8,377
					0
Depreciation	(12,268)	(2,780)	(3,067)	287	(12,268)
Amortisation	(10)	(2)	(2)	0	(10)
Impairments	0	0	0	0	0
Net Interest	29	6	7	(1)	29
Dividend	(4,409)	(1,102)	(1,102)	0	(4,409)
					0
Surplus / (Deficit)	(8,281)	(5,731)	(2,748)	(2,983)	(8,281)
Normalised Postion:					
Donated Assets	452	(50)	138	(188)	452
Impairments	0	0	0	0	0
I&E Position	(7,829)	(5,781)	(2,610)	(3,171)	(7,829)

I&E Performance

- Financial performance for the period ended June 2014 is a normalised deficit of £5.8m, compared to a planned deficit of £2.6m giving rise to an adverse variance of £3.1m for the first quarter..
- Income is £1.6m adverse to plan. (May £0.8m;April £0.6m).
- Pay expenditure is £0.75m adverse to plan. (May £0.41m; April £0.15m)
- Non-Pay expenditure is £0.9m adverse to plan. (May £0.46,;April £0.15m).
- TDA require the Trust to deliver the I&E plan as submitted in May (£7.8m deficit). This remains subject to a range of risks and assumptions, notably in relation to CIP delivery and the reinvestment of the excess MRET penalty which is not currently agreed wit the host CCG.

Key issues

SLA Income

- Underling overperformance offset by requirement to make provision for potential fines and penalties.
- EL activity 354 spells below plan in June. Daycase activity fallen by 52 cases month on month; 86 below plan in month of June.
- NEL activity above plan in June giving rise to increased MRET exposure.
- Proposal for MRET fine "capped" at 50% above plan not agreed by NENE CCG (full provision now accrued in M3).

Other Income

- £77k adverse to plan for Q1. Private Patient income £66k adverse to plan and RTA income £11k adverse to plan.
- Income Generation £322k adverse to plan. (May £289k adverse).

Pay

- Pay expenditure £0.75m adverse to plan.
- Locum medical staff and ADH costs increased by £27k month on month to £398k in June.
- Nursing pay expenditure increased to £396k adverse to plan overall.
- Temporary management and administration costs reducing.

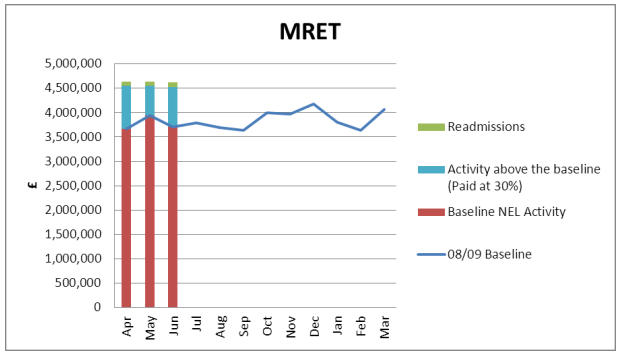
Non-Pay

- Non-Pay expenditure £0.9m adverse to plan.
- Medicines £286k adverse to plan.
- Consultancy Fees £203k adverse to plan.
- Staples and ligatures £120k adverse to plan.
- Equipment hire & maintenance £104k adverse to plan.
- Non-Pay CIPs £170k adverse to plan.

4.SLA Income

Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
Elective Daycase	9,395	8,924	(471)	5,738	5,604	(134)
Elective Inpatients	1,756	1,628	(128)	4,588	4,399	(190)
Elective Excess Bed Days	722	501	(221)	173	118	(55)
Non Elective	12,105	14,163	2,058	19,303	21,480	2,177
Non Elective Excess Bed Days	8,067	6,897	(1,170)	1,865	1,574	(291)
New Outpatients	15,806	14,955	(851)	2,392	2,289	(103)
Follow Up Outpatients	31,427	32,184	757	2,766	2,783	17
Non Cons Led Outpatients New	6,824	5,334	(1,490)	602	498	(103)
Non Cons Led Outpatients Follow Up	16,058	10,247	(5,811)	759	440	(320)
Outpatient Procedures	15,762	18,088	2,326	2,668	2,957	289
CQUIN		3	3	1,326	1,127	(199)
Block Contracts - Fixed				5,090	5,077	(14)
Cost Per Case	649,372	605,607	(43,765)	5,578	5,334	(244)
A&E	25,970	27,840	1,870	2,580	2,837	257
Excluded Medicines				3,687	4,011	325
Excluded Devices		388	388	374	462	88
Contract Challenges		111	111	34	(1,641)	(1,675)
Readmissions				(419)	(72)	346
MRET				(390)	(1,550)	(1,159)
Other Central SLA Income	(2,909)	746	3,655	(213)	159	372
Productivity CIPs				585		(585)
Total SLA Income				**59,087**	**57,886**	**(1,201)**

MRET Profile



Key issues

Underlying Performance

Month 3 position shows an underperformance of £1.2m. The main driver is c£2m over performance in non elective activity, offset by provisions for challenges. There is a £0.6m adverse variance relating to productivity CIPs which will continue to drive an adverse variance throughout the year unless identified to specific points of delivery. There is also underperformance in outpatient and elective activity.

Non Elective (NEL)

The main drivers of the Non Elective over performance are General Medicine (£1.1m) and A&E admissions (£0.5m). There is a joint investigation underway with the CCG to ascertain the reasons for this over performance. The CCG have challenged the whole of the NEL over performance value as part of their challenge and reconciliation process.

Fines & Penalties

An assessment of potential fines and penalties have been deducted from the M3 income estimate. Month 1 and 2 challenges have been received and are substantial although not fully substantiated. The process is underway to determine which challenges are valid and will be accepted. The final reconciliation point for Month 1 has been reached and final reconciliation and agreement of the M1 position is being agreed with the CCG.

Risks

The Trust is responding to a range of contractual and data challenges from NENE CCG which amount to c£5m for the first two months of the financial year. The Trust will ensure that all issues are dealt with robustly and in accordance with PbR and NHS standard contractual terms.

MRET

There continues to be a significant risk to the Trust as 30% income will not cover the costs associated with delivering all of the non-elective over performance and emerging costs pressures. The Trust is actively pursuing the reinvestment of all MRET above plan and will develop and MRET rebasing proposal for 15/16 with the TDA.

5. Statement of Financial Position

	Balance at 31-Mar-14	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
Opening Net Book Value	143,694	143,694	143,694		143,694	
In year revaluations		518	248	(270)	240	240
In year movements		1,029	1,587	558	19,851	19,851
Less depreciation		(2,045)	(2,780)	(735)	(11,764)	(11,764)
Net Book Value	143,694	143,196	142,749	(447)	152,021	8,327
Current Assets						
Inventories	5,136	5,311	5,543	232	5,300	164
Receivables:						
NHS Debtors	6,902	2,852	3,795	943	6,200	(702)
Other Trade debtors	1,710	1,378	1,374	(4)	1,800	90
Debtor impairments provision	(675)	(675)	(675)		(500)	175
Capital receivables						
Non NHS other debtors	236	510	673	163	250	14
Compensation debtors (RTA)	2,694	2,626	2,683	57	2,900	206
Other receivables	1,058	1,241	1,011	(230)	1,300	242
Irrecoverable provision	(548)	(548)	(548)		(600)	(52)
Prepayments & accruals	1,124	2,176	2,537	361	1,100	(24)
	12,501	9,560	10,850	1,290	12,450	(51)
Non Current Assets for sale						
Cash	4,445	5,335	2,566	(2,769)	4,842	397
Net Current Assets	22,082	20,206	18,959	(1,247)	22,592	510
Current Liabilities						
NHS	637	898	931	33	918	281
Trade Creditors Revenue	1,302	3,652	3,401	(251)	4,682	3,380
Trade Creditors Fixed Assets	3,261	1,084	940	(144)	2,700	(561)
Tax and NI owed	3,433	3,441	3,414	(27)	3,500	67
NHS Pensions agency	2,201	2,241	2,225	(16)	2,300	99
Other creditors	374	388	358	(30)	400	26
Short term loans	285	285	285		220	(65)
Accruals	6,658	6,513	7,421	908	6,500	(158)
Receipts in advance	535	917	543	(374)	500	(35)
PCD Dividend due		713	1,080	367		
Staff benefits accrual	811	712	712		750	(61)
Provisions < 1 yr	2,338	1,993	1,937	(56)	857	(1,481)
Net Current Liabilities	21,835	22,837	23,247	410	23,327	1,492
NON CURRENT LIABILITIES						
Short Term Loans > 1 year	341	341	341		230	(111)
Provsions > 1 year	1,384	1,384	1,384		998	(386)
Net Current Liabilities	1,725	1,725	1,725		1,228	(497)
Total Assets Employed	142,216	138,840	136,736	(2,104)	150,058	7,842
Financed by:						
PDC Capital	103,611	103,611	103,611		119,267	15,656
Revaluation Reserve	35,727	36,247	35,977	(270)	35,977	250
I & E balance	2,878	2,878	2,878		2,878	
I & E current year		(3,896)	(5,730)	(1,834)	(8,064)	(8,064)
FINANCING TOTAL	142,216	138,840	136,736	(2,104)	150,058	7,842

Key Movements

Non Current Assets

- Movement due to indexation and additions being offset by the depreciation charge in June.

Net Current assets

- Increase in Inventories (predominantly pharmacy).
- Increase in NHS Receivables of £0.9m.
- Decrease in Other Receivables of £0.2m.
- Increase in Prepayments £0.4m.
- Overall cash balance decreased to £2.6m.

Net Current Liabilities

- Decrease in net current liabilities led by Trade and Fixed Asset Creditors of £0.4m.
- Increase in Accruals of £0.9m.
- PDC dividend accrued – 6 months dividend due for half year payment in September.
- Receipts in advance decreased by £0.4m.

Non Current Liabilities

- No movement month on month.

Financing

- General reserve movement relates to fixed asset indexation adjustment now finalised for April 2014.

6. Capital Expenditure

Capital Scheme	Plan 2014/15 £000's	M3 Plan £000's	M3 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Linacc corridor	0	0	0	0	0%	0	0%
MES Equipment - Do Minimum Option FBC	7,207	0	0	0	0%	0	0%
SHSWTF - E Prescribing National Funding	738	54	34	-20	5%	490	66%
CEF Scheme	350	150	127	-23	36%	387	111%
A&E / Orthopaedics	2,331	520	558	38	24%	2,473	106%
Annual Strategic Planning Approvals	209	0	0	0	0%	0	0%
Annual Strategic Planning Approvals - MES	0	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	1,795	237	240	3	13%	304	17%
Estates Sub Committee	4,085	337	178	-159	4%	568	14%
IT Sub Committee	2,787	470	460	-10	17%	1,227	44%
Other	349	4	-10	-14	-3%	80	23%
Total - Capital Plan	**19,851**	**1,772**	**1,587**	**-185**	**8%**	**5,529**	**28%**
Less Charitable Fund Donations	-306	-180	-180	0	59%	-198	65%
Total - CRL	**19,545**	**1,592**	**1,407**	**-185**	**7%**	**5,331**	**27%**

Funding Resources	
Internally Generated Depreciation - Core	11,764
SALIX	125
SHSWTF - E Prescribing	449
MES - PDC subject to approval	7,207
Total - Available CRL Resource	**19,545**
Uncommitted Plan	**0**

Key Issues

- Linear Accelerator Corridor originally required to facilitate first linear accelerator replacement in MES in existing bunker and has now been delayed in 2014/15.
- MES Equipment – "Do Minimum" FBC Option relates to the business case submitted to the TDA, as a capital loan to be submitted to the Independent Trust Finance Facility. Unlikely that the funding if approved will be available until late October.
- SHSWTF - E Prescribing National Funding is the second year of approved funding from DH and has been matched by £300k of Trust funds.
- CEF Scheme - this is now due to complete in July / August .
- There is a current contingency of £0.209 million (was £0.223 million).
- Full year depreciation forecast is currently £11.764 million (was £12.268 million) and includes revised phasing associated with the MES purchases.
- Charitable Donations assumptions for additions in year are assumed £306k (was £100k).

7. Receivables, Payables and BPPC Compliance

Narrative	Total at June £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,374	252	240	44	838
Receivables NHS	2,226	925	221	169	911
Total Receivables	**3,600**	**1,177**	**461**	**213**	**1,749**
Payables Non NHS	(4,343)	(4,342)		(1)	
Payables NHS	(931)	(931)			
Total Payables	**(5,274)**	**(5,273)**		**(1)**	

Narrative	Total at May £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,378	322	67	324	665
Receivables NHS	2,005	472	285	883	365
Total Receivables	**3,383**	**794**	**352**	**1,207**	**1,030**
Payables Non NHS	(3,343)	(3,303)	(38)	(1)	(1)
Payables NHS	(203)	(203)			
Total Payables	**(3,546)**	**(3,506)**	**(38)**	**(1)**	**(1)**

Narrative	April 2014	May 2014	June 2014	Cumulative 2014/15	Cumulative 2013/14
NHS Creditors					
No.of Bills Paid Within Target	165	170	138	473	1,680
No.of Bills Paid Within Period	200	180	159	539	2,341
Percentage Paid Within Target	**82.50%**	**94.44%**	**86.79%**	**87.76%**	**71.76%**
Value of Bills Paid Within Target (£000's)	1,080	1,586	1,729	4,395	18,359
Value of Bills Paid Within Period (£000's)	1,164	1,643	1,875	4,682	20,478
Percentage Paid Within Target	**92.84%**	**96.53%**	**92.22%**	**93.89%**	**89.65%**
Non NHS Creditors					
No.of Bills Paid Within Target	6,363	6,405	6,280	19,048	74,920
No.of Bills Paid Within Period	6,897	6,649	6,435	19,981	81,899
Percentage Paid Within Target	**92.26%**	**96.33%**	**97.59%**	**95.33%**	**91.48%**
Value of Bills Paid Within Target (£000's)	7,759	8,607	7,382	23,749	87,974
Value of Bills Paid Within Period (£000's)	8,214	8,667	7,575	24,456	92,882
Percentage Paid Within Target	**94.46%**	**99.31%**	**97.46%**	**97.11%**	**94.72%**
Total					
No.of Bills Paid Within Target	6,528	6,575	6,418	19,521	76,600
No.of Bills Paid Within Period	7,097	6,829	6,594	20,520	84,240
Percentage Paid Within Target	**91.98%**	**96.28%**	**97.33%**	**95.13%**	**90.93%**
Value of Bills Paid Within Target (£000's)	8,840	10,193	9,111	28,144	106,333
Value of Bills Paid Within Period (£000's)	9,378	10,310	9,449	29,137	113,360
Percentage Paid Within Target	**94.26%**	**98.87%**	**96.42%**	**96.59%**	**93.80%**

Receivables and Payables

- Continued progress in reducing age profile of non current debt. Continued focus on reducing level of NCA debt.
- All monthly SLA's fully paid in June.
- Increase in over 90 day debt of £0.7m, predominantly relates to agreement of 2013/14 invoice with Herts & South Midlands Area Team. Other significant balances relate to CRIPPS, NCA's and Overseas Patients debt represents of £0.8m of the total.
- 99% of registered creditors current (due within 30 days).
- Appropriate provision and write off has been made in accordance with the stated DH and local Trust policies.

BPPC Compliance

- BPPC has continued to improve from last month to (95.13% by volume, 96.59% by value) with the payments team continuing to achieve processing within the targets once approved.
- Volume of temporary staffing invoices causing majority of poor performance trust wide. Work ongoing with bank office to improve invoice processing.

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	FORECAST JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	232,055	16,228	23,419	18,511	21,229	18,372	18,372	21,217	18,372	18,372	21,217	18,372	18,372
SLA Performance/ Other CCG Investment	-5,000					-2,000		-1,000	-1,000	-1,000			
Health Education Payments (SIFT etc)	9,569	130	2,089	218	776	776	799	799	799	799	799	799	786
Other NHS Income	16,720	3,110	1,187	675	1,407	1,714	1,232	1,232	1,232	1,232	1,232	1,232	1,232
PP / Other (Specific > £250k)	612	264		348									
PP / Other	12,767	953	941	973	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	125									45	40	40	
PDC - Capital	7,655							1,265	4,381	230	359		1,420
PDC - Revenue	8,000								3,000	2,000		1,000	2,000
Temporary Borrowing	3,000						3,000						
Interest Receivable	29	3	2	2	2	2	3	2	2	3	2	2	4
TOTAL RECEIPTS	285,533	20,689	27,638	20,727	24,514	19,965	24,506	24,615	27,887	22,782	24,749	22,546	24,915
PAYMENTS													
Salaries and wages	169,150	14,056	14,151	14,043	14,100	14,100	14,100	14,100	14,100	14,100	14,100	14,100	14,100
Trade Creditors	69,163	3,909	9,598	6,906	6,435	6,539	6,012	6,502	6,516	3,125	6,575	6,447	600
NHS Creditors	18,682	1,123	1,645	1,874	1,611	1,611	1,611	1,611	1,611	1,611	1,611	1,198	1,564
Capital Expenditure	20,390	1,749	1,231	667	652	913	1,368	2,152	2,202	4,659	1,654	1,344	1,800
PDC Dividend	4,387						2,183						2,205
Repayment of Loans	3,000								3,000				
Repayment of Salix loan	301						177						124
TOTAL PAYMENTS	285,074	20,837	26,625	23,489	22,798	23,163	25,451	24,365	27,429	23,495	23,940	23,089	20,393
Actual month balance	458	-148	1,014	-2,762	1,716	-3,199	-944	250	457	-714	809	-543	4,522
Cash in transit & Cash in hand adjustment	-62	48	-24	-7	-79								
Balance brought forward	4,445	4,445	4,345	5,335	2,566	4,204	1,005	61	311	768	54	863	320
Balance carried forward	4,842	4,345	5,335	2,566	4,204	1,005	61	311	768	54	863	320	4,842

Key Issues

- June cash balance decreased to £2.6m as a result of utilising the quarterly SLA payments, Herts & S. Midlands LAT invoice relating to 2013/14 not being paid yet as planned (£700k) and payments weekly batches being higher than average.
- Cashflow plan includes receipt of temporary borrowing of £3m which will be converted to permanent borrowing during the financial year due to planned I&E deficit. Application to access temporary borrowing to be submitted to TDA in July and PDC to be submitted to TDA/ITFF in July.
- Cashflow plan includes a net £5m reduction to SLA income relating to fines and under performance (subject to contract reconciliation process).
- Revised capital PDC loans of £7.2m included in forecast relating to the MES FBC, application to Independent Trust Financing Facility (ITFF) to be submitted in July following submission of LTFM to TDA.
- Capital expenditure profile includes the revised planned phasing of Radiology and Radiotherapy equipment.
- As a result of the impact of fines and underperformance, cash availability will impact creditor payments in December. This may have a significant impact on the BPPC performance, as payments are then likely to be delayed to the end of the financial year.

11. Conclusions and Recommendations

Conclusion:

The financial position for June continues to demonstrate that the current run rate may lead to a significant financial deficit unless remedial action is taken to address the contractual position, CIP delivery and budgetary performance. The level of fines and challenges proposed by NENE CCG continue to be excessive with "blanket" challenges being levied against he Trust for NEL activity. Further, there is an unwillingness on behalf of the CCG to commit to the reinvestment of the excess MRET penalty with the Trust. The Trust has been unable to secure any inward investment from the CCGs 2% Transformation reserve to meet additional costs incurred in 14-15. In response the Trust is taking additional steps to ensure all challenges a robustly defend and the core principles of Payment by Results and the NHS Standard contract are followed in all aspects.

The month 1 contract reconciliation is not yet completed and the CCG have indicated that they will not pay for any non-elective over performance. A joint review of the NEL position has now been concluded which highlights an increase in NEL admissions primarily due to the introduction of the Emergency Observation Area in A&E earlier in the year. The CCG have challenged the contractual basis of this activity despite the pathway having been agreed by the Urgent Care Board and being recognised as best practice.

The most likely forecast position based on known assumptions is for a deficit of £14.2m, an increase of £6.4m above the plan position submitted in May. Key to delivery of this position is identification and delivery of the £2.3m CIP shortfall in the second half of the financial year. This position includes a range of additional cost pressures in the second half of the financial year together with assumptions about the level of winter funding to be received to offset these costs.

The TDA are aware of the potential risk to the I&E position but require the Trust to maintain focus in delivering the £7.8m deficit plan and have not permitted the Trust to increase the forecast deficit at Q1.

Recommendations & actions

- Executive Team to further develop Financial Recovery Plan and strategy to address emerging financial position.
- M1 contract reconciliation to be swiftly concluded and robust response to CCG M2 challenges to income position required.
- Agreement of 100% reinvestment of excess MRET above plan to be secured with CCG.
- CIP delivery – ongoing review of financial projections, project plans and milestones to inform financial recovery plan.
- Identification of mitigating actions to eliminate CIP risk.
- CQUIN – 85% of income accrued. Establish early review of CQUIN metrics and performance to inform CCG reviews.
- Significant expenditures – curtail all significant / new expenditure until I&E run rate is stabilised.
- PDC loans – applications for temporary borrowing and capital PDC to be progressed (target date for submission July).
- Increased controls over agency usage in Nursing and medical staffing required / increased recruitment.
- Engagement with the NTDA to understand the potential impact to NGH in relation to national announcements regarding System Support, RTT and winter funding.
- Develop case for MRET rebasing in 15-16 with support of NTDA and reinvestment of excess MRET penalty in 14-15.

Appendix 1: Continuity of Service Risk Rating (CSR)

		M3 £000's	M2 £000's	M1 £000's	EOY £000's
LIQUIDITY RATIO (DAYS)		**£000's**	**£000's**	**£000's**	**£000's**
Working Capital Balance					
Total - Current Assets	+	18,959	20,206	23,757	22,592
Total - Current Liabilities	+	-23,247	-22,837	-23,334	-23,327
Inventories	-	5,543	5,311	4,860	5,300
Non-Current Assets Held for Sale	-	0	0		
PFI Prepayments - Current Portion	+	0	0		
Financial Assets Available for Sale	+	0	0		
Current Assets held for Sale by Charitable Funds	+	0	0		
Current Liabilities held for Sale by Charitable Funds	+	0	0		
(1) Working Capital Balalnce		**-9,831**	**-7,942**	**-4,437**	**-6,035**
Annual Operating Expenses					
Gross Employee Benefits	+	-45,895	-30,521	-30,521	-179,314
Other Operating Costs	+	-23,964	-16,195	-16,195	-92,898
Impairments: IFRIC 12	+	0	0	0	0
Depreciation	+	2,780	2,045	2,045	11,764
Amortisation	+	0	0	0	0
Stock Write down	+	0	0	0	0
Impairment of Receivables	+			0	0
(2) Annual Operating Expenses	* -1	**67,078**	**44,672**	**44,672**	**260,448**
Liquidity Ratio Days		**-13**	**-11**	**-3**	**-8**
(A) LIQUIDITY SCORE		2	2	3	2
CAPITAL SERVICING CAPACITY					
Revenue Available for Debt Service		-2,028	-1,249	-938	7,908
Annual Debt Service		1,102	735	367	4,815
Capital Servicing Capacity (times)		**-1.8**	**-1.7**	**-2.6**	**1.6**
(B) CAPITAL SERVICING CAPACITY SCORE		**1.0**	**1.0**	**1.0**	**2.0**
CONTINUITY OF SERVICES RATING		**1.5**	**1.5**	**2.0**	**2.0**

Key issues

CSR

- Replace previous monitor Financial Risk Ratings
- Monitored by TDA (monthly).

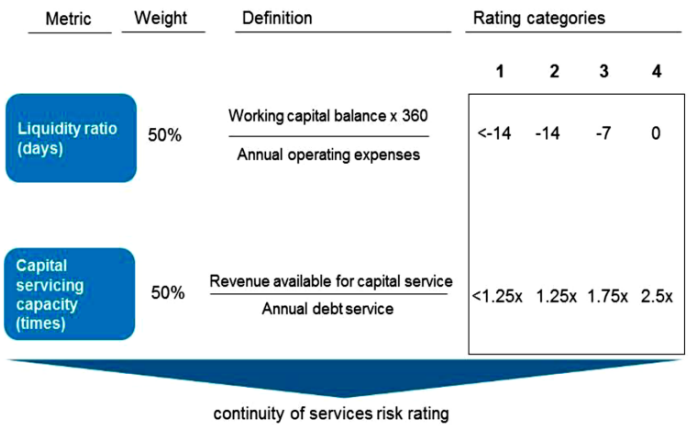
M3 Position

- Overall score of 1.5 for Q1.
- Liquidity score of 2, increase in -ve working capital balances
- Debt capacity score of 1 due to in year deficit.

Forecast EOY

- Forecast based on achievement of £7.8m deficit plan.
- Forecast score of 2 overall.
- Liquidity score will reduce if planned deficit not maintained / ITFF application unsuccessful.
- 14-15 TDA system support funding unconfirmed.

Monitor Guidance (extract)



Report To	**Public Trust Board**
Date of Meeting	**31 July 2014**

Title of the Report	**Improving Quality and Efficiency Report**
Agenda item	13
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Paul Devlin – Assistant Director Improving Quality and Efficiency
Purpose	Update to the Committee on the Latest Thinking Financial forecast of the Improving Quality and Efficiency Programme
Executive summary The most likely delivery at M3 is £10.323m, which is up by £1.4m against month 2. This is off plan by £2.345m against the £12.668m plan prior to mitigation. The plan submitted to the TDA required delivery of £1.6m in the first 3 months. Actual delivery is £2.1m, ahead of plan by £449k.	
Related strategic aim and corporate objective	Strategic Aim 5: To be a financially viable organisation.
Risk and assurance	The latest thinking forecast is £12.136m against the £12.668m required delivery.
Related Board Assurance Framework entries	BAF 21
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

The Trust Board is asked to note and challenge the content of the report.

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

JULY 2014

Executive Summary

Northampton General Hospital NHS
NHS Trust

IQE Plan for 2014/15

The Trust submitted a deficit plan for 2014/15 of £7.8m to the TDA. The main drivers for this deficit were:

- A shortfall in recurrent delivery of the 2013/14 CIP programme
- 50% MRET non reinvestment
- Essential quality investment

This deficit plan leaves the Trust with a CIP requirement of £12.7m for 2014/15

The most likely forecast for Month 3 June 2014

The most likely delivery at M3 is £10.323m, which is up by £1.4m against month 2. This is off plan by £2.345m against the £12.668m plan prior to mitigation.

The plan submitted to the TDA required delivery of £1.6m in the first 3 months. Actual delivery is £2.1m, ahead of plan by £449k.

Next Steps

A number of high priority next steps have been identified in order to rapidly progress the programme and ensure delivery:

- Optimise the delivery of all schemes and themes through increased governance arrangements (IQE Recovery Plan page 8/9)
- Identify 'quick wins' from the Deloitte Clinical Strategy workshops and include in 2014/15 programme.
- Ensure that all Directorate and Service areas contribute to the CIP.
- Increase the scope of existing Trust wide Themes and place greater focus on all Amber and Red rated schemes to ensure maximum delivery.

Quality Impact Assessments (QIAs)

The completion of QIAs for all appropriate schemes continues prior to the start of any project work.

A QIA confirm and challenge session with the Commissioners was held in June to determine the effectiveness of our current processes.

Having reviewed 4 QIA's in detail; Commissioners were satisfied that the process used was appropriate. They did however make some recommendations; those relating to the sign off process have been put in place.

The Trust's QIA Policy will be revised to reflect the new recommendations as part of its annual review which will be completed by August 2014.

Risks and Issues

Given that a proportion of plans for 2014/15 schemes are in the development and early delivery phase; some of the financial targets will not be fully achieved in year due to slippage in delivery or risk materialising.

Action has previously been taken to mitigate the risk of under-delivery by integrating an additional £2.237m worth of new schemes into the existing work streams. All but two of these initiatives have been integrated with existing work streams.

Further mitigating is required to address the gap ensuring that the overall target of £12.668m will be delivered.

2014/15 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M2 Most Likely £000s	M3 Most Likely £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	12,005	95%	8,927	↑ 10,323	81%	-1,682
Shortfall	663	5%	3,741	↓ 2,345	19%	1,682
Total Efficiency	**12,668**	**100%**	**12,668**	**12,668**	**100%**	**0**
CIP delivery vs turnover	**4.6%**		**3.4%**	**4.0%**		

Identification of the Transformation Programme 2014/15
The table outlines the current most likely delivery compared to the plan submitted to the TDA in April 2014. The current forecast of £10.323m if delivered in full would be a 4% CIP.

This leaves a shortfall of £2.3m to be identified.

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Recurrent schemes	8,226	65%
Non-recurrent schemes	2,097	17%
Total needed to be identified	2,345	19%
Total Efficiency	**12,668**	**100%**

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Pay	4,137	33%
Non pay	2,316	18%
Income	3,870	31%
Total needed to be identified	2,345	19%
Total Efficiency	**12,668**	**100%**

Pay schemes account for 33% whereas pay costs are 68% of turnover.
This suggests that there are likely to be more opportunities from workforce related schemes.

Over £2m of schemes are non-recurrent. This poses a risk in 2015/16

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
CIP Schemes	6,959	55%
Run rate Schemes	3,364	27%
Total needed to be identified	2,345	19%
Total Efficiency	**12,668**	**100%**

Of the £10.323m forecast delivery, £7m is a budgetary CIP and £3.4m is a run rate reduction.

This poses a significant risk to the planned financial position of £7.8m deficit as the £12.668m has been assumed to bridge the gap between budgeted income and expenditure targets.

Most Likely forecast 2014/15

Northampton General Hospital NHS
NHS Trust

Theme	Year to date			Full year 2014/15		
	Plan	Actual	Variance	Plan	Most Likely	Variance
Workforce	£60,000	£114,646	£54,646	£239,000	£317,046	£78,046
Back Office	£0	£0	£0	£250,000	£120,300	-£129,700
Rightsizing the Organisation	£21,000	£42,500	£21,500	£85,000	£170,000	£85,000
Individual Driven Themes	£0	£0	£0	£0	£0	£0
Urgent Care	£0	£0	£0	£25,000	£10,000	-£15,000
Medical Productivity	£75,000	£24,847	-£50,153	£800,000	£397,504	-£402,496
Patient Pathways	£0	£36,000	£36,000	£537,000	£360,529	-£176,471
Nursing & Midwifery Productivity	£0	£0	£0	£1,001,000	£406,750	-£594,250
Procurement	£167,000	£210,779	£43,779	£1,249,000	£694,742	-£554,258
Directorate CIPs	£1,123,000	£1,558,755	£435,755	£5,669,000	£6,811,101	£1,142,101
2013/14 FYE	£0	£72,165	£72,165	£0	£139,854	£139,854
New Schemes	£0	£0	£0	£2,150,000	£894,800	-£1,255,200
Unidentified	£165,000	£0	-£165,000	£663,000	£0	-£663,000
Total	**£1,611,000**	**£2,059,693**	**£448,693**	**£12,668,000**	**£10,322,626**	**-£2,345,374**

The most likely case of current schemes has been assessed based on 40% of the red rated schemes being achieved, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

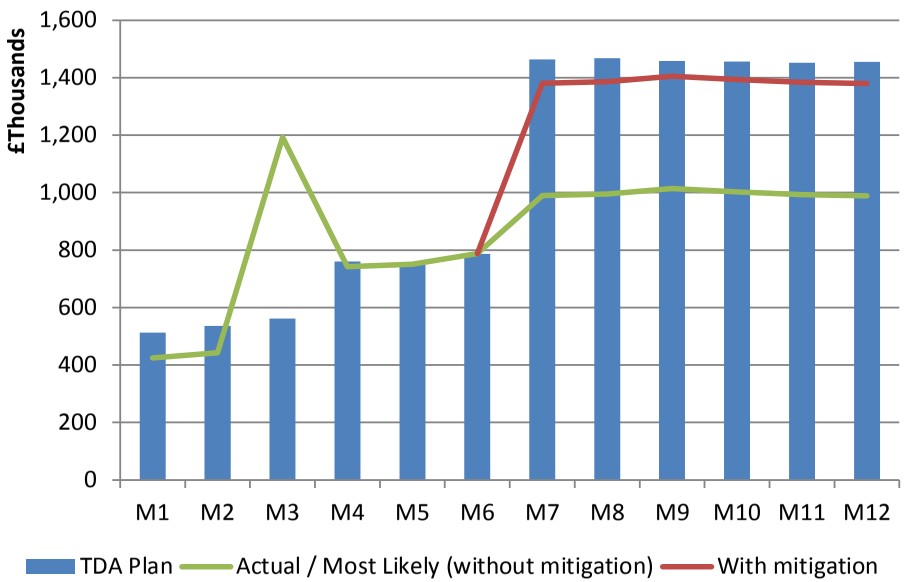
Mitigations to close the gap include

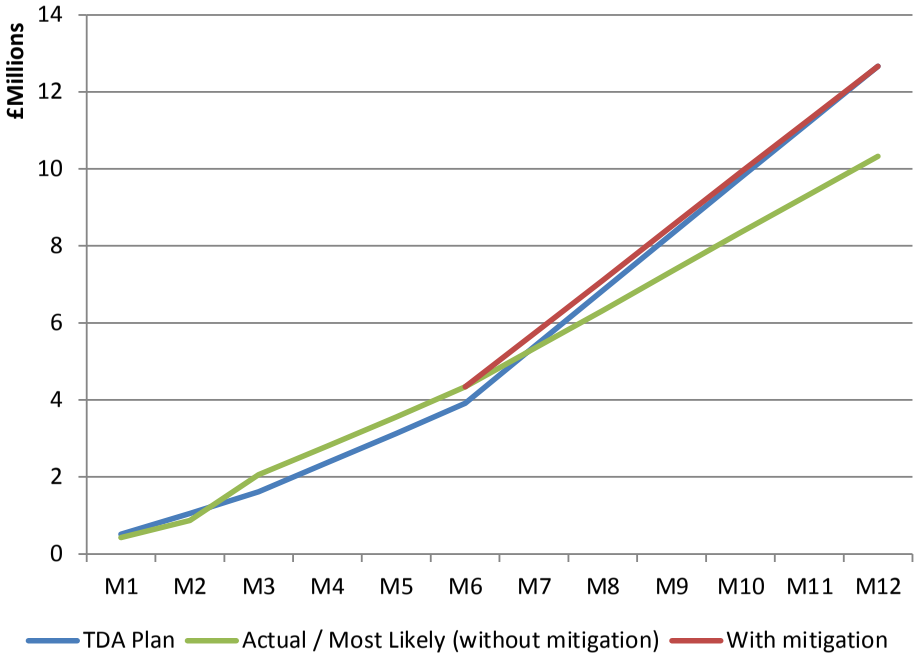
- Ensure that we convert the red and amber schemes into full delivery (£3.7m)
- Refocusing the remit of the existing Trust wide themes to include a central procurement model and expansion of patient
- flow initiatives.
- Improvement of performance management processes at Directorate level.
- Improvement of central governance processes through a dedicated Programme Management Office.
- Following completion of Clinical Strategy Consultancy, identify any ‘quick wins’ and include in 2014/15 programme.
- Identify quick wins as well as ongoing opportunities from the Making Quality Count Trust wide Service Improvement Programme.
- Ensure that we have some level of CIP contribution from each Directorate & Service area.

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

Overall Performance | **On trajectory**





Actual delivery in month 3 was £1.2M against planned delivery of £562k. This is primarily due to non-recurrent savings being reported in month 3 which had not been in previous months, so there was a catch-up in month 3.
The monthly plan increases significantly from M7 onwards. Development of additional schemes will mitigate the risk of falling off trajectory going forward.

The cumulative delivery of schemes is £449k ahead of the TDA plan at month 3. The plan submitted to the TDA requires savings to accelerate from month 7 onwards.

Risk Delivery Profile

Northampton General Hospital NHS
NHS Trust

	Most Likely	% of Total target	Most Likely with mitigation	Worst Case
	£'000s		£'000s	£'000s
Green	6,394	50%	6,394	6,394
Amber	1,868	15%	2,491	1,868
Red	2,061	16%	3,784	0
Total	**10,323**	**81%**	**12,668**	**8,262**
Gap	2,345	19%	0	4,406

All schemes, including individual Care Group, Corporate and Trust wide initiatives have been RAG rated.

The most likely case of current schemes has been assessed based on 40% of the red rated schemes being achieved, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

The downside assessment of current schemes has been assessed based on none of the red rated schemes are achieved, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

The downside case based on current RAG rating would see the programme realise £8.262m.

If all schemes fully deliver, with the mitigations, the full £12.668m can be delivered.

	FY14/15 LTF £'000			
Scheme	R	A	G	Total Identified
A1: Site Bed Team	-	-	-	-
A2: Surgery	-	-	516	516
A3: Anaesthetics	-	-	1,107	1,107
A4: T&O	25	151	74	250
A5: Head & Neck	-	98	50	147
A6: Child Health	-	450	455	905
A7: Obs & Gynae	454	138	89	681
A8: Opthalmology	75	334	67	476
A9: Surgical Care Management	-	-	24	24
SCG sub total	**554**	**1,171**	**2,381**	**4,106**
B1: General Medicine	150	-	1,437	1,587
B2: Pathology	67	63	188	318
B3: Oncology	5	41	120	166
B4: Radiology	2	71	90	163
B5: Research & development	-	-	10	10
B6: Pharmacy	33	14	123	170
B7: Therapies	-	-	-	-
B8: Medical Care Management	-	-	-	-
MCG sub total	**257**	**189**	**1,967**	**2,414**
C1-C7 Corporate Areas	-	50	323	373
C7: Facilities	-	590	315	905
Support sub total	**-**	**640**	**639**	**1,278**
Care Group & Corporate CIP Total	**811**	**2,000**	**4,987**	**7,798**
Workforce	113	-	272	385
Back Office	192	58	-	250
Rightsizing the Organisation	-	-	170	170
Individual Staff Lead Themes	-	-	-	-
Urgent Care	25	-	-	25
Medical Productivity	819	-	70	889
Patient Pathways	-	433	36	469
Nursing Productivity	955	-	25	980
Procurement	-	-	695	695
FYE of 13/14 schemes	-	-	140	140
New Schemes	2,237	-	-	2,237
Gap	(1,369)	-	-	(1,369)
Total	**3,783**	**2,491**	**6,394**	**12,668**

Theme Savings

Northampton General Hospital NHS
NHS Trust

Theme	Year to date			Full year 2014/15		
	Plan	Actual	Variance	Plan	Most Likely	Variance
Workforce	£60,000	£114,646	£54,646	£239,000	£317,046	£78,046
Back Office	£0	£0	£0	£250,000	£120,300	-£129,700
Rightsizing the Organisation	£21,000	£42,500	£21,500	£85,000	£170,000	£85,000
Individual Driven Themes	£0	£0	£0	£0	£0	£0
Urgent Care	£0	£0	£0	£25,000	£10,000	-£15,000
Medical Productivity	£75,000	£24,847	-£50,153	£800,000	£397,504	-£402,496
Patient Pathways	£0	£36,000	£36,000	£537,000	£360,529	-£176,471
Nursing & Midwifery Productivity	£0	£0	£0	£1,001,000	£406,750	-£594,250
Procurement	£167,000	£210,779	£43,779	£1,249,000	£694,742	-£554,258
2013/14 FYE	£0	£72,165	£72,165	£0	£139,854	£139,854
Total	**£323,000**	**£500,937**	**£177,937**	**£4,186,000**	**£2,616,724**	**-£1,569,276**

The Improving Quality & Efficiency Themes are currently projecting a shortfall of £1.6m against the required plan of £4.186m.

Work is currently underway to within Directorates to prepare plans for closing any gaps and these will be presented to the IQEG. This is in response to a new approach by IQEG stating that no Themes will be valued down unless new initiatives are found to close the gap.

Workforce is ahead of plan by £55k after 3 months due to admin bank & agency costs coming down year on year ahead of plan.

Back Office savings are due to start in the second half of the year. It is not expecting to fully deliver to plan.

Rightsizing the Organisation are over achieving YTD and will exceed the full year target.

Urgent Care savings are due to start in the second half of the year. It is not expecting to fully deliver to plan.

Medical Productivity is off plan by £50k after 3 months and forecasting £402k off plan full year due to phasing of job planning, medical recruitment and the locum managed service initiatives.

Patient Pathways are ahead of plan by £36k after 3 months due to savings starting earlier than expected. It is forecast to be £176k off the annual plan, this is due to the removal of the expected PA efficiencies.

Nursing & Midwifery Productivity are behind plan by £594k .

Procurement are behind plan by £554k. This is due to a stretched target.

IQE Recovery Plan 1

Northampton General Hospital NHS
NHS Trust

Objective	Strategy for Achieving Objective	Lead	Date
1. Improve the effectiveness of the IQEG meeting	a) The IQEG meeting will run as a robust confirm & challenge session	JB/PD/Execs	8th Jul
	b) Theme work stream leads to present their update reports at IQEG instead of IQET	WSL's	15th Jul
	c) Mandatory attendance by Theme Leads or reps. reporting progress/remedial actions	TEL's	15th Jul
	d) Action log circulated within one day of the IQEG meeting	VB/IM	8th Jul
	e) Action updates & presentations must be with the IQE PMO by 12:00 on Thursdays	IM/ IQE Leads	15th Jul
	f) PMO will chase updates that are late and track the progress of action log items	IM	15th Jul
	g) Late updates on actions or presentations will be escalated to Exec/Theme Leads	IM	15th Jul
	h) IQEG papers will be circulated by the 17:00 Friday before each IQEG meeting	VB	18th Jul
	i) No papers will be tabled at IQEG on the day of the meeting	TEL's	8th Jul
2. Improve the effectiveness of Theme Steering Groups	a) Theme Steering Groups will meet at least monthly	TEL's	1st Aug
	b) Theme work stream groups will meet at least monthly	WSL's	1st Aug
	c) All works streams will have an up to date project brief & master schedule	WSL's	1st Aug
	d) Milestones and key tasks will be phased correctly with correct lead times	WSL's	1st Aug
	e) Highlight Reports will be reviewed for all work streams at each meeting	TEL's	1st Aug
	f) Work stream master schedules will be reviewed for progress at each meeting	TEL's	1st Aug
	g) Meetings convened versus scheduled & attendees will be reported to IQEG	IM	1st Aug
	h) The benefits realisation plan will match finance phasing schedule	IQE Leads	1st Aug
	i) Financial variance will be monitored & mitigated, attend IQEG to report	IQE Leads	1st Aug
	j) Allocate savings in line with the Theme Savings Guidance Document	WSL's	1st Aug
	k) Ensure that services leads deliver master schedule tasks as required	WSL's	1st Aug

IQE Recovery Plan 2

3. Strengthen IQE project management processes	a) Produce a standardised set of IQE project documentation	PD	3rd Jul
	b) PMO will undertake the initial population of the new project documentation	IM	18th Jul
	c) Cascade standard documentation for use across all Themes & work streams	IQE Leads	18th Jul
4. Improve monitoring & accountability processes	a) IQET, SL & JB will meet weekly to assess progress against milestones & this plan	PD	1st Aug
	b) IQE Leads & work stream leads will review master schedules weekly	IQE Leads	1st Aug
	c) IQE Leads will produce weekly Highlight Reports for each work stream	IQE Leads	18th Jul
	d) PMO will produce a weekly milestone tracking report for covering all Themes	IM	18th Jul
	e) Performance management reviews will monitor Themes progress	SL/JB	1st Aug
5. Strengthen governance around planned financial values of Themes	a) No changes to Theme or work stream values/phasing prior to IQEG approval	TEL's	8th Jul
	b) Executive Theme Leads will present recovery plans for any variance at IQEG	TEL's	1st Aug
	c) Implement a formal income sign off process with the contracting team	PD	18th July
	d) Steering Groups will ensure compliance to Theme Savings Guidance document	TEL's	1st Aug
6. Increase IQE visibility across Directorates & optimise Theme engagement	a) PD or SL will attend all Theme Steering Groups except workforce (JB)	PD/SL	1st Aug
	b) Zero base all non-point of delivery savings from themes	IQE	3rd July
	c) IQE Leads will be allocated a service area to meet with to promote IQE Themes	JB/IQE	3rd July
	d) IQE Leads briefed on themes for sharing with managers	IQE team	7th July
	e) Themes briefing meetings will be provided to General & Service Managers *	CGD's	8th July
	f) Care Groups identify opportunities for their directorates	IQE	29th July
	g) Themes briefing meetings will be provided to Corporate directors	IQE/CGD's	29th July
	h) Formula's/apportionments for allocations to be approved by IQEG	IQE	8th July
	i) CIP apportioned to directorates upon delivery	Fin/IQE	Upon delivery
7. Focus more of IQET's time on facilitating progress against Theme action plans (master schedules)	a) Ensure that all Theme work stream master schedules are current	IQE Leads	18th Jul
	b) Ensure that IQET are tasked against work stream master schedule activities	PD	25th Jul
	c) Minimize any non-related Theme activity undertaken by IQET colleagues	PD	25th Jul
	d) Theme Executive leads to provide administrative support for Steering Groups	TEL's	25th Jul
	e) Project leads to provide administrative support for work stream meetings	WSL's	25th Jul
	f) Appoint a PMO Management Accountant to lead Theme finances (in post TBC)	PD	31st Aug
	g) Use external support to release some IQE members from MQC training days	PD	31st Aug
	h) Use external support to cover the IPP Theme and Medical Care Group	PD	31st Aug

* Existing meetings will be utilised as much as possible such as monthly budget holder meetings & Care Group Boards.

Key to Leads:

JB:	Janine Brennan	GW:	Gwawr Evans	IM:	Innocent Muza
SL:	Simon Lazarus	TEL's:	Theme Executive Leads	IQE Leads:	Gwawr Evans, Lorna Gould, Sandy Jennings, Richard Milestone
PD:	Paul Devlin	WSL's:	Work Stream Leads		
VB:	Vikki Burgess	CGD's:	Care Group Directors	Document prepared by Paul Devlin Assistant Director of IQE.	

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Workforce Report**
Agenda item	14
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Joanne Wilby, Workforce Planning & Information Manager
Purpose	This report provides an overview of key workforce issues

Executive summary

The key matters affecting the workforce include:

- The key performance indicators show an increase in Total Workforce Capacity (excluding Medical Locums) employed by the Trust, and an increase in sickness absence.
- An update on Mandatory and Role Specific Essential Training, and Appraisals.
- An update on current Organisational Development workstreams.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 17
Equality Impact Assessment	No
Legal implications / regulatory requirements	No

Actions required by the Trust Board

The Board is asked to note the report

K

Public Trust Board
31 July 2014

Workforce Report

1. Introduction

This report identifies the key themes emerging from June 2014 performance and identifies trends against Trust targets.

It also sets out current key workforce updates.

2. Workforce Report

2.1 Key Workforce Performance Indicators

The key performance indicators show:

Sickness Absence

The financial year to date rate for sickness absence rose slightly to 4.25%. In month sickness absence increased by 0.26% to 4.32% which is above the Trust target.

The non-medical sickness absence rate for the General Surgery Care Group increased to 4.96%. There were improvements in the General Surgery and Trauma & Orthopaedics Directorates but increases in all other areas.
The non-medical sickness absence rate for the General Medicine Care Group increased to 4.73%, with improvement in Pharmacy, Radiology, and Oncology & Haematology. Pathology was unchanged but there were increased rates in Therapies and General Medicine.

The total sickness absence rate within Facilities increased in June to 4.11%. Hospital Support also saw an increase to 3.47%. The rate for Support Services remains below Trust target, and 3.75%.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) increased by 84.22 FTE in June to 4,414.11 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,560.93 FTE.

Substantive workforce capacity increased by 9.93 FTE, to 4,090.16 FTE.

Temporary workforce capacity (excluding Medical Locums) increased by 74.29 FTE to 323.95 FTE.

With effect from 1st August 2014, a new regional agency framework comes into place which is managed by the East of England Commercial Procurement Hub.

The framework covers the following services:

- Community Nursing
- General Nursing
- Critical Nursing
- Mental Health
- Midwifery
- Specialist Nursing

Within the new framework agreement there are some significant changes in the way that agencies are selected as suppliers and the way in which the framework is both monitored and managed by Trusts and the Regional NHS Procurement Hubs.

The framework provides a transparent contract pricing mechanism to realise efficiency savings through negotiating service level agreements which benefit from additional discounts for Tier 1 and volume of business agreed with the appointed framework agencies.

2.2 Workforce Updates

Appraisals

The current rate of completed PDP's or Appraisals recorded is 66.09%; continuing the improvement seen since March. The appraisal audit was completed at the end of June to enable the new system to become embedded. To support the new system a regular audit on quality of appraisals will commence in July. The current Trust target for appraisal compliance is set at 85%, to be achieved by March 2015 in accordance with the Contract Quality Schedule. It is proposed that all areas currently achieving less than 85% compliance with Appraisals should ensure that this is identified on their Risk Register and develop action plans accordingly to demonstrate how they will achieve this by March 2015.

Mandatory and Role Specific Essential Training

The Mandatory & Role Specific Essential Performance Wave has been refined and simplified so that all Managers are aware of what they will receive on a monthly basis and what is required of them to be able to provide assurance. General Managers are also provided with information to enable them to raise challenges and seek assurance. Mandatory Training compliance has increased to 78.42% in June.

RSET compliance has increased to 65.43%. The scoping of Role Specific Essential Training has been shared with Training Leads and General Managers. The aim is for the ESR system to be updated as soon as possible, matching competences to positions, to enable more accurate monitoring and reporting of compliance. The first course to be successfully uploaded was BLS Cardiac Prevention. Work will now continue in uploading the other courses.

Areas that are currently achieving less than the required compliance levels should ensure that this is identified on their Risk Register and action plans are developed accordingly to demonstrate when they will achieve overall compliance.

Organisational Development

The Organisational Development (OD) department are progressing with each of the work streams as identified in the organisational effectiveness strategy.

Highlights for this month include:

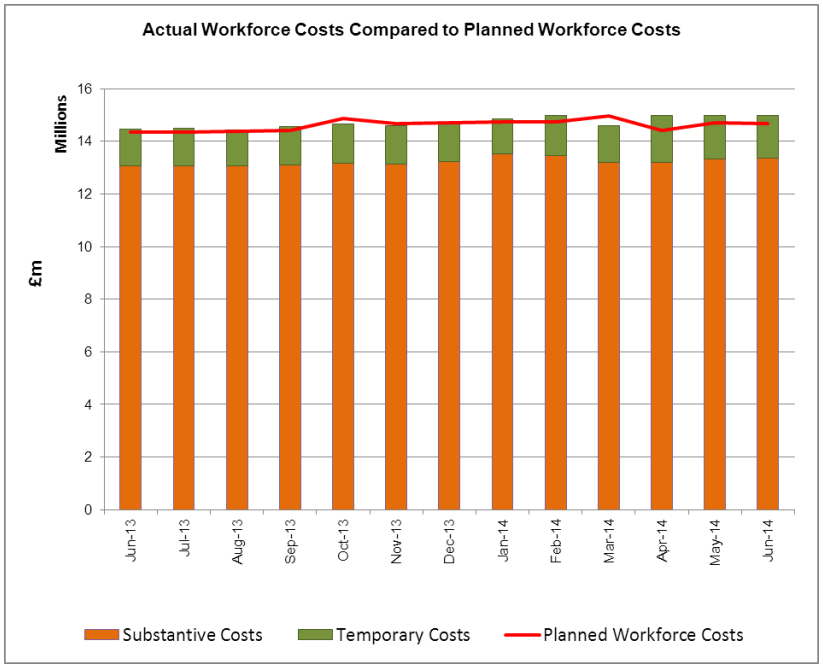
- The department are currently working on 19 work streams, one of which includes 9 separate departments with specific OD interventions.
- OD continues to support the people part of the Making Quality Count programme.
- To date we have trained in excess of 200 people in the Colours programme with some excellent feedback.
- A management development programme is in the process of being designed.
- Following Deloitte's work regarding governance the team were involved in supporting and facilitating workshops consulting with senior staff on options for service models.
- The staff friends and family test is now being undertaken in the Medicine care group.

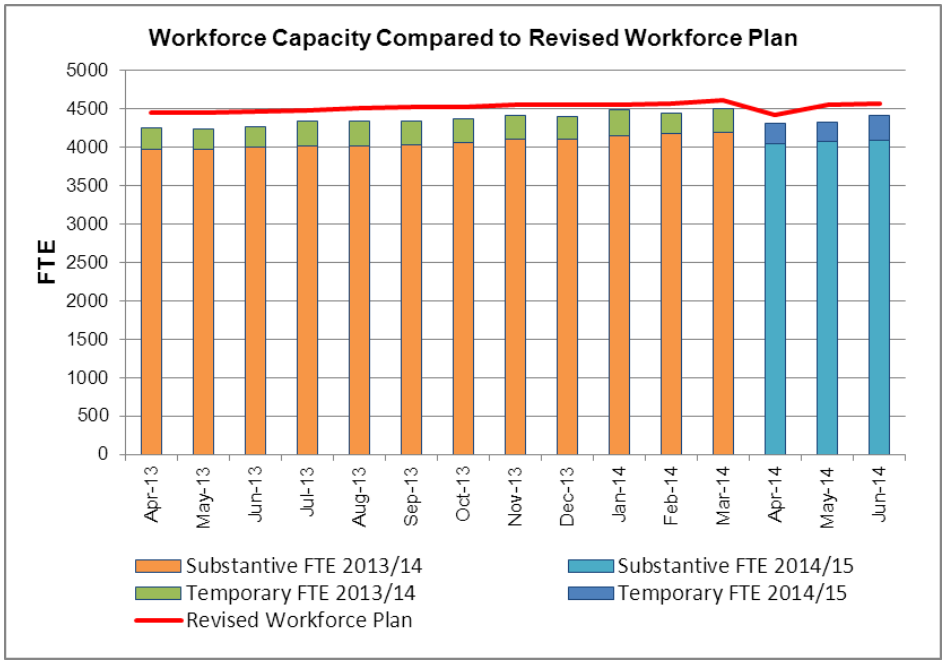
3. **Assessment of Risk**
   Managing workforce risk is a key part of the Trust's risk assessment programme.

4. **Recommendations**
   The Board is asked to note the report.

5. **Next Steps**
   Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Human Resources Workforce Performance Indicators 2014/15 Month 03





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive Costs 2013/14 (£1,000's)	12927	12979	13057	13056	13070	13111	13153	13148	13238	13521	13470	13193
Substantive Costs 2014/15 (£1,000's)	13197	13317	13353									
Temporary Costs 2013/14 (£1,000's)	1311	1370	1399	1444	1371	1443	1493	1460	1420	1325	1530	1387
Temporary Costs 2014/15 (£1,000's)	1774	1674	1646									
Planned Workforce Costs 2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14876	14691	14710	14738	14752	14961
Planned Workforce Costs 2014/15 (£1,000's)	14422	14702	14669									

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive FTE 2013/14	3,976	3,977	4,000	4,016	4,013	4,035	4,059	4,108	4,110	4,149	4,179	4,185
Substantive FTE 2014/15	4,040	4,080	4,090									
Temporary FTE 2013/14	266	263	260	329	329	305	316	303	291	334	269	324
Temporary FTE 2014/15	267	250	324									
Revised Workforce Plan 2013/14	4,452	4,450	4,462	4,476	4,502	4,522	4,522	4,553	4,555	4,558	4,564	4,619
Revised Workforce Plan 2014/15	4,420	4,551	4,561									

Workforce Expenditure

Total Workforce Expenditure (all pay elements) increased by £8,530 in June to £14.999m (this is above plan for Month 3).

Substantive workforce expenditure increased by £36,342 to £13,353,244.

Temporary Workforce Expenditure (including Medical Staff) decreased by £27,813 to £1,645,958, equating to 10.97% of the of the total workforce expenditure.

Workforce Capacity

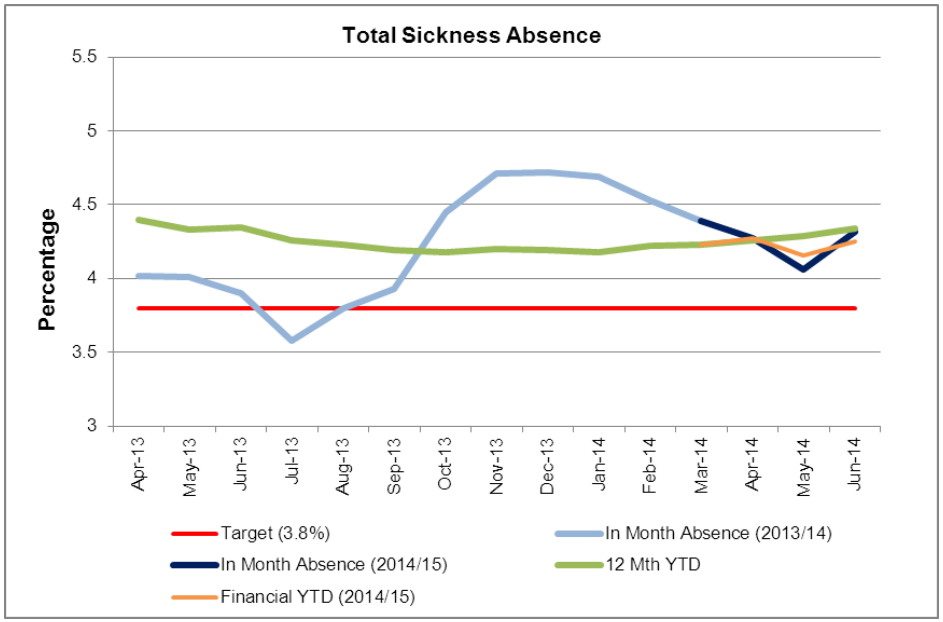
Total Workforce Capacity (including temporary staff but excluding Medical Locums) **increased by 84.22 FTE in June to 4,414.11 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,560.93 FTE.**

Substantive workforce capacity increased by 9.93 FTE to 4,090.16 FTE.

Temporary workforce capacity (excluding Medical Locums) **increased by 74.29 FTE to 323.95 FTE.**

Human Resources Workforce Performance Indicators 2014/15 Month 03

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Support Services
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	89.68%	88.39%	93.02%	84.66%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	7.34%	10.31%	5.80%	**3.18%**
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	**96.78%**	98.56%	98.75%	87.44%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	8.71%	9.13%	**7.77%**	10.03%



Trust Target 3.8%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Absence (2013/14)	4.02	4.01	3.90	3.58	3.80	3.93	4.45	4.71	4.72	4.69	4.53	4.39
In Month Absence (2014/15)	4.27	4.06	4.32									
12 Month YTD (2013/14)	4.40	4.33	4.35	4.26	4.23	4.19	4.18	4.20	4.19	4.18	4.22	4.23
12 Month YTD (2014/15)	4.26	4.29	4.34									
Financial YTD (2014/15)	4.27	4.16	4.25									

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 33,393 hours (205.50 FTE), which is an increase of 1376 hours (8.47 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 43.49% (increase of 0.76%), Agency fill rate = 32.78% (increase of 1.35%). Total bank & agency fill rate = 76.27% (increase of 2.11% compared with the previous month).

Sickness Absence

The financial year to date rate for sickness absence rose slightly to 4.25%.

In month Sickness Absence increased by 0.26% to 4.32% which is above the Trust target.

- Short term sickness absence increased from 2.06% to 2.43%.
- Long term sickness absence decreased slightly by 0.11% to 1.89% which remains below Trust Target.
- The total calendar days lost to sickness absence increased by 290 to 6205 days lost.
- The number of days lost per employee increased to 1.30 days.

Human Resources Workforce Performance Indicators 2014/15 Month 03

		Surgery Care Group							
		Directorate							
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck		Women	Children
Short Term Sickness Absence		1.60%	3.01%	4.16%	2.98%	3.48%		3.07%	2.46%
Long Term Sickness Absence		2.20%	2.62%	1.16%	0.77%	1.89%		2.47%	1.25%
Total Sickness Absence	Over 4.2%	3.80%	5.63%	5.32%	3.75%	5.37%		5.54%	3.71%
	3.9-4.2%								
	Under 3.8%								

Surgery Care Group Summary

- The non-medical sickness absence rate for the General Surgery Care Group increased to 4.96%. There were improvements in the General Surgery and T&O Directorates but increases in all other areas.
- The highest ward based sickness was on Singlehurst Ward with total sickness absence of 11.26%. Both Paddington and Sturtridge Ward have seen increases in long-term sickness rate due to several instances of long-term sickness; one employee on each ward has now resigned, while the other cases are being actively managed. All short-term sickness is being actively managed.

		Medicine Care Group							
		Directorate							
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies		Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	0.82%	1.94%	2.05%	1.04%		2.64%	3.06%
Long Term Sickness Absence		2.20%	0.00%	2.47%	1.53%	2.28%		2.13%	2.48%
Total Sickness Absence	Over 4.2%	3.80%	0.82%	4.41%	3.58%	3.32%		4.77%	5.54%
	3.9-4.2%								
	Under 3.8%								

Medicine Care Group Summary

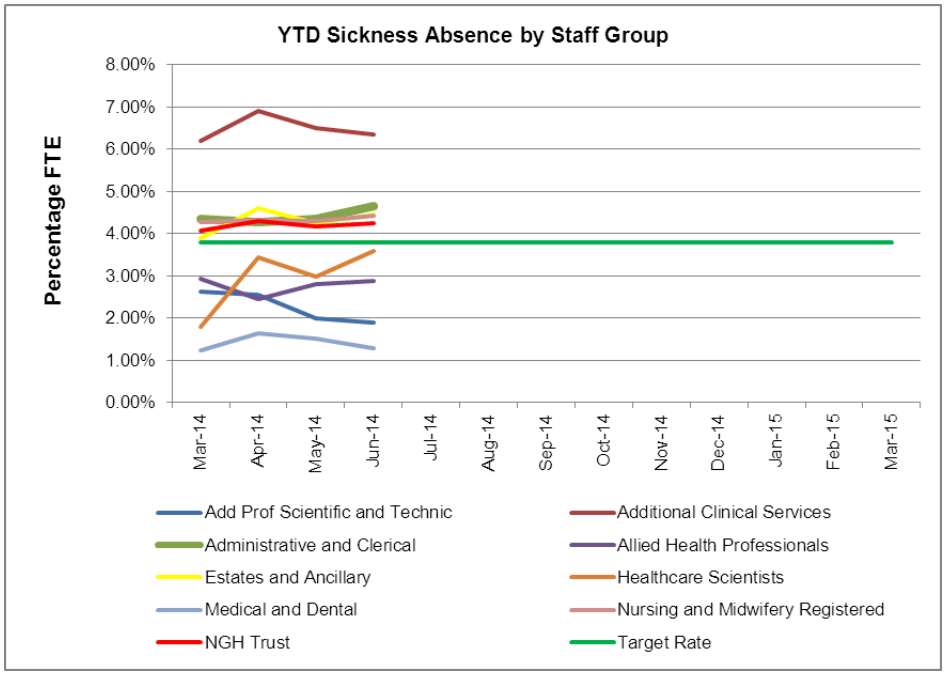
- The non-medical sickness absence rate for the General Medicine Care Group increased to 4.73%, with improvement in Pharmacy, Radiology, and Oncology & Haematology. Pathology was unchanged but there were increased rates in Therapies and General Medicine.
- Compton Ward (sickness rate 14.22%) has 5 individuals on long-term sickness; one individual is in the process of leaving through ill-health, the others are being assessed further by Occupational Health. In both Creaton and Collingtree several individuals have been issued improvement letters relating to short-term sickness.

		Support Services				M&D
		Directorate				
	Threshold	Target	Facilities	Hospital Support		Medical & Dental
Short Term Sickness Absence		1.60%	2.77%	1.66%		0.01%
Long Term Sickness Absence		2.20%	1.34%	1.81%		1.74%
Total Sickness Absence	Over 4.2%	3.80%	4.11%	3.47%		1.75%
	3.9-4.2%					
	Under 3.8%					

Hospital Support and Medical & Dental Summary

- The total sickness absence rate within Facilities increased in June to 4.11%. Hospital Support also saw an increase to 3.47%. The rate for Support Services remains below Trust target, at 3.75%.
- Medical & Dental staff sickness absence increased by 0.40% to 1.75% in June 2014.

Human Resources Workforce Performance Indicators 2014/15 Month 03



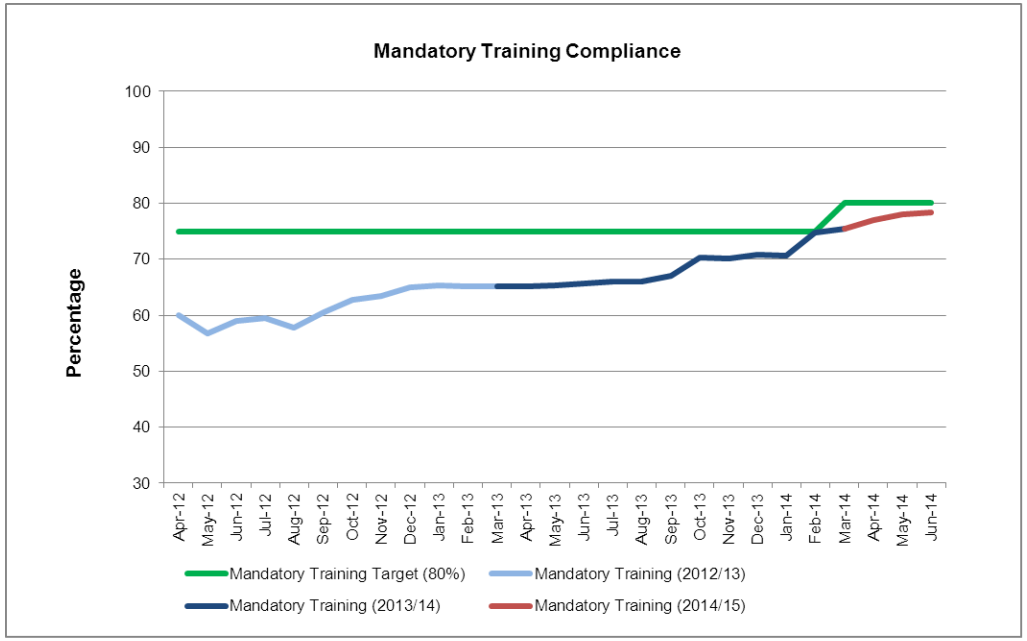
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Add Prof Scientific and Technic	2.63%	2.56%	1.98%	1.90%									
Additional Clinical Services	6.20%	6.90%	6.50%	6.36%									
Administrative and Clerical	4.36%	4.27%	4.34%	4.64%									
Allied Health Professionals	2.94%	2.45%	2.81%	2.87%									
Estates and Ancillary	3.88%	4.61%	4.24%	4.44%									
Healthcare Scientists	1.79%	3.44%	2.99%	3.58%									
Medical and Dental	1.23%	1.64%	1.50%	1.28%									
Nursing and Midwifery Registered	4.26%	4.31%	4.30%	4.43%									
NGH Trust	4.06%	4.29%	4.16%	4.25%									
Target Rate	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%

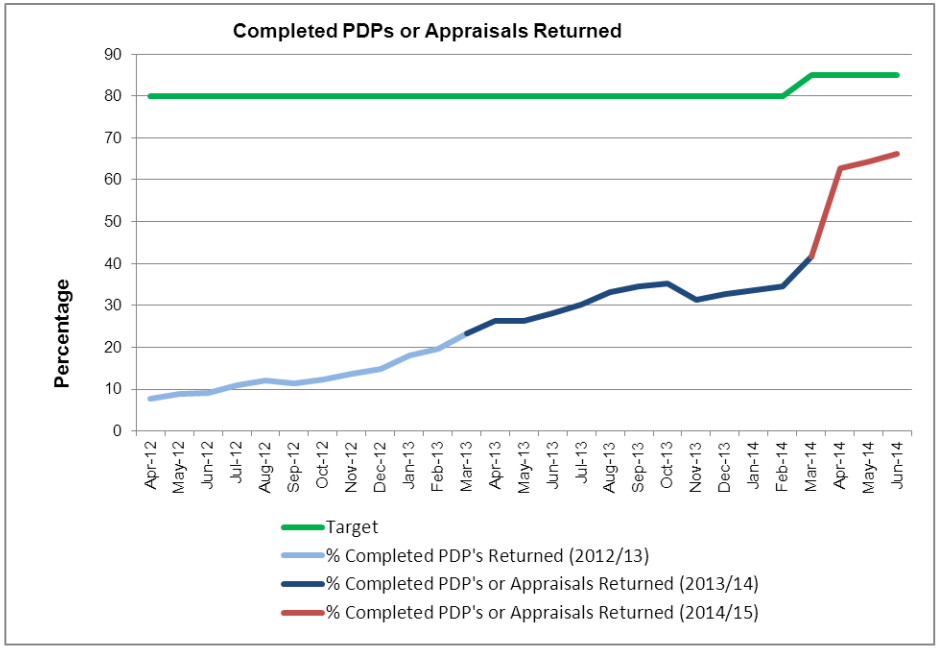
	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Support Services
Sickness Absence Rate (%) - in Month	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	4.32%	4.50%	4.36%	3.72%
No. of completed PDPs returned & completed Appraisals	Under 75% 75 - 79% 80% & over	80% by Oct-14	66.09%	65.00%	64.58%	72.42%
% Statutory & Mandatory Training Compliance	Under 75% 75 - 79% 80% & over	80% by Oct-14	78.42%	79.15%	77.34%	79.56%
% Role Specific Training Compliance	Under 75% 75 - 79% 80% & over	80% by Oct-14	65.43%	66.29%	64.40%	69.31%

Completed PDPs Returned, Completed Appraisals, and Mandatory Training & Role Specific Training Compliance

- The current rate of completed PDP's or Appraisals recorded in ESR is 66.09%; continuing the improvement seen since March.
- Mandatory Training compliance has increased again to 78.42%. RSET compliance has increased to 65.43%.
- The scoping of Role Specific Essential Training has been shared with both Training Leads and General Managers. The aim is for the ESR system to be updated as soon as possible, matching competences to positions, to enable more accurate monitoring and reporting of compliance. The first course to be successfully uploaded was BLS Cardiac Prevention. Work will now continue in uploading the other courses.

Human Resources Workforce Performance Indicators 2014/15 Month 03





Mandatory Training Target 80%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mandatory Training (2012/13)	60.09	56.68	59.03	59.42	57.71	60.59	62.68	63.47	64.93	65.31	65.2	65.2
Mandatory Training (2013/14)	65.14	65.4	65.75	65.93	66.09	66.97	70.23	70.20	70.84	N/A	74.68	75.51
Mandatory Training (2014/15)	76.91	78.06	78.42									

Completed and Returned PDP Target 85%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Completed PDP's Returned (2012/13)	7.83	8.95	9.02	10.93	11.98	11.35	12.24	13.72	14.89	18.07	19.65	23.35
% Completed PDP's Returned (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17	31.27	32.76	33.58	34.52	41.71
% Completed PDP's Returned (2014/15)	62.81	64.30	66.09									

Role-Specific Essential Training

It is planned to include charts relating to Role-Specific Essential Training (RSET) compliance data once the work to agree competence requirements for all positions is complete and loaded into ESR.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Clinical Audit Annual Report**
Agenda item	15
Sponsoring Director	Dr Mike Wilkinson, Interim Medical Director
Author(s) of Report	Liz Gill, Senior Clinical Effectiveness and Audit Officer
Purpose	Assurance

Executive summary

- The Audit Forward Plan 2014/15 comprises both risk and compliance based audits which are aligned with corporate objectives and the Board Assurance Framework.
- The work of the Department of Clinical Audit, Safety and Effectiveness (DCASE) continues to expand to meet local and national compliance and information requirements.
- Recruitment to the DCASE Lead and the new Senior Clinical Effectiveness and Audit Officer posts has now been completed with the new postholders starting on 1 July 2014. The Department is in the process of recruiting a full-time TARN Coordinator and Governance Facilitator following the retirement of a part-time member of staff (0.6).
- The Mortality and Coding Review Group continues its work in monitoring mortality; acting on alerts and engaging clinicians in clinical audits relating to mortality concerns. This group is responsible for the Trustwide casenote mortality review.
- In 2014/15 there is a Local CQUIN for Mortality and Morbidity (M&M) meetings at a Trustwide and directorate level. Compliance with Q1 of the local M&M CQUIN is on schedule.
- NGH participated in 100% of national audits and 100% of confidential enquiries on the Quality Account in 2013/14.

Related strategic aim and corporate objective	(1) To be an organisation focussed on quality outcomes, effectiveness and safety (5) To provide effective and commercially viable services for our patients ensuring a sustainable future for NGH.
Risk and assurance	Risk: Increasing demands on the Department particularly with regard to the 2014/15 Mortality and Morbidity CQUIN with no new staff resource. Assurance: DCASE activities provide assurance of compliance with clinical standards.

L

Related Board Assurance Framework entries	BAF1, 2 and 4
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	Audit programme provides assurance of compliance with current statutory and mandatory requirements for healthcare providers.

Actions required by the Trust Board

The Trust Board is asked to:

- To approve the Audit Forward Plan 2014/15
- To support the appointment of the TARN Coordinator and Audit Facilitator
- Note the increasing workload, particularly in engaging clinicians in monitoring outcome data and supporting the M&M process trustwide and within directorates

Public Trust Board
31 July 2014

Clinical Audit Annual report and forward plan

1. Introduction

Clinical audit is designed to improve patient outcomes. Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care (Ref: HQIP).

A structured programme of audits is needed

- to meet requirements for external monitoring e.g. commissioners, CQC, TDA
- to monitor progress in completing audits
- to monitor the quality of clinical audit activity
- to monitor the impact of the programme
- To identify risks

2. Annual Review

Department of Clinical Audit, Safety and Effectiveness (DCASE)
Organisational changes

The Department has been led by an interim for 15 months but from 1 July there is a substantive Lead in post, releasing the interim to take up appointment as the new Band 6 Senior Clinical Effectiveness and Audit Officer with responsibility for clinical outcomes monitoring including support for Dr Foster tools. With the planned retirement of the Band 4 TARN Coordinator and Clinical Audit Facilitator (0.6) in September the Department is seeking to recruit a full-time member of staff to provide accurate and timely data to the National Trauma and Research Network; liaise with clinical staff to compile and submit completed data sets for national confidential enquiries and to support Audit Officers in a range of clinical audits.

Mortality and Coding Review Group

This group was formed in 2011 under the chairmanship of the Medical Director and was re-launched in a different form and with increased support in November 2012 with the aim of promoting trustwide ownership of issues raised by Dr Foster data and engaging clinicians in monitoring and acting on this outcome data. Meetings are held bi-monthly and are chaired by the Associate Medical Director (Clinical Governance). Attendees include Care Group Chairs and Care Group Managers for Medicine and Surgery; Coding Manager and Coding Audit Officer; Head of Information; Specialty Doctor Audit and Governance and DCASE Lead; clinicians from a variety of specialties and Dr Foster customer support.

When concerns over performance are raised the quality of clinical care is reviewed by the specialty undertaking a detailed case note review and the clinical coding is reviewed by the coding manager. The findings are presented to the Group together with details of actions to be undertaken.

The Group has commissioned work and received presentations related to the following areas of concern:

Fig 1: Clinical care and coding reviews for Mortality and Coding Review Group since October 2013

Reviews for Mortality and Coding Review Group
Biliary disease / Patients receiving therapeutic biliary procedures - mortality
CQC Dermatology basket – emergency mortality
CQC Gastro/liver basket – emergency mortality
Diabetes with complications - mortality
GI haemorrhage - mortality
Intestinal infection - a mortality
Leukaemia's - mortality
Other gastrointestinal disorders - mortality
Perforation of the intestine - mortality
Perinatal deaths including stillbirths - mortality
Peritonitis - a mortality
Secondary malignancy - mortality
Upper GI bleed - mortality

Trustwide Mortality Reviews (Mortality Case Note Review)

The clinical audit department supports a programme of Mortality Case Note Review.

The first Trustwide review was carried out in November 2011 (222 consecutive deaths) and repeated in November 2012 (50 consecutive deaths). Following this it was decided to continue with Trustwide Mortality Case Note Reviews twice a year looking at 50 consecutive deaths each time. The first of these was completed in March 2014 and the learning points have been shared with Mortality and Morbidity (M&M) leads for discussion at directorate M&M meetings. These reviews looked at quality of care, record keeping and information, and avoidable mortality and were a very valuable exercise in identifying areas for improvement and directing the work of the Safety Teams. The review will also provide quality assurance of directorate M&M processes. The reviews also demonstrated that on the whole care was good and the likelihood of avoidable mortality very low. The current review is well underway with the notes review and challenge meetings scheduled to be completed by the end of July 2014 (report to be completed by September 2014).

Directorate Mortality Reviews and M&M CQUIN

As part of the Local CQUIN for M&M Meetings, Terms of Reference for Directorate M&M have been agreed (Q1). In addition, clinical leads for M&M have been identified for each directorate and dates of meetings for the rest of 2014 have been scheduled as per the Terms of Reference. Compliance with Q1 of the local M&M CQUIN is on schedule with all milestones met by the end of June 2014.

In future quarters, M&M meetings will continue to be undertaken on a regular basis across all clinical directorates and will be enhanced with a programme of shared learning within the organisation and county wide.

Prioritisation of Audits on the Audit Forward Plan

The first step in developing the Audit forward Plan is to identify all clinical audits which **must** be undertaken. It is essential that these audits are treated as priority and appropriate resources are provided to support them. Failure to participate may carry a penalty for the trust either financial or in the form of a failed target or non-compliance.

These are the core activities and include:

- NCAPOP and other national clinical audits reported on the Quality Account
- Audits demonstrating compliance with regulatory requirements e.g. NICE guidance, NSFs.
- Audits required by external accreditation schemes e.g. NHSLA, cancer peer review standards.
- Commissioner priorities including national and regional CQUINS audits.

The approval of additional audits for inclusion on the Audit Forward Programme is undertaken using a risk-based approach. From the initial discussion with the clinician and the information detailed on the 'Audit Proposal Form' the audit is assessed, aligned with the corporate objectives and key Trust strategies such as the Clinical Audit Strategy; Quality Strategy; Patient Safety Strategy and prioritized accordingly. Resources and support from DCASE will only be available for those audits that are 'risk based' and which aligned to corporate objectives, relevant strategies and target high risk areas.

Risks are identified by:

- Review of audit proposal forms by the Associate Medical Director and Clinical Audit lead to align with corporate/BAF objectives, Trust priorities, and risks identified on Corporate/Directorate risk registers
- Identification of audit requirements arising as a result of serious untoward incidents or complaints.
- Identification of audits arising from poor clinical outcomes as notified by the Medical Director or Associate Medical Director.

The audit is entered onto the Audit Forward Plan, aligned with the relevant corporate objective, BAF No and linked risk. Audits that do not meet this risk based approach will not be undertaken by the department. However the audit may be undertaken locally with resource identified from within the Directorate. Details of the audit are still required for the Audit Forward Plan to maximize organizational learning.

Monitoring Progress

On a quarterly basis Directorates are required to report on published clinical audits reports and to identify actions and recommendations arising as a result of these audits. For national audits this is a formal system in place monitored via Health Assure. Information and milestones are tracked for each audit and feedback is sent to the relevant Directorate. Exception reports are reviewed by the Audit Strategy Group and follow-up actions are agreed. It is a requirement that doctors reflect on the findings of relevant national audits as part of their appraisal and revalidation process.

Recent focus of activity to improve performance has included:

- identifying barriers to data collection and/or submission of national audit data and supporting/facilitating the clinical teams to enable participation e.g. identification of qualifying cases; obtaining clinical notes; on-line data entry.
- transferring the process for reviewing national clinical audit reports to the Care Group Governance Teams (with support from the Audit Department)
- assisting in the identification of data quality issues with national audit data related to individual surgical outcomes
- updating the Audit section on the Revalidation site on the Intranet to include the 2014/15 Quality Account Audit list.
- Giving presentations to Consultants and SAS Grade doctors in the Trust to highlight the importance of the National Clinical Audits, how to get involved and how to make the most of the audits for appraisal and revalidation.

Audit Forward Plan 2014/15
There are 141 audits included on the 2014/15 audit forward plan including 9 audits where the audit proposal form has been submitted but approval has not yet been given and further clarification may be required. The Audit Forward Plan is available to view on the Governance shared drive and is updated on a monthly basis.

Fig 2: Percentage distribution by category of audits entered onto Audit Forward Plan 2014/15

Category	%
National Clinical Audits	41.6%
Regional Audits	2.7%
Compliance Audits e.g. NICE	15.9%
Patient Safety/ Mortality outcomes	15.0%
Local Audits	24.8%

National Audits
Since the first Confidential Enquiry in 1952, national clinical audits have evolved and increased in number and there are now national audits relating to almost all areas of clinical practice. The audits may involve continuous data collection (e.g. MINAP, ICNARC) or can be snapshot audits (e.g. The National Comparative Audits of Blood Transfusion). **The national clinical audits for inclusion in the Quality Account 2014/15 are** listed in Appendix 1.

Participation in National Clinical Audits at Northampton General Hospital was excellent during the reporting period 2013/14; NGH participated in 100% of national audits and 100% of confidential enquiries on the Quality Account. Participation in clinical audit is regarded as an indicator of good performance by external regulators (e.g. TDA, CQC).

Although the number of national audits has not increased significantly, many audits comprise several additional audits or surveys in addition to the core audit. This has resulted in greater demands on the Audit Department to support directorates with new data collections or patient surveys.

Participation

Fig 3: List of all National Audits (Quality account audits and other) in which NGH participates

List of all National Audits (Quality Account audits and other) in which NGH participates
Acute cornonary syndrome or Acute myocardial infarction (MINAP)
Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (NS) Standards for Ulnar Neuropathy at Elbow (UNE) testing
Adult bronchiectasis
Adult community acquired pneumonia
Adult critical care (Case Mix Programme - ICNARC CMP)
Bowel cancer
Cardiac arrhythmia (HRM)
Chronic Obstructive Pulmonary Disease (COPD)
Coronary angioplasty
Diabetes (Adult) ND(A) includes National Diabetes Inpatient Audit (NADIA)
Diabetes (Paediatric) (NPDA)
Elective surgery (National PROMs) programme
Epilepsy 12 audit (Childhood Epilepsy)
Falls & Fragility Fractures Audit Programme (FFFAP). Incorporates both Hip Fracture Database and National Inpatient Falls Audit
Familial hypercholesterolaemia (National Clinical Audit of management of FH)
Fitting child (care in emergency departments)
Head and neck oncology (DAHNO)
Heart failure (HF)
Inflammatory bowel disease (IBD)
Lung cancer (NLCA)
Maternal newborn and infant clinical outcome review programme (MBRRACE)
Maxillofacial & Orthodontics Audits: (Orthognathic minimum dataset, Feedback for surgery patients V8, Elective orthognathic treament, Orthognathic quality of life questionnaire)
Mental health (care in emergency departments)
National audit of dementia (NAD)
National audit of seizure management (NASH 2)
National cardiac arrest audit (NCAA)
National comparative audit of blood transfusion programme
National emergency laparotomy audit (NELA)
National joint registry (NJR)
National vascular registry
NCEPOD - Acute Pancreatitis
NCEPOD - Sepsis
Neonatal intensive and special care (NNAP)
Non-invasive ventilation - adults
Oesophago-gastric cancer (NAOGC)
Older people (care in emergency departments)
Ophthalmology
Paediatric pneumonia
Pleural procedures
Prostate Cancer
Renal replacement therapy (Renal Registry)
Revalidation on patients referred with impacted third molars
Rheumatoid and early inflammatory arthritis
Sentinel Stroke National Audit Programme (SSNAP)
Severe trauma (TARN)
SNAP 1(Sprint National Anaesthetics Project)

Everyone Counts
HQIP continues to coordinate the project 'Everyone Counts' to produce activity, clinical quality measures and mortality rates from national audits for consultants practising in the following areas:

- Adult cardiac surgery [not carried out at NGH]
- Bariatric surgery [not carried out at NGH]
- Colorectal surgery for bowel cancer
- Head & Neck Surgery for cancer
- Interventional cardiology
- Orthopaedic surgery [hip and knee replacement and revision]
- Thyroid & Endocrine surgery
- Upper GI surgery
- Urology
- Vascular surgery

In 2014 three new National Clinical Audits will begin publishing data. Those that published in 2013 will begin to expand the number of procedures and quality measures covered. The new audits are:

- Lung cancer
- Neurosurgery [not carried out at NGH]
- Urogynaecology

Reports are due to be published in October 2014 and the deadline for data submission is August 2014.

Charges
Provision has been made in the Clinical Audit budget in 2014/15 for the 8 NBOCAP national audits which have recently introduced charges [approximately £24,000] and for the compulsory Patient Reported Outcomes Service [PROMS] Audit [approximately £4,000]. Other audits e.g. College of Emergency Medicine audits are paid for by the appropriate directorate.

Other Audits
Audits may be undertaken as a result of risks identified by the Patient Safety Academy or through locally identified risks. Other priority audits include audits to measure compliance against national standards including NICE; Liverpool Care Pathway/End-of-Life Care audit. The following audits have been registered as a result of locally identified risks:

Fig 4: List of all audits undertaken as a result of risks identified as directorate priorities

List of all audits undertaken as a result of risks identified as directorate priorities
Assessment of children on the paediatric assessment unit
Audit of compliance with BCSH guidelines on investigation and management of newly diagnosed follicular lymphoma
Audit of services provided by NGH for people with Multiple Sclerosis 2013 (carried forward to 2014/15)
Clinical variation in practice of cholecystectomy and surgical outcomes
Investigation and management of subarachnoid haemorrhage (NCEPOD enquiry "Managing the Flow" recommendations)
Infection Control Audits
Infection Rates in Peritoneal Dialysis patients
Management of UTIs in children
Maxillofacial 3rd Molar Audit
Medicines Omissions
Prospective audit of patient/staff understanding of patient care plans
Protocol for the use of Victoria Discharge Ward and Victoria Discharge Lounge
Repeat radiographs with templating marker ball in patients presenting o elective lower limb arthroplasty clinics - costs and clinical implications

National Audits – Exceptions / Points of Note
NDA: National Diabetes Audit
During 2013/14 there was a shortage of consultants in Diabetology. The National Diabetes Audit is made up of 3 parts with 2 additional topics which will start in 2014/15. NGH participated in 2 of the 3 parts in 2013/14 but due to manpower issues was unable to enter data to the core audit. The Department is now fully staffed and therefore this issue has been discussed with the new team. NGH has registered for the new audit starting in July 2014 [Footcare] and the issue of the core audit is to be raised at the next meeting of the Clinical Audit Strategy Group.

Inflammatory Bowel Disease (IBD Audit)
NGH has enhanced its participation in this audit over the last year. Data is now entered for the Biologics part of the audit and NGH submitted data for all relevant cases for the Inpatient Care Audit. Since December 2013 there has been an IBD specialist nurse in post who is supporting the clinical lead with this process. In the past NGH has not submitted data to the Paediatric IBD Audit [number of qualifying cases would be very low] however this will be discussed with the Paediatric Team prior to the next round of the audit.

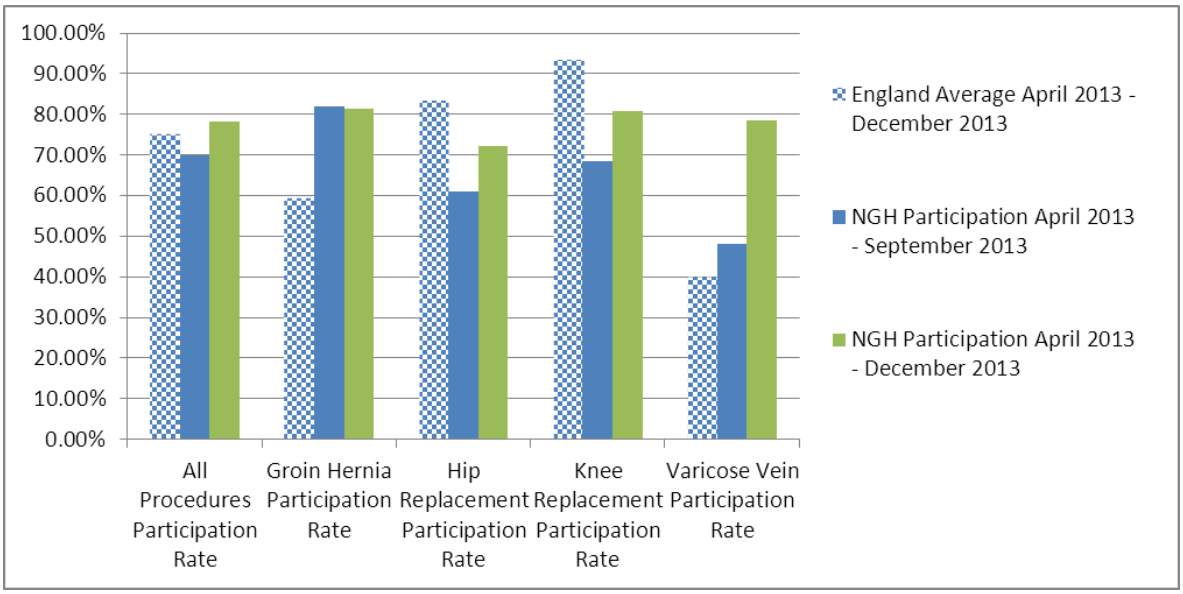
New Audits on Quality Account
The following audits have been added to the 2014/15 Quality Account:

- Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing
- Adult bronchiectasis
- Adult community acquired pneumonia
- Familial hypercholesterolaemia (National Clinical Audit of Management of FH)
- Fitting child (care in emergency departments)
- Mental health (care in emergency departments)
- National audit of dementia (NAD)
- Non-invasive ventilation – adults
- Older people (care in emergency departments)
- Ophthalmology TBC
- Paediatric pneumonia
- Pleural procedures
- Prostate Cancer
- Specialist rehabilitation for patients with complex needs [at procurement stage - relevance to NGH unclear]

Patient Reported Outcome Measures
The Patient Reported Outcome Measures programme is a compulsory audit that measures a patient's health status or health-related quality of life. The measures are a means of collecting information on the clinical quality of care delivered to the NHS patients as perceived by the patients themselves. The procedures covered in the survey are hip and knee replacement, groin hernias and varicose veins. It should be noted that the number and participation rates for varicose vein surgery are very low and the data is therefore not thought to be of value.

The latest Quarterly HES data (published May 2014) on participation rates for PROMS is illustrated below.

PROMS Data- April 2013 to December 2013 (Published May 2014)



In 2012/13 NGH was above the national average participation rate for all procedures although the 80% target was not met for varicose veins procedures. However preliminary data for the first half of 2013/14 shows a fall in the participation rate for hip and knee replacements compared with previous years. Orthopaedic patients are now recruited on the day of surgery which will make it easier to monitor participation internally.

Participation rates for Groin hernias have been maintained and are considerably higher than the national average. Participation rates for varicose veins are almost twice the national average.

Self-Assessment Matrix

Appendix 2 contains the latest review of progress against the Self-assessment matrix published by HQIP. Limited progress has been achieved since October 2013 because the Department has only been fully staffed since July 2014 and there have been difficulties with continuity of staff in Care Group and Directorate governance teams.

3. Assessment of Risk

The workload of the Department is increasing, particularly in relation to the Trustwide and directorate mortality and morbidity processes. There is a risk to compliance with the 2014/15 M&M CQUIN through limited staff resource.

4. Recommendation

The Board is asked to note this report which is provided for assurance and to consider the increasing requirement for robust clinical audit to support the Trust's vision and values. The requirements are likely to increase as the focus on accurate data relating to clinical outcomes increases**.**

5. Next Steps

The recruitment of the TARN Coordinator and Clinical Audit Facilitator must be expedited to ensure continuity and to increase the resource available to facilitate NCEPOD studies.

Appendix 1

National audits for inclusion in Quality Accounts 2014/5

- Coverage - intention to achieve participation by all relevant providers in England.
- Data collected on individual patients
- Provides comparisons of providers
- Recruiting patients during 2014-15

**** Services are not provided by Northampton General Hospital***

Peri-and Neo-natal

Neonatal intensive and special care (NNAP)
Maternal, Infant and newborn clinical outcome review programme (MBRRACE-UK)

Children

Childhood epilepsy (RCPH National Childhood Epilepsy Audit)
*Paediatric intensive care (PICANet)**
*Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit**
Diabetes (RCPH National Paediatric Diabetes Audit)
Fitting child (Care provided in emergency departments)
Paediatric pneumonia (British Thoracic Society)

Acute care

Cardiac Arrest (National Cardiac Arrest Audit)
Adult critical care (ICNARC CMPD)
Emergency Laparotomy
Trauma (Trauma Audit & Research Network)
National Audit of Seizure Management (NASH 2)
National Vascular Registry, including CIA and elements of NVD
Adult community acquired pneumonia (British Thoracic Society)
Non-invasive ventilation – adults (British Thoracic Society)
Pleural procedures (British Thoracic Society)

Long term conditions

Diabetes (National Adult Diabetes Audit)
Inflammatory Bowel Disease (IBD Audit)
Adult bronchiectasis (British Thoracic Society)
National Joint Registry
Renal Registry (Renal Replacement Registry)
Chronic Obstructive Pulmonary Disease
Elective Surgery (National PROMs Programme)
Rheumatoid and early inflammatory arthritis
Ophthalmology TBC
Chronic kidney disease in primary care TBC
Specialist rehabilitation for patients with complex needs
Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing
Familial hypercholesterolaemia (National Clinical Audit Mgt of FH)

Heart

Acute Myocardial Infarction & other ACS (MINAP)
Heart failure (Heart Failure Audit)
Cardiac arrhythmia (Cardiac Rhythm Management Audit)
Coronary angioplasty (NICOR Adult cardiac interventions audit
Pulmonary Hypertension
*Adult cardiac surgery audit (ACS)**

Older People

Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database
Stroke National Audit Programme (Sentinel & SINAP)
National Audit of Intermediate Care 2013
Older people (Care provided in emergency departments)

Cancer

Lung cancer (National Lung Cancer Audit)
Bowel cancer (National Bowel Cancer Audit Programme)
Head & Neck cancer (DAHNO)
Oesophago-gastric cancer (National O-G Cancer Audit)
Prostate Cancer

Mental health

*Prescribing Observatory for Mental Health (POMH-UK)**
National Audit of Dementia
Mental Health (Care provided in the emergency departments)

Blood & Transplant

National comparative audit of blood transfusion

Confidential Enquiries

Asthma Deaths (NRAD)
Child Health (CHR-UK)
Patient Outcome & Death (NCEPOD)
Suicide & Homicide in Mental Health (NCISH)

Appendix 2. Clinical Audit Self Assessment Matrix

Key Elements	1. Basic Level	2. Principle Accepted	3. Developing	4. Working Well	5. Exemplar	*Review Date & Actions*	RAG Status
1. Use clinical audit as a tool in strategic management	Clinical audit is integral to the core strategy the board is seeking to address.	Clinical Audit programme is resourced to provide assurance against risks to strategic objectives.	There is a capable and confident team leading and delivery audit.	The Audit committee oversee the clinical audit programme focussing on topic selection, gaps, and completeness and supporting the skills of NEDs to seek assurance of service compliance to standards.	The Board directors lead as part of a unified board supported by appropriate sub committees, commissioners and the Nursing or Medical Director.	• *The AFP including Quality Account audits is overseen by the Audit Strategy Group and is published on the governance shared drive. All audits are approved by ASG Chair.* • *Audits that appear on the AFP are aligned with Corporate objective and Risk identified from the Board Assurance Framework, Corporate and Directorate risk registers* • *A new Audit Lead and Senior Audit Officer are now in post.*	**3**
2. Develop an annual programme of work	There is a confirmed direction and focus for clinical audit.	This is clarity on how/which clinical audit activity will be supported.	An annual programme is prioritised and resourced.	Resources and correct skill-base have been identified for each audit.	There is an expectation and commitment from Board to see action plans arising from clinical audit implemented.	• *Link with Pharmacy/Safety Academy/NMCTB for inclusion of other audits.* • *Email circulated to Directorates in February 2014 requesting details of planned audit s for 14/15* • *As guidelines are approved, DCASE to be notified of audit requirements for inclusion on AFP*	**4**
3. Instigate clinical audit as a direct result of mortality ratios, adverse clinical events, critical	Appropriate processes in place to respond to incidents complaints and SMR trends.	Audit process linked with clinical leaders who initiate data collection and report on the findings.	Audits are designed to check alignment to complaints and incident recording with resources in	Agreed structure of audit champions in place who have received appropriate training to promote and initiate audit and	Board is able to identify and anticipate priority areas of concern.	• *AMD Governance instigates audits as a result of monitoring mortality outcomes. Findings are reported to M&CRG.*	**3**

Version 1	**Issue Date: 9th May 2011**		**Review Date: July 2014**	**Identify Final Completion Date TBC**
Meeting: Audit Strategy Group	**V6. July 2014**	**Reviewed by: Clinical Audit Strategy Group / reviewed annually**		

Appendix 2. Clinical Audit Self Assessment Matrix

incidents and breaches in patient safety.			place for prompt response to adverse events.	ensure actions are followed through.		• *Audits may be a result of SUI's e.g. Surgical site infections* • *Audits may be undertaken as part of inquest preparation.*	
4. Ensure the clinical audit programme is relevant to board strategic interests and concerns.	Board has rehearsed priorities and can match audit programme to its priorities.	The clinical audit programme should align to the strategic objectives through the board assurance framework generated by the board and used as an ongoing working document.	Board challenge focuses on clinical compliance with standards and better practice and asks the appropriate assurance questions about clinical audit.	The audit programme is itself subject to audit for materiality, completeness and return on investment.	Results are always turned into action plans, followed through and re-audit completed.	• *Each audit is mapped to the strategic objectives.* • *HGC can highlight audits to Audit Strategy Group* • *Audit milestones including the requirement for action plans are monitored using Health Assure.*	***3***
5. Ensure there is a lead clinician who managed clinical audit within the trust, with partners / suppliers outside.	Lead clinician identified who is clearly accountable at board level.	Lead clinician is clear of role and resources available and has access to the corporate board.	Lead clinician has adequate resources and commitment is supported through CQUINS, job descriptions, induction, job plans and merit payments.	Lead clinician is strategically linked, with high level leadership skills and is delivering on key outcomes.	Lead clinician has national as well as a local profile on networks to drive integrated audit possibly as a shared post across a healthcare economy.	• *Access to Board via Medical Director.* • *AMD Clinical Governance is joining RSM Council and a member of the Panel of Experts for the forthcoming NCEPOD study on Mental Health Care in Acute Hospitals*	**5**
6. Ensure patient involvement is considered in all elements of clinical audit.	Share with patients priority setting, means of engagement, sharing of results and plans for sustainable improvement.	Patients influence is recorded and has impact.	Patients and health and social care partners involved in priority setting for clinical audit.	Users have direct access and influence over audit selection, planning and results without need for mediators between the patient and the audit.	For FTs share the development audit strategy with governors so that they have a context to inform them. Use the Healthwatch to inform priorities.	• *Patient Experience Lead in post.* • *Through Patient Surveys.* • *AFP is sent out to Directorate PPI Groups/Links/ Governors.* • *SUI's/ Being Open.*	***2***
7. Build clinical audit into planning, performance	Clinical audit cycle aligned to planning cycles.	Long term and immediate (one year plans) draw on audit results and capacity.	Reporting is integrated and covers systems and behaviours,	Clinical and finance/system audit programmes are integrated.	Clinical audit is an integral part of the culture and the operating process of	• *National Audit Programme implemented.* • *Clinical audit outcomes on Directorate scorecards.*	***5***

Version 1	**Issue Date: 9th May 2011**		**Review Date: July 2014**	**Identify Final Completion Date TBC**
Meeting: Audit Strategy Group	**V6. July 2014**	**Reviewed by: Clinical Audit Strategy Group / reviewed annually**		

Appendix 2. Clinical Audit Self Assessment Matrix

management reporting			quality and costs.		the organisation.	• *Safety Academy audit programme*	
8. Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway.	Primary, acute, mental health ambulance. Independents and social care invited to engage in joint audit plan.	Joint audit plan agreed across primary, acute and social care.	Audits cover the patient journey not just our component of it.	Action plans agreed across primary, acute and social care.	Whole system approach seeking to rationalise service improvement is the norm.	• *Hospital Deaths Review completed biannually.*	**3**
9. Agree the criteria of prioritisation of clinical audits.	Balance national and local interests and the need to address specific local risks, strategic interests and concerns.	Recognise the tension between national and local audit – Boards must realise there is a tension.	Boards are allowed to prioritise audit subjects.	Criteria for prioritisation of clinical audits is in place, explicit and applied Boards agree the audit programme.	Audit shows the board has agreed the clinical audit programme using the agreed risk assessed prioritisation approach.	• *AFP to be approved by Board July 2014* • *Quality Account audits and compliance audits against national standards are prioritised* • *Process in place for prioritising audits as a result of local concerns/risks.*	**4**
10. Confirm clinical audit is leading to improved outcomes.	A clear process in place that links areas of failing service to inform the annual clinical audit programme.	A system of expected outcome improvements as a return on investment (ROI) is in place.	Action plans are developed setting out both service improvement and cost savings and implementation is audited against these expectations.	Re-audits/monitoring takes place that demonstrates improvements in patient care related to patient feedback/complaints.	An exemplar organisation would come out in the top quartile of patient satisfaction, renowned for its customer care and have a low number of complaints referred onto the Ombudsman.	• *Audits undertaken in response to Dr Foster /SOVA* • *Audits results reported at CQEG* • *Patients Safety quarterly report includes performance data monitoring improvements in patient care.* • *Patient satisfaction surveys undertaken via Hospedia system and national surveys.*	**3**

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Risk Management Annual Report**
Agenda item	16
Sponsoring Director	Dr Mike Wilkinson, Interim Medical Director
Author(s) of Report	Christine Ainsworth, Senior Quality, Risk & Litigation Manager Caroline Corkerry, Deputy Director Quality & Governance
Purpose	This report summarises the key activities relating to risk management between 1 April 2013 and 31 March 2014

Executive summary

This is the first annual Risk Management Report

- The current Risk Management Strategy does not include any measurable objectives or key performance indicators. These will be developed and included in the Strategy when it is reviewed in February 2015

- During 2013/14 there have been a number of changes within the Governance Department's staffing establishment. As at 1 April 2013 there were 12 wte vacancies within the team, to which 10 wte staff have been recruited during the year. The remaining two posts are expected to be filled by August 2014

- Despite the fact that the majority of the Governance Team are new in post and predominantly also new to the Trust, the Department have undertaken some key pieces of work, which will be further developed throughout 2014/15.
    - **Corporate Risk Register**: A significant exercise has been carried out to review the Corporate Risk Register to ensure that risks reflect the actual risk to the organisation and that actions to mitigate are in progress

    - **Incident Reporting:** Since its implementation in 2009, the Trust has not upgraded the Datix system and staff were therefore working with an extremely outdated version. The Trust were not benefitting from the improvements and 'fixes' which had been made to the system over the previous 4 – 5 years. Datix system has now been upgraded to the latest version. This was fully tested by the Governance Team prior to roll out

    - The total number of incidents recorded on Datix continues to rise year on year which demonstrates that the organisation has a positive safety culture

    - The National Reporting & Learning System (NRLS) data for incidents which were reported between 1 April 2013 and 30 September 2013 demonstrates that NGH is just below the top quartile of reporters (within their category) with a reporting rate of 8.27 per 100 admissions compared to the median reporting

rate for this cluster of 7.23 per 100 admissions.

- The NRLS data also shows that NGH report a high number of patient safety incidents with a low number of severe harm incidents. This represents a positive risk profile

- **Serious Incidents (Sis):** There were a total of 116 SI's reported in 2013/14. This is an increase on the 76 SI's reported in the previous financial year. The increase is predominantly attributable to the revised process for the reporting of Pressure Ulcer, with 25 pressure ulcer STEIS declarations made in Quarter 3 and 23 in Quarter 4.

- Excluding pressure ulcer serious incidents, there were 54 STEIS declarations made which represents a 14.8% increase on the previous year.

- **The Central Alerting System (CAS) Alerts:** The Trust procedure for the review, action and monitoring of safety alerts was updated in March and has since been ratified. There were 199 alerts reported into the Trust during the period 2013/2014, from various sources.

- NHS England now manages the National Patient Safety Alerting System and has issued two alerts on improving incident reporting and learning, one in Medication incidents and the other in Medical Devices. The Trust has identified safety officers for both areas and actions are underway.

- **Claims Management**: The NHS Litigation Authority (NHSLA) has discontinued assessments against the risk management standards; however they will continue to pay the discounts against the levels the Trust has attained in 2014/15 (Level 1 – Acute; Level 2 – Maternity)

- The contributions paid by the Trust into the Clinical Negligence Scheme for Trusts (CNST) have risen year on year over the last 5 years; however the amount paid out on behalf of the Trust by the NHSLA exceeds the Trust's contributions by £1.6 million.

Related strategic aim and corporate objective	Strategic Aim 1 : Be a provider of quality care for all our patients Objective No 1: Invest in enhanced quality including improvements in the environment in which we deliver care
Risk and assurance	Risks to patient safety if the Trust does not robustly investigate root causes identify remedial actions required and ensure cross Trust learning to prevent recurrence of SIs.
Related Board Assurance Framework entries	BAF 1 2013/14
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N)** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)

Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper **N**

Actions required by the Trust Board

The Board is asked to:

- Accept this report
- Endorse the actions being taken forward to provide assurance

Public Trust Board
31 July 2014

Risk Management Annual Report

1. Introduction

This is the first Risk Management Annual Report for Northampton General Hospital NHS Trust. The purpose of the report is to:

- Summarise the key activities relating to risk management undertaken between 1 April 2013 and 31 March 2014
- Highlight the progress in the ongoing development of the Trust's risk management arrangements
- Outline the risk management objectives for the coming year

The overall aim of the report is to provide assurance that a programme of work is in place to identify, measure and manage risk and the report focuses on the following key areas:

- Corporate Risk Register
- Incident Reporting and Management
- Serious Incidents
- Central Alert System (CAS)
- Claims Management

2. Background

Patient safety, clinical error, and adverse event reporting has become a high priority within the NHS. The Government set out its plans for promoting patient safety in its publication "Building a Safer NHS for Patients" (2001) and latterly Safety First (2006). This places patient safety in the context of the NHS quality programme and highlights key linkages to other Government initiatives which were developed, i.e. NHS Litigation Authority Risk Management Standards, Trust Performance Ratings, National Patient Safety Agency and Care Quality Commission. The theme running through all these initiatives is that risk management must be viewed as part of quality care rather than a separate programme of work.

Over the last year, the challenges generated by the Francis Report, the Keogh Reviews and the Berwick Report have reiterated the fact that in order for an NHS organisation to function safely and effectively, risk management must form an integral part of the organisations philosophy, practices, activity and planning.

Northampton General Hospital NHS Trust recognises that risk management is an integral part of clinical and corporate governance. The nature of providing healthcare means that risk is inherent in everything we do as an organisation and the identification, management and minimisation of risks that could cause unnecessary harm to patients, staff and visitors is a key component of providing good quality healthcare. The management of risk is a key organisational responsibility and involves all staff being aware of risk and understanding their responsibilities for managing it.

The Trust has a legal duty to deliver safe care to patients and to ensure that Northampton General Hospital is a safe place to work and visit. Failure to manage risks effectively can result in injury; loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation or unwanted publicity.

2013/14 Risk Management Strategy
The Risk Management Strategy was reviewed by the Trust Board in July 2013 and again in February 2014.

The Risk Management Strategy for 2013/14 identified the following key strategic objectives;

- Cultivate and foster an 'open culture' in which risk management is identified as part of continuous improvement of patient care and staff wellbeing;
- Integrate Risk Management into all our business decision making, planning, performance reporting and delivery processes to achieve a confident and rigorous basis for decision-making
- Ensure a systematic approach to the identification, assessment and analysis of risk and the allocation of resources to eliminate, reduce and/or control them in order that the Board of Directors can meet its objectives;
- Encourage learning (individual and organisational) from all incidents, mistakes, accidents and 'near misses' be they related to clinical, financial, environmental or organisational events;
- Minimise damage and financial losses that arise from avoidable, unplanned events;
- Ensure the Trust complies with relevant statutory, mandatory and professional requirements

The current Risk Management Strategy does not include any measurable objectives or key performance indicators. These will be developed and included in Strategy when it is reviewed in advance of the February 2015 deadline. This will enable the changes to the governance structure within the organisation to be included within the strategy.

Risk Management
Following the Governance restructure in March 2013, the Risk Management facilitation and oversight was integrated into the Governance Department, with Executive leadership and direction provided by the Director of Nursing, Midwifery & Patient Services. In December 2013, Executive leadership of the Department was changed to the Medical Director.

During 2013/14 there have been a number of changes within the Governance Department's staffing establishment. As the following table demonstrates as at 1 April 2013 there were 12 wte vacancies within the team, to which 10 wte staff have been recruited during the year. Despite the fact that the majority of the Governance Team are new in post and predominantly also new to the Trust, the Department have undertaken some key pieces of work, which will be built on throughout 2014/15.

Role	1 April 2013	31 March 2014
Governance Department Management		
Deputy Director of Quality & Governance	Filled by interim agency post	Post substantively filled – June 2013
Senior Risk & Litigation Manager	Filled by 3rd interim agency post until May 2013. Filled by 4th interim agency post until August 2013 Filled by internal secondment September – March 2014	Job title changed to Senior Quality, Risk & Litigation Manager. Job re-banded and substantively filled. Post holder commenced 1 April 2014
Vacancies	2 wte	0 wte
Risk Management		
Risk Manager	Post Vacant	Post substantively filled – January 2014
Health & Safety Manager	Post Vacant	Post substantively filled May 2013
Risk Management Facilitator	Post substantively filled	Post substantively filled
Governance Administrator	Post covered by agency interim	Post covered by agency interim
Vacancies	3 wte	1 wte
Compliance		
Quality Assurance Manager	Post covered by agency interim	Post substantively filled, commenced in post 1 April 2014
Governance Manager (Surgery)	Post Vacant	Post substantively filled – November 2013
Governance Manager (Medicine)	Post Vacant	Post substantively filled – August 2013
Compliance Facilitator	Post substantively filled	Post substantively filled
Governance Facilitator (Surgery)	Post covered by agency interim	Post substantively filled – November 2013
Governance Facilitator (Medicine)	Post substantively filled	Post substantively filled – August 2013
Governance IT Systems Facilitator	Post Vacant	Post substantively filled – November 2013
Governance Administrator	Post Vacant	Post substantively filled – commenced June 2014
Vacancies	6 wte	0 wte
Litigation		
Litigation Manager	Post substantively filled	Post substantively filled
Litigation Officer	Post substantively filled	Post substantively filled
Governance Administrator	Post vacant	Post covered by agency interim
Vacancies	1 wte	1 wte

Corporate Risk Register

A Corporate risk is a potential or actual event that:

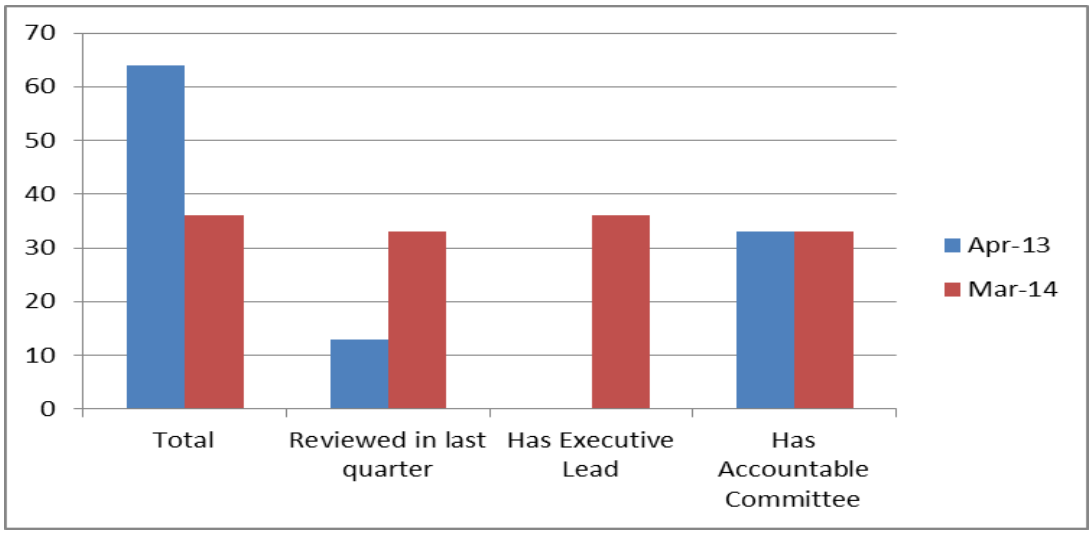
- Interferes with the achievement of a corporate objective / target; or
- Would have an extreme impact if effective controls are not put in place; or
- Is operational in nature but cannot be mitigated to an acceptable level of risk

A review of the corporate risk register was initiated in July 2013 and a comprehensive report was submitted to the IHGC meeting in October 2013 which outlined further actions to strengthen the risk registers and risk assessment process across the Trust. This second stage of work was completed in January 2014.

A significant exercise has been carried out to liaise with owners of all risks on the Corporate Risk Register. This focus has been on reviewing risks to ensure:

- The description and title of the risk is reflective of the actual risk to the organisation
- Risks are in review date where possible
- Risk scoring is aligned across the Trust
- Mitigating actions are reviewed monthly
- Each risk is reviewed and where appropriate is linked to the Board Assurance Framework (BAF)
- Each risk has a Risk Owner within the Directorate / Department who is responsible for updating the actions taken to mitigate the risk
- Each risk has an Executive Director who is aware of the risk is able to update the Board if required
- Each risk has an Accountable Committee responsible for ensuring that appropriate actions are in place to mitigate the risk

A summary of the changes to the Corporate Risk Register is shown in the following chart:



During 2013/14 there has been a review and refocus of the Risk Group. The purpose of the Risk Group is to provide a clear and equitable framework to set direction for and monitor progress of any activity within its agreed responsibilities, which includes providing challenge and moderation to risks on the Corporate Risk Registers. The Risk Group is chaired by the Medical Director and membership includes representation from the Care Groups and all Departments within the Trust who sit outside the Care Group Governance framework.

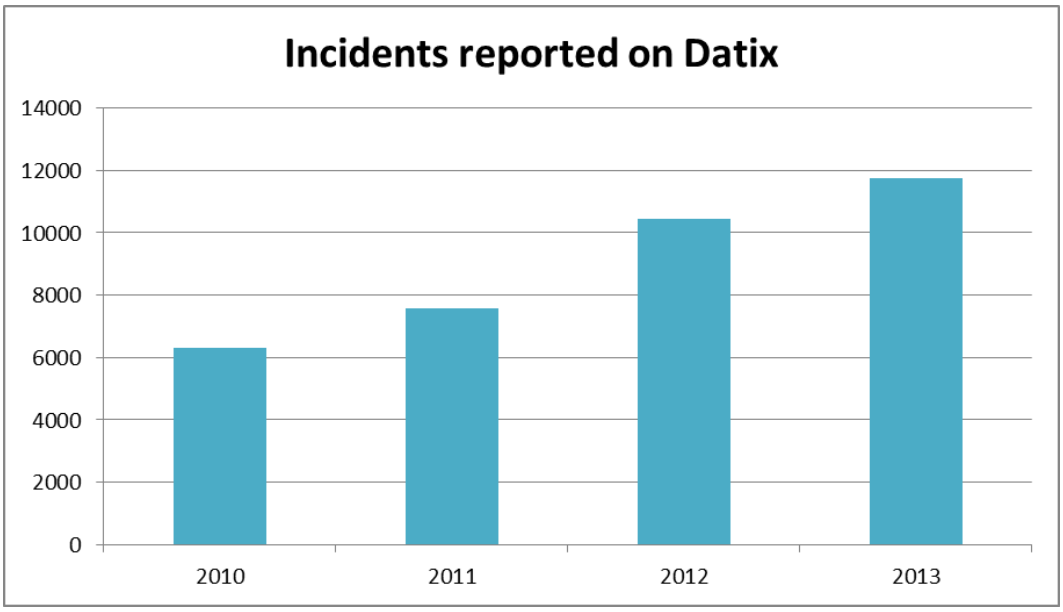
2.2 Incident Reporting

The Trust introduced Datix electronic system for incident and adverse event reporting in September 2009 and it is accessible to all staff in the hospital via the intranet site. Datix offer two major upgrades per annum in addition to a number of 'hot fixes' to improve the system's functionality. Since its implementation in 2009, the Trust has not upgraded the system and staff were therefore working with an extremely outdated version and the Trust were not benefitting from the improvements and 'fixes' which had been made to the system over the previous 4 – 5 years.

The Datix system was upgraded to the latest version in February 2014 and following a period of testing by the Governance Team, phase 1 went live in May 2014. The Governance Team are continuing to work with staff to review and continuously improve the reporting process. Two members of the team attend the Datix User Group Forums, the last of which was facilitated by NGH. Moving forward, the team will ensure that the system is upgraded bi-annually as recommended by Datix and this has been built into the budget.

The Governance Team review all incidents reported via Datix and challenge the grading where necessary in order to assure the integrity of the data. Any discrepancies are clarified in consultation with clinical & non-clinical teams prior to amendment of the incident report. The Datix feedback function is used to request a review of the incidents by clinical & non-clinical teams. Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken.

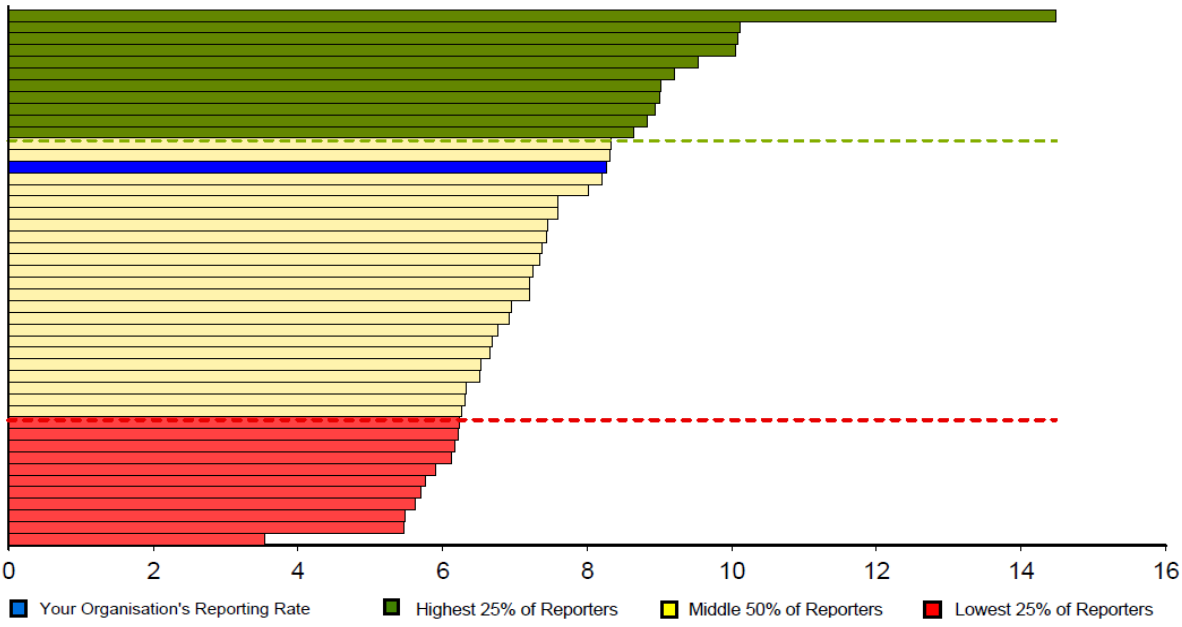
The total number of incidents recorded on Datix continues to rise year on year which demonstrates that the organisation has a positive risk culture.



NRLS Data: 1 April 2013 – 30 September 2013
The National Reporting & Learning System (NRLS) published the latest 6 month data for incidents which were reported between 1 April 2013 and 30 September 2013.

The comparative reporting rate summary below provides an overview of incidents reported by NGH compared to 45 other medium acute organisations. Figure 1 demonstrates that NGH is just below the top quartile of reporters with a reporting rate of 8.27 per 100 admissions compared to the median reporting rate for this cluster of 7.23 per 100 admissions. The NRLS report states that organisations that report more incidents usually have a better and more effective safety culture.

Figure 1: Comparative reporting rate, per 100 admissions, for 46 medium acute organisations.

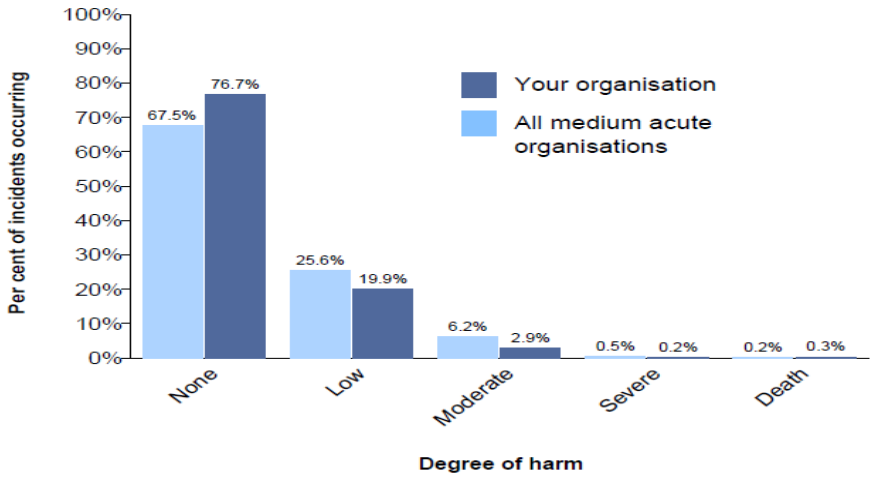


The evidence shows that teams, departments, and organisations that report more safety incidents are much more willing to learn from their mistakes and this promotes an open and healthy culture. Whilst the incident reporting rate within the Trust is slightly above the national average when compared to other medium sized Acute Trusts, there is room for improvement and as part of the Trust's Quality Priorities, we aim to be in the top 25% of reporters by the end of March 2015.

By achieving this, the Trust will maximise the opportunities to learn from experience, which is a core part of any risk management strategy.

Nationally, 68% of incidents are reported as no harm and less than 1% as severe harm or death. The table below illustrates the number of incidents reported by NGH to the NRLS by degree of harm. 0.5% of incidents reported by NGH resulted in severe harm or death. This represents a positive risk profile with a high number of patient safety incidents being reported and a low number of severe harm incidents.

Figure 3: Incidents reported by degree of harm for medium acute organisations



Your figures:	None	Low	Moderate	Severe	Death
	3,053	790	115	9	13

The initiatives planned in the coming year will ensure that robust processes for both organisational and individual learning is in place, which if effective will result in an increase in the number of incidents being reported but a decrease in the number of incidents which result in harm to patients and staff.

2.3 Serious Incidents

The Trust works to the National guidance as set out in the 'National Framework for the Reporting and Learning from Serious Incidents Requiring Investigation' published by the National Patient Safety Agency (March 2010) and updated in March 2013. From this NPSA guidance, the NHS Nene and NHS Corby Clinical Commissioning Group published their local policy, Policy for the Reporting and Management of Serious Incidents 2013/14 which the Trust utilises for guidance.

There is a formal procedure for management of Serious Incidents (SIs), which includes the completion of an Incident Investigation Form, production of an Early Management Report (EMR) where applicable, and completion of an SI Investigation Report including Root Cause Analysis (RCA) and Action Plan. EMRs and SI Investigation Reports are reviewed for appropriateness by the Governance team prior to their approval and sign off by the Lead Executive Director.

The Trust has established a Serious Incident Group (SIG) that meets weekly. Standing agenda items include a summary of SIs, details of active SIs, EMRs, action plans and

Inquests. Email correspondence between the Group members is utilised for urgent incidents which occur between the meetings.

The Serious Incident Group membership includes:

- Medical Director
- Associate Medical Director
- Deputy Director of Nursing, Midwifery and Patient Services
- Deputy Director of Quality & Governance
- Senior Quality, Risk & Litigation Manager

- Risk Manager
- Quality Assurance Manager
- Head of Safeguarding
- Patient Safety Academy Lead for Learning from Incidents

An SI Monthly Summary Report is provided to the Clinical Quality and Effectiveness Group, IHGC and to the Trust Board.

Overview of Serious Incidents
During the period 1st April 2013 – 31st March 2014, there were a total of 116 SI's reported. This is an increase on the 76 SI's reported during the same period (1st April 2012 – 31st March 2013) in the previous financial year.

The increase in the reporting of SIs is partly attributable to the increase in the number of Pressure Ulcer SI's reported, with 25 declarations made on the Strategic Executive Information System (STEIS) in Quarter 3 and 23 in Quarter 4. This reflects a revised process for the reporting and validation of pressure damage and suggests that the Trust was under reporting in this category previously.

Prior to August 2013, the Trust were only reporting pressure ulcers as an SI if an initial investigation found the tissue damage to be avoidable. The Senior Tissue Viability Nurse has now implemented a revised process whereby all pressure ulcers are validated within one working day and all hospital acquired pressure ulcers are reported on STEIS and the root cause analysis investigation determines whether the pressure ulcer was avoidable or unavoidable. Following submission of the RCA report to the CCG, all unavoidable pressure ulcers are requested to be downgraded.

The total number of Serious Incidents reported by Directorates is shown in the table below. In both years the highest reporting Directorates were Medicine and General Surgery.

Directorate	2013/14 Number Reported	2012/13 Number Reported
Medicine	66	42
General Surgery	16	15
Anaesthetics & Critical Care	19	2
T & O	8	9
Women & Children's	6	5
Pathology	1	1
Head & Neck	1	1
Radiology		1
Oncology	1	
Total	**118**	**76**

The following table shows the number of Serious Incidents reported by Directorate when pressure ulcers are excluded.

Directorate	2013/14 Number Reported	2012/13 Number Reported
Medicine	32	28
General Surgery	7	7
Anaesthetics & Critical Care	4	0
T & O	4	5
Women & Childrens	5	4
Pathology	1	1
Head & Neck	1	1
Radiology		1
Total	**54**	**47**

The above table shows that there has been a 14.8% increase in the number of SI's (excluding pressure ulcers) declared by the Trust when compared to the same period last year.

2.4 CAS Alerts

The Central Alerting System (CAS) is a web-based system for issuing patient safety alerts and other safety critical guidance to the NHS and other health and social care providers. It brings together the Public Health Link (PHL) and the Safety Alert Broadcast System (SABS). Safety alerts, emergency alerts, drug alerts, Dear Doctor letters and medical device alerts will be sent through CAS IT system on behalf of the following:

- Medicines and Healthcare Products Regulatory Agency (MHRA)
- NHS England
- Department of Health (DoH)
- Chief Medical Officer (CMO)
- NHS Blood and Transplant
- National Institute for Health and Clinical Excellence
- NHS Estates

Whilst the above agencies may also send the alerts directly to key stakeholders within the Trust, CAS is a means to ensure that important safety information is communicated and collated corporately via the Trust's nominated CAS Liaison Officer (Risk Manager). The CAS Liaison Officer is responsible for acknowledging receipt of the alerts (when required), cascading the alerts to the relevant groups and individuals and entering responses into CAS within the agreed deadlines. There is a distinction between the two types of alerts sent via CAS:

Non-emergency alerts – issued on behalf of MHRA Medical Devices, NHS England and DH Estates and Facilities, have set deadlines for acknowledgement and completion of actions. NHS Trusts are required to submit responses on the action they have taken on alerts and are monitored on their compliance with completing such alerts within agreed deadlines.

Emergency alerts – are currently sent by the following originators:

- MHRA Drug Alerts
- MHRA Dear Doctor Letter
- CMO Messaging. Although

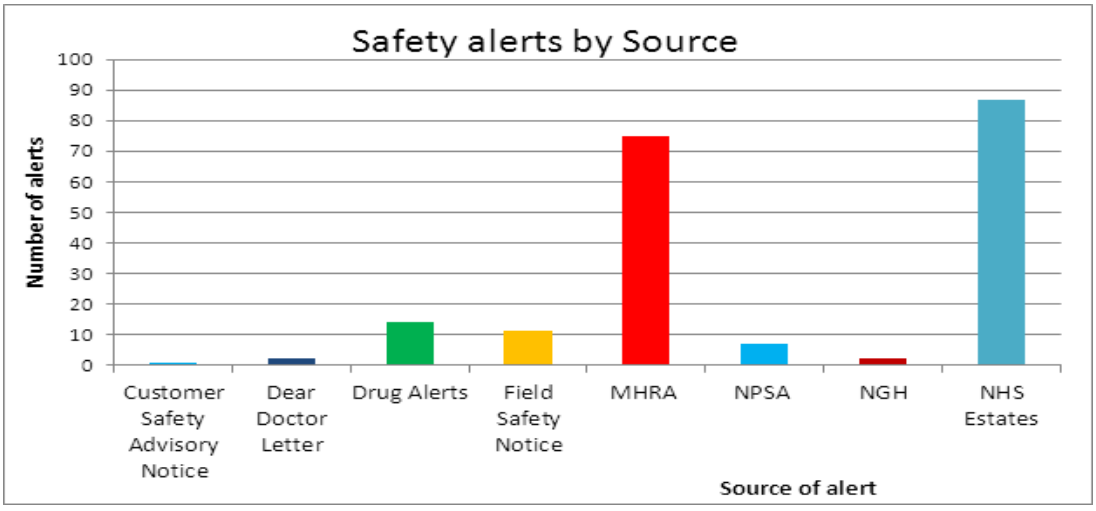
These alerts are sent to the Medical Director and Chief Executive as they are considered to require immediate dissemination. The CAS Liaison Officer is only notified of alerts which have set deadlines for acknowledgement and completion by the Trust and as emergency alerts do not require acknowledgement these were not automatically being sent to the CAS Liaison Officer. In order to ensure that the Trust has a robust process and audit trail for all the safety alerts issued by CAS, the Trust requested notification of all the emergency alerts. This was actioned in October 2013 and the CAS Liaison Officer now receives notification of all alerts.

The Datix Safety Alerts Module is used to manage all alerts issued via CAS and provides a monitoring function to enable the Trust to comply with any deadlines provided.

There were 199 alerts reported into the Trust during the period 2013/2014, from various sources. A graph of the figures is shown below. The Trust procedure for the review, action and monitoring of safety alerts was updated in March and has since been ratified with minor changes to the process.

NHS England now manages the National Patient Safety Alerting System and has issued two alerts on improving incident reporting and learning, one in Medication incidents and the other in Medical Devices. The Trust has identified safety officers for both areas and actions are underway.

The Governance Department provide a monthly report to the Clinical Quality & Effectiveness Group on all received and open CAS alerts. The following table shows the number and source of alerts received during 2013/14.



2.5 Claims

The NHS Litigation Authority (NHSLA) was established as a Special Health Authority in 1995. The remit of the organisation is to provide indemnity cover for legal claims against NHS organisations and to drive improvements in risk management practice.
Indemnity cover is provided through three schemes managed by the NHSLA:

- The Clinical Negligence Scheme for Trusts (CNST)
- Liabilities to Third Parties Scheme (LTPS)
- Property Expenses Scheme (PES)

Membership of the schemes is voluntary and open to all NHS organisations in England. Members pay an annual contribution (premium) to join the relevant scheme. Contributions are assessed actuarially each year with the total amount collected from members equating to the anticipated expenditure in the following year ("pay as you go" approach). CNST contributions are based upon a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs.

Until recently the NHSLA produced risk management standards by which member organisations were required to control their risks. The standards address organisation, clinical and non-clinical or health and safety risks. There was a single set of risk management standards for each type of NHS organisation e.g. ambulance, acute, mental health & learning disability, and primary care trusts. Organisations that were able to demonstrate compliance with the standards received a discount on their contributions.

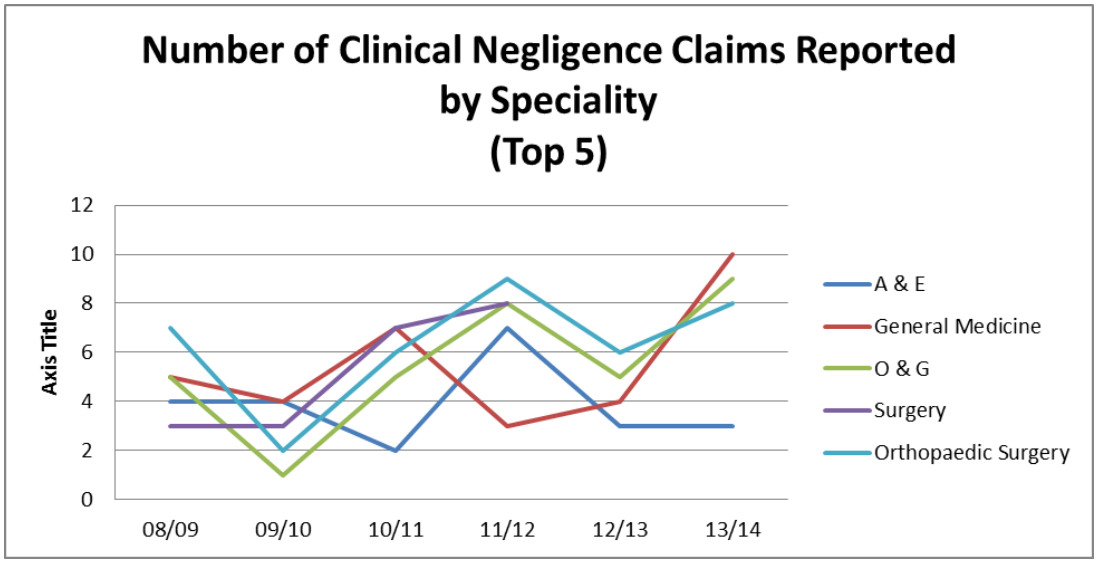
Annual Contributions and claims payments

The Trust achieved Level 1 accreditation for the acute risk management standards in December 2011 equating to a 10% discount and Level 2 accreditation for the maternity risk management standards in March 2010 equating to a 20% discount. The absence of a NHSLA pricing mechanism limits any meaningful interrogation into the true value of discounts. There is consensus within the limited literature that discounts are artificial, as contributions are directly linked to the number and value of claims and existing liability.

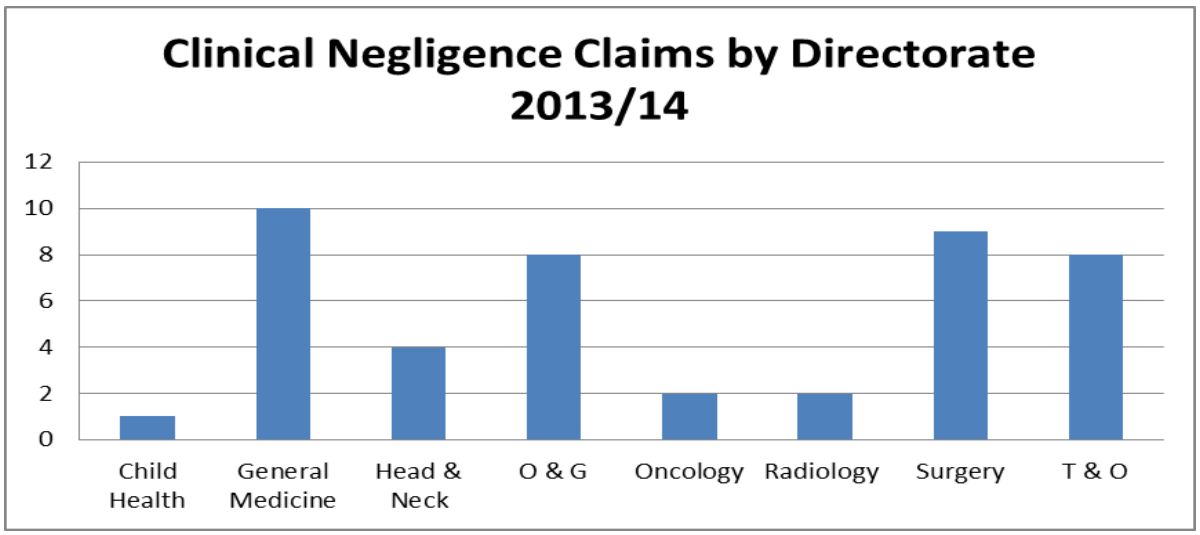
The table below shows the annual contribution payable by the Trust to the CNST and the amount the NHSLA has paid out on behalf of the Trust to resolve claims for each year for the last 5 years:

	2008/09	2009/10	2010/11	2011/12	2012/13	Total
Contribution (£)	2,424,000	4,378,000	4,948,000	5,020,000	5,604,000	22,373,000
Payments (£)	3,690.000	3,172,000	6,608,000	5,227,000	5,295,000	23,992,000
Variance	- 1,266,000	1,206,000	- 1,660,000	- 207,000	309,000	- 1,618,000

The graph below shows the number of claims reported to the NHSLA by the Trust over the last 6 years by Speciality.



The following chart shows the number of Clinical Negligence Claims reported to the NHSLA in 2013/14



Suspension of NHSLA and CNST Assessments
During 2012/13 the outcome of the Industry Review of the NHSLA, led by Marsh Limited, was published. Marsh found that the risk management standards had introduced a consistent framework for risk management and had helped to elevate clinical risk management to board level; however they concluded that there were opportunities to increase incentives for Trusts to improve their risk management standards and learning from claims.

In July 2013 the NHSLA announced that it had stopped assessments against the risk management standards; however they will continue to pay the discounts against the levels the Trust has attained in 2014/15 (Level 1 – Acute; Level 2 – Maternity).

The NHSLA new safety and learning service, which will replace the current risk management standards and assessments, aims to provide organisations with support to learn from claims, reduce harm and thereby reduce claims in the future.

The extranet was launched in September 2013 and will replace the Solicitors Risk Management Report which was previously sent through quarterly and provided very little information other than the number of outstanding claims.

The extranet is a secure web portal which will provide both members and solicitors with real-time access to claims data. The NHSLA claims that the extranet will enable members to log new claims, track the progress of on-going claims, assess and manage their risks; thereby enabling them to prevent harm to patients and staff which might otherwise lead to future claims against the NHS.

In addition it is claimed that the extranet will enable organisations to:

- benchmark themselves against other NHS organisations, drawing on the NHSLA unique database of NHS claims data
- access good practice guidance on safety standards
- share information and learning with NHS colleagues through an online help forum
- share files and information securely through the system's document transfer service

Learning from experience is critical to the delivery of safe and effective services across the Trust. In order to avoid repeating mistakes that have led to a claim, the Trust must learn from previous similar events and ensure the development of workable plans for improving safety.

At present the extranet provides limited information however, it is hoped that the resource will provide more valuable and meaningful information moving forward.

3. Plans for 2014/15

The coming year holds significant challenges and the Department's priorities will be shaped by a number of national and local factors. In particular, guidance on the new National Serious Incident framework is expected in late July 2014.

Locally, the availability of real-time data is of particular importance to clinical teams. The Governance Department are currently working on ways to improve this to ensure that all managers and senior clinicians can have easier access to live risk data on their patients and clinical areas.

Learning from incidents and near-misses is a key priority for 2014/15 and the Governance Department will continue to improve the link between risk management and the Patient Safety Academy in order to facilitate this.

The most significant challenges for the next 12 months are to:

- Comprehensive review the Risk Management Strategy
- Complete the roll out of the major upgrade of the Datix system
- Develop a training needs analysis for all aspects of risk management training and roll out training to all relevant staff (to include RCA & incident investigation training)

- Further improve the Trust's incident reporting rate with the aim to be in the top 25% of reporters by the end of March 2015. By achieving this, the Trust will maximise the opportunities to learn from experience, which is a core part of any risk management strategy
- Ensure that Serious Incident action plans are monitored and evidence of completion is available
- Ensure lessons learnt from adverse incidents are shared across the organisation and where appropriate, the wider health economy
- Ensure significant risks to the organisation are reflected on the Corporate Risk Register and actions are in place to reduce the risk to their target level
- Ensure all extreme risks are linked to the Board Assurance Framework (BAF)

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Medical Education Annual Report 2013 - 2014**
Agenda item	17
Sponsoring Director	D r Mike Wilkinson, Interim Medical Director
Author(s) of Report	Dr Andrew Jeffrey, Director of Medical Education
Purpose	Assurance & Information

EXECUTIVE SUMMARY OF CRITICAL POINTS

- This report highlights current issues with respect to postgraduate medical training at NGH. Junior doctors are an essential part of the workforce
- Junior doctor training is provided largely by consultant medical staff and is reliant on clinical leadership and engagement with changing patterns and demands on training.
- Multiprofessional learning and links are increasingly important if the workforce as a whole is to be able to deliver high quality care and staff satisfaction and involvement is increased if high quality learning is provided for doctors and other staff groups.
- Not all training posts within the hospital are filled despite the trust receiving good reports from trainees who work here. Consideration is being given to redistributing trainees throughout the region.
- A number of innovative schemes are being developed to fill the gaps in junior rotas. These are outlined in the text and may increasingly include individuals without a medical background.
- The trust needs to continue to recognise training as an essential part of Consultant work

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? All
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF 14

N

Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

The Board is asked to note the content of the report which is provided for information and discussion of key points. The challenge of maintaining adequate numbers of Doctors in Training is a national one but impacts very significantly on District General Hospitals. The Local Education and Training Boards have an increasing role in future developments relating to the planning of the medical workforce and it will be important to influence these appropriately.

Public Trust Board
31 July 2014

Medical Education Annual Report 2013-14

1. Introduction

Northampton General Hospital undertakes the training of both undergraduate and post graduate medical trainees. Our trainee numbers have remained stable since last year's report. We have approximately 65 undergraduates on site and 180-200 post-graduate trainees on the payroll at any one time. Our reputation for the quality of training at all levels is high as judged by trainee feedback and external review.

We received this year income similar to last through the Learning Development Agreement with the Local Education Training Board (LETB) of approximately £2.0m per annum from the universities for undergraduate training (SIFT) and £5.9m for postgraduate medical training for doctors on the national training schemes. From this latter sum approximately £5.4m is allocated to support the salary costs of the trainees with the remainder allocated to salary costs for the postgraduate medical administrative team, revenue costs for the training facilities and a contribution to the Programmed Activity costs of the 3 consultants (6 PAs in total) who deliver the Quality Control and educational governance and organise and support the learning environment, training programmes and trainee support within the Trust.

We were one of the few organisations not to see a reduction in our SIFT income in face of a national reduction. This was due to a new contract with the University of Leicester to provide leadership in the development and delivery of Quality Improvement and patient safety training to all their medical students. This offset the loss from a reduction in the per-capita payments for undergraduate education.

The postgraduate trainees provide a significant part of the service delivery within the Trust, indeed the service is dependent upon them. We are subject to annual review of the quality of our training by the LETB as part of the GMC Quality Assurance process. The LETB have the power to withdraw trainees and their funding if we fail to deliver training of an adequate quality or indeed to allocate extra trainees with funding to our organisation as and when expansion or reallocation takes place. The most recent review took place on the 30 April 2014. The report forms **Appendix 1.**

The Undergraduates come from both the University of Leicester and the University of Oxford. We provide clinical placements and tutorials for students at all stages of clinical training across most of our specialties. The quality of our training is reviewed annually by both universities. Again they have the discretion to remove students and their funding if the quality of our training is inadequate.

We have had no training posts withdrawn as a result of poor quality training in over a decade and regularly receive highly flattering reports from the Universities for the standard of our training.

This report will focus on the postgraduate training as this has the greatest impact on the functioning of the organisation, but will include a specific update on a development in undergraduate training highlighted in last year's report that will have Trust wide implications.

2. Progress in 2013-14

In the course of the last year the new educational governance process for medical training has been implemented and is starting to become embedded. The principle changes have been to formalise the best practice of departments and to standardise the reporting mechanisms. It has not been easy to get these accepted across the whole organisation but there has been a significant improvement in the last 6 months. The demand for increasing amounts of evidence both in terms of the quality of training and the personal performance of the trainees has stretched resources (particularly consultant time) at a time of increasing clinical pressures.

Our postgraduate training performance is judged through a variety of means; LETB Quality Management visits, GMC surveys of trainees and trainers and Quality Control data fed from the Trust to the LETB via the Specialty Schools. We have continued to work closely with the LETB Quality team through full once yearly and 3 interim visits. The most recent annual report is appended (Appendix 1).

We are moving to a new structure for the external assessment by the LETB which will integrate the assessment of all clinical training, not just that of doctors. The first implementation of this is due in the autumn and will require the collection and reporting of data that we have not previously gathered. Discussions are ongoing with the quality management team to establish workable solutions to the problems this is generating, but inevitably they will require administrative time. Our new governance processes will make things easier and the much more closely aligned inspections by the LETB and CQC are a lever to drive change if needed.

Access to outpatient clinics for Core Medical Trainees, highlighted as a significant deficiency last year has significantly improved. There is now a rolling programme of clinic dates for each trainee during a ring fenced week in their rota. This has been running for about 4 months at the time of writing.

The GMC trainee survey is a compulsory on-line survey for all trainees that takes place annually in spring. The 2013 results are publically available on line, but the 2014 results will not be released until late July. The LETB had no specific concerns coming from the 2013 survey. The results for NGH were around the average for the UK.

3. Developments

(i) Physician Associates

a. For the last 2 years NGH has employed 2 Physician Associates (PAs) in acute medicine. These individuals have undertaken a formal Master's level training over 2 years that in many ways mirrors the clinical training of medical students. They all have first degrees in biomedical sciences and are capable of basic clinical care tasks and minor procedures. They are employed at Agenda for Change band 7. Their introduction has been of great benefit to the acute medical service in terms of delivery of care. We have attempted to increase the numbers but applications have been low, largely because there

are very few trained PAs in the market. We have therefore agreed to take on PA students who will be studying in the University of Birmingham for clinical placements.

Initially we will have 3 students placed in general medicine starting in September 2014. We are looking to increase the numbers and range of speciality placements available to the Birmingham students in NGH in the hope of attracting them to subsequently work here. The University are keen to support this “recruit and train locally to work locally” approach.

We have chosen to include our existing PAs in the regular training sessions offered to our postgraduate doctors which they have appreciated greatly. With expansion we will need to consider moving to a more formal programme of training tailored to the PAs to ensure that they develop skills appropriate not only to our clinical needs, but that integrate with the training needs of our post graduate medical trainees who they complement but do not replace.

(ii) Simulation Training

a. Simulation training activity continues to increase. This year the LETB funded the purchase of a laparoscopic surgery simulator and an ultrasound training mannequin (total value £120,000) which will both be used across a number of directorates.
b. Due to the increasing use of the simulation facilities we have this year set aside 4 full days in the training suite for the provision of training specifically focussed on issues that have been raised by Significant Incidents (SIs) that have occurred in the hospital. We continue to prioritise patient safety training in the unit.
c. Further opportunities for income generation are being explored.
d. The Quarter 4 activity report is attached for illustration (Appendix 2).

(iii) Undergraduate Quality Improvement training

a. As part of the University of Leicester Medical school funded project we have started recruiting staff to deliver it.
b. We have appointed Dr Philip Pearson to the clinical lead post for this project. He will work as a consultant physician in NGH and honorary senior lecturer in the University of Leicester on a 60/40 split contract. He is starting in NGH in September 2014.
c. We now provide approximately 10% of the overall clinical placements for the University of Leicester Medical School and continue to receive good feedback for the training we provide.

(iv) LETB and workforce distribution

The change to the new organisation has had only a limited impact on postgraduate medical training which has to follow national patterns, but the investigation into the distribution of trainees throughout the East Midlands, started last year, has now reported and agreed in principle that there should be some redistribution of posts to better

match numbers to population. If implemented this would benefit NGH. However, the East Midlands has a historically low number of trainees in all specialties for its population size and within the region a very uneven distribution of those that we do have, with NGH having amongst the smallest number, despite having a history of better training delivery. Large scale re-distribution is unlikely so the size of the benefit to NGH remains unclear. Our CEO, Sonia Swart, has been asked to chair the LETB group overseeing this process.

Further information on the LETB can be found at:
http://www.eastmidlandsletb.net/

(v) "Chief Resident" Project

Amongst a wide range of proposals to cope with the future demands in hospitals in the UK put forward by the Royal College of Physicians of London **"**Future Hospital Commission" they proposed the creation of "Chief Resident" posts within departments of medicine. They define them as a doctor in training, reporting to the "chief of medicine", and responsible for liaising between doctors in training in the Medical Division and the "chief of medicine" and senior clinical managers.

Development sites are being sought by the RCP to trail many of the ideas from the Commission report which will be actively supported by the RCP. We propose to bid for such support to implement the Chief Resident role next year.

Further information on the FHC can be found at:
http://www.rcplondon.ac.uk/projects/future-hospital-programme

(vi) Innovative posts

(a) Anaesthetics / Critical care
Five Fellowship posts have been created and recruited. The Fellows will spend 60% of their time working in ITU and 40% supporting quality improvement and patient safety initiatives in line with Trust needs.
(b) Emergency Medicine
There are plans to recruit 8 doctors to stand-alone Trust based training programmes of 4 years duration in emergency medicine. These will be structured to provide evidenced experience sufficient to support the doctors' applications for GMC specialist recognition through the CESR route. Significant interest in these posts has already been identified from a number of potential applicants. These doctors will also work in Medicine, Anaesthesia and Critical Care.
(c) Medicine
2 posts as part of the Royal College of Physicians pilot project on post-CCT Fellowships were approved and advertised this year, but unfortunately did not attract appointable candidates.

4. Challenges

(i) Recruitment

We do not expect to get a full allocation of trainees from the LETB this year. There have been particular problems with GP recruitment nationally this year and many of our GP posts may be unfilled. We are working with the LETB to try and fill these with “Pre GP” candidates (doctors wishing to be GPs but who did not meet the recruitment criteria this year). These would be funded by the LETB, but clearly would not be of the calibre of successful GP trainees. How we can adequately support such doctors is the subject of current discussions.

Action: The Trust has agreed again to fund locally recruited posts to fill gaps. Recruitment is on-going at present. 9 overseas graduates have started in emergency medicine and Medical Training Initiative posts have been filled in Plastic Surgery, ENT, Ophthalmology and Anaesthesia. 2 trainees from Malta will join in August 2014, with a 3rd planned for later in the year.

(ii) Educational and Clinical Supervisor Recognition

The GMC requirement for all doctors acting as educational or clinical supervisors for trainees to be fully trained for this task has moved into its next phase. By August 2014 we must have a complete register of all doctors in this role and of the training they have received. This data has been difficult to gather but at the time of writing only 9 consultants have not responded to our requests for this information. They will be followed up personally so we should meet this milestone. By 2016 all must be trained and those already trained must be able to demonstrate ongoing CPD in medical education. This will require time and commitment and must be managed in a way that does not put consultants off taking these roles, as without them we cannot have trainees.

Action: in house training and CPD have been set up to encourage wider participation in educational training. Excellent feedback received for the courses delivered to date (example in Appendix 3).

(iii) Governance of Innovative training posts

With an increasing number of non-standard medical posts that involve strong elements of training in the hospital (as described above) it is essential that these are included in the educational governance processes of the organisation. To date only the numbered national training posts have been monitored in this way. There is no external scrutiny of these posts but it is good practice for us to oversee all training done in the name of the Trust with equal rigour. Systems for doing this need to be introduced, preferably modelled on the national criteria.

Action: Discussion with Clinical Directors and Specialist Tutors to be arranged to decide on appropriate mechanisms to deliver this.

(iv) Medical Education Manager Replacement

Mrs Pat Hawkins, who has been our Medical Education Manager for over a decade, has retired this year (although she has come back part time while a

replacement is found). This is a key role in overseeing the processes required in ensuring our effective responses to the changing requirements of medical training and its quality assurance. She has headed the team of 7 staff in the post-graduate office, and kept a careful eye on our adherence to the requirements of the LDA within the available budget. We are about to advertise for a replacement.

I would like to thank her formally for all her help and support over her time in post. The challenge will be to find a suitable replacement as some of our near neighbours have struggled to recruit to similar posts in the near past.

Action: to create an attractive job description and employment package to attract high quality applicants.

Appendix 1
LETB EAR report 2014

Local Education Provider: Northampton General Hospital			Date: 5th June 2013		Interim 6th November 2013		Interim 30th April 2014	
Red = immediate action required **Amber = update required for scheduled follow-up visit** **Green = on going review for annual update**								
Notes/ Issues/ GMP	**GMC Domain**	**Grade**	**Specialty**	**RAG**	**Interim Update** All	**RA**	**Interim Update** Clear Filter All	**RA**
Trust Wide								
The visit team welcome the engagement of the Trust senior management team and are grateful for the efforts of the team to organise the visit. The team would particularly like to thank Andrew Jeffrey and Pat Hawkins as the programme the Trust devised enabled the visit team to spend time with the Trust Education Team and a range of trainers in order to get a sense of the current and future plans for Education and training the Trust. The visit team found the visit to the Simulation Suite extremely valuable and commend the Trust on the progress made to develop the Suite so far.	2	All grades	Trust Wide	Green				Green

The visit team would recommend that the Trust explore methods for ensuring that all supervisors have clear understanding of their roles. During the visit the team heard some feedback which suggested some supervisors were unclear about their remit. Whilst this may be particularly pertinent for newly appointed supervisors, it would nonetheless be beneficial to confirm all supervisors understand their roles and responsibilities. During the visit the education and visit teams discussed the potential misunderstanding around the postponement of trust provided training and whether this might be reinstated in the future. The visit team confirmed it would be beneficial to have locally tailored courses running to supplement and enhance any LETB wide training requirements.	6	All grades	Trust Wide	Amber	The Trust are looking into developing a tailored training course for trainers. The aim is to offer a half day face to face course with some modules of e-learning incorporated. The course will focus on areas such as giving feedback, the trainee in difficulty and will provide further details concerning the local	Green		Green

					education governance structure. Ensuring that all supervisors have attended this training will help to assure the quality of all supervisors and provide them with clarity concerning their roles.			
The team were given some instances where Educational Supervisors had not been allocated to trainees at the beginning of their posts, which had resulted in some issues for trainees trying to identify and confirm their own supervisors. The visit team recommend that the allocation of supervisors for all trainees is in place for the start of placements and look forward to hearing how this has progressed at the next review meeting,	6	All grades	Trust Wide	Amber	AJ confirmed that work is underway in order to define post numbers for all trainee posts within the Trust. This will then	Amber	AJ is closely linked with the Recognition of trainers project and as such has been strengthening the process around allocation of appropriately trained supervisors to trainees. This work should have already improved the experience for trainees, but the Quality Team	Green

					enable supervisors to be allocated in advance to those post numbers. The Quality Team look forward to hearing how this approach works following the next changeover.		will be able to test this against the 2014 GMC survey results. AJ also shared a copy of the NGH guide to Postgraduate Medical Education, which contains a guide for supervisors and clear definitions for the roles and responsibilities for all parties.	
The team heard a number of examples where the lack of a weekend phlebotomy service had impacted on trainees and resulted in an increased number of routine tasks (bloods) the trainees were undertaking. The team would like to encourage the trust to look at extending the Hospital at Night system to cover the weekends as the team received positive feedback on the benefits of having this system with particular praise being given to nurse practitioners.	5	All grades	Trust Wide	Amber	AJ confirmed that there are areas where Nursing staff could be trained to take blood to provide greater support. However, work in on-	Amber	Work is ongoing to look at support structures across the Trust alongside the patient safety work being led by Sonia Swart. The quality team will look forward to receiving an update at the next meeting.	Amber

					going to look at the provision of Phlebotomy across the Trust. The Quality Team will look forward to receiving an update at the next meeting.			
Educators Workstream								
The visit team were interested to hear about the work the Trust and the Education team are undertaking in order to ensure a process is in place to collect and confirm information on the training of supervisors within the Trust. The links the Trust is developing with safety and support systems are particularly interesting and the LETB will be keen to hear more as these arrangements develop. The team would also like to note the linking of these process to trainers appraisals as good practice.	6	All grades	Trust Wide	Green				Green
The Educators stream of the visit discussed some of the challenges the Trust has faced trying to fill post gaps and how the links with	4	All grades	Trust Wide	Green				Green

the LETB and Speciality Schools involved could be further strengthened to support this. Those discussions were very useful and the visit team will progress this feedback with both schools and internally within the LETB to ensure the Trust is supported.								
Foundation Trainees								
The trainees reported that the four day shadowing period had been beneficial.	5	Foundation	Trust Wide	Green				Green

General Medicine trainees reported that on-call shifts were busy and demanding. The trainees confirmed they cover 9 wards on nights and 11 wards at weekends when there are less trainees to cover. The feedback seemed to suggest that whilst there was a system for recording jobs, those tasks were put onto the system but did not get prioritised. There also appeared to be no system in place to provide feedback to those who had logged the original jobs around the lack of prioritisation. The trainees felt there was confusion about which trainees should be covering which wards and there had been poor communication when changes were made leading to confusion around ward names and designations. The team would recommend that the Trust look at ways to reduce this uncertainty through clear communications.	1	Foundation	Medicine	Amber	The Trust are looking to implement new team based methods of working from early 2014, which will include having 3 Consultants during weekend mornings. Whilst this means the Acute Medical structure will change, the Trust continues to consider the issues raised.	Amber	The medical acute pathway has been changed significantly there are now four teams in place which are colour coded and each consultant is paired with a team. The Consultant will work in blocks of three and five days or in an a row of eight. The teams are blue, green, red and white and are all static with trainees always workign with the same team. Patients are allocated to the teams led by the consultant who first reviewed them, which ensures that the consultant may well look after them for their whole stay (it is anticipated that if a patient has to move they will only do so once). This system will ensure that trainees get continuity as do patients, and the consultants will always work to the same team with their on call coming round every three weeks. This means	Amber

							the trainees get used to the teams and a smaller number of consultants they work with. Those patients with a specialty need will move on to a specialist ward ASAP. When a patient arrives at their destination ward that patient becomes the responsibility of that ward, there are no outliers. Four consultants will be on site from 8:30 till 4 and there will be 3 consultants every Saturday morning, 3 consultants every Sunday and one from lunchtime until next day. Night patients arriving after 10pm are all allocated to teams evenly. These steps have increased consultant ward cover, but another impact is when consultants undertake medicine cover in blocks they	

							are less visible on the specialist wards. Which impacts on their ward colleagues.	

There seemed to be a particular issue with handover between Surgery on-call cover and Medical ward day cover and a disconnect between handover times. i.e. On-call finishing at 8:00am and clinical ward cover commencing at 9:00am making handover problematic.	1	Foundation	Medicine, Surgery	Amber	The Trust confirmed that work continues to strengthen night handover and ensure that all staff attend handover at shift start. The Trust are also adopting a standard format for those handover sessions. Morning handover will change when the new medicine structures are in place, however	Amber	See 3.2, work continues to strengthen handover arrangements in light of the new medical structure and the quality team will test this against the GMC NTS results for 2014.	Amber

					work is still required to ensure that morning handover is further strengthened.			
Hospital at Night is in place at the Trust and the trainees felt that the Nurse Practitioners were extremely valuable during the week on-calls and would significantly ease pressure if Hospital at Night could be extended to 24 hour cover at weekends. Similar feedback was also expressed concerning the Phlebotomy service (see 1.4).	16	Foundation	Trust Wide	Amber	The Trust are looking to implement new Team based methods of working from early 2014. The visit team recommends that these issues be considered as part of that implementation.	Amber	See 3.2	Green

Feedback was gathered concerning the amount of work required for discharges, which trainees were undertaking as part of their on-call duties, it appeared that these tasks appeared to build up and then trainees felt they were put under pressure to complete discharge letters and TTOs in order to move patients through the system. The team would suggest that the Trust look into these potential issues and whether there is way to streamline discharge processes within normal working hours to prevent a backlog for on-call.	5	Foundation	Trust Wide	Amber	The Trust are looking to implement new Team based methods of working from early 2014. The visit team recommends that these issues be considered as part of that implementation.	Amber	See 3.2	Green
The trainees described some incidences where patients had been moved following decisions by bed managers, which was a concern for continuity of care and a potential patient safety issue. The team would suggest that Trust investigate these comments and provide feedback to the visit team as a matter of urgency.	1	Foundation	Trust Wide	Red	AJ confirmed that it appears that incidents of this nature have decreased. A new site management team is being created and	Amber	AJ confirmed that McKinsey had been working with the Trust on a number of areas including a key focus on patient safety and an imitative called "breaking the cycle" which focusses on creating greater clinical involvement in patient movement around the Trust. The Trust has also developed patient safety	Green

					ambition for this team is that they will work more closely with clinicians to identify appropriate patients for transfer / discharge. The Quality Team look forward to hearing further updates concerning this area of work.		huddles, where all ward managers gather together.	
Some trainees reported having to find their own educational and clinical supervisors at the start of their placements (see 1.3), whilst other trainees expressed some concerns over their supervisors knowledge of their roles including knowledge of mandatory sign off items and use of e-portfolios. The visit team understands that	6	Foundation	Trust Wide	Red	See the response for 1.3.	Amber	See 1.3	Green

the Trust is already planning to undertake developmental work with supervisors and so the LETB looks forward to receiving an update on progress.								
FY2 teaching was raised as a potential issue for the trainees as the late release of dates was making attendance an issue. Similar comments were also raised around the CRIMP course and therefore the visit team would encourage the Trust to look at the timing of courses and early release of dates to encourage attendance.	5	Foundation	Trust Wide	Amber	The Trust are looking at the format of the Wednesday afternoon teaching , it is acknowledged that the release of information is on occasion late. Work is underway to strengthen the planning and content of the sessions, particularly with regard to potentially including a regular	Amber	Work continues to develop the format and structure of teaching and the quality team look forward to hearing an update on progress at the next meeting.	Amber

					patient safety slot.			
Core Medical Trainees								
Whilst weekly teaching did take place, trainees felt it was at times unstructured, however the trainees also confirmed that they were timetabled in to present at the sessions which was felt to be a valuable experience. Some trainees fedback that they had been informed they could not attend teaching if minimum numbers were not maintained on the ward. The visit team would welcome clarification around minimum staff numbers on wards and whether this is impacting on trainees being released for teaching.	5	Core Trainees	Medicine	Amber	The Trust confirmed that staffing ward numbers were mandated, but this issue largely impacted upon the Acute take as opposed to the ward.	Amber	The ongoing developments should help to address the issues trainees have experienced attending teaching and the quality team will test progress against the NTS GMC survey 2014 survey results.	Amber

Attendance at clinics was variable and somewhat specialty dependent with some trainees reporting being advised to take annual leave to attend clinics. Rheumatology, Haematology, Dermatology and GUM were specialties mentioned where trainees were able to attend clinics. The team will support the Trust to identify ways to share good practice around clinic attendance to improve access for all trainees to enable them to meet their curriculum requirements.	8	Core Trainees	Medicine	Amber	AJ confirmed that a plan is in place for trainees who are due to start a block of on-call nights, those trainees will start those shifts on a Thursday. The preceding Monday to Wednesday will then be timetabled clinics between 9-5pm. Trainees will be expected to volunteer to the clinics they wish to attend and those clinics	Green		Green

					will be allocated on a first come first served basis with the aim of the trainees attending between 12 and 18 clinics. The Quality Team look forward to hearing more about this plan and how this works in practice.			
Trainees expressed some concerns around completing ACATS and getting adequate exposure to clerking patients during regular hours, however the trainees did get access to clerk patients during nights but then had limited opportunity to undertake a verbal handover. The Trust are advised to look at methods to maximise these experiences as	5 6	Core Trainees	Medicine	Amber	AJ confirmed that work continues on this issue, particularly how to address within the	Amber	This is an ongoing issue, but the new team structure will help to provide greater opportunities to maximise learning opportunities.	Amber

learning opportunities wherever possible.					wider hospital system. The Quality Team would like to offer support to assist the Trust in finding solutions to these issues.			
CT Trainees seemed unaware of the initial assessments by Consultants but did confirm that two Consultants clerked patients with the CT between 5:00pm - 9:00pm which provided a good learning opportunity. The trainees raised the mismatch between the rota which is between 9:00am - 5:00pm and the patient flow, which is heaviest between 5:00pm - 9:00pm and suggested it may be beneficial if the staffing reflected the patient flow.	5 6 8	Core Trainees	Medicine	Amber	AJ confirmed that this practice is no longer happening as the initial FIT assessments are being undertaken by the Emergency Medicine Staff.	Green		Green
The trainees raised the split Oncology and Haematology post, which has two months split in each area. This fragmentation was felt to be challenging and had been raised with the TPD.	6	Core Trainees	Medicine	Amber	AJ confirmed that the pattern for both of these	Green		Green

					posts has been amended to address the issues raised to the TPD.			
The CT Trainees confirmed they had not been allocated their supervisors immediately and when they were allocated it became clear that a number were allocated the same supervisor. This resulted in trainees having to look for another supervisor. The trainees also confirmed that where they had raised issues with a supervisors understanding of the role the Trust was confirmed to have been supportive.	6	Core Trainees	Medicine	Amber	See 1.3	Amber	See 1.3	Green
Formal teaching was reported as difficult for trainees to attend due to the timing of the sessions and work commitments. The team would be interested to receive an update from the Trust on whether there is any evidence to support these comments (i.e. attendance levels).	5	Core Trainees	Medicine	Amber	See 3.8	Amber	AJ confirmed that the teaching had been patchy on occasions due to securing Consultant attendance, but work continues to improve this.	Amber
Surgery / ACCS Trainees								

The trainees reported the Trust was friendly place to work with excellent consultants and nursing staff. The trainees also fedback that support and pastoral care within A&E was excellent, but felt that the experience within the department could be improved by having clinical guidelines readily available. Whilst these guidelines may be available on the intranet, this was currently not user friendly.	1	Core Trainees	Emergency Med	Amber	AJ confirmed that work has been undertaken to ensure that guidelines are available in a consistent format. This work continues, but Emergency Medicine is an areas committed to ensuring guidelines are in place and accessible.	Amber	Work is ongoing to ensure guidelines are readily accessible, but the quality team would request an update on progress to date at the next meeting.	Amber

The trainees were unsure about the frequency of the Junior Doctors forum and whether attendance was mandatory. This may require some clarification to assist the Trust in engaging effectively with trainees.	6	Core Trainees	Emergency Med, Surgery	Amber	AJ confirmed that a Surgical Forum has started and the most recent meeting has good attendance, as run by Clinical Director of Surgery and identified a number of issues. The Trust has undertaken to run forums in all departments with the DME and Chief Executive attending each forum where	Green		Green

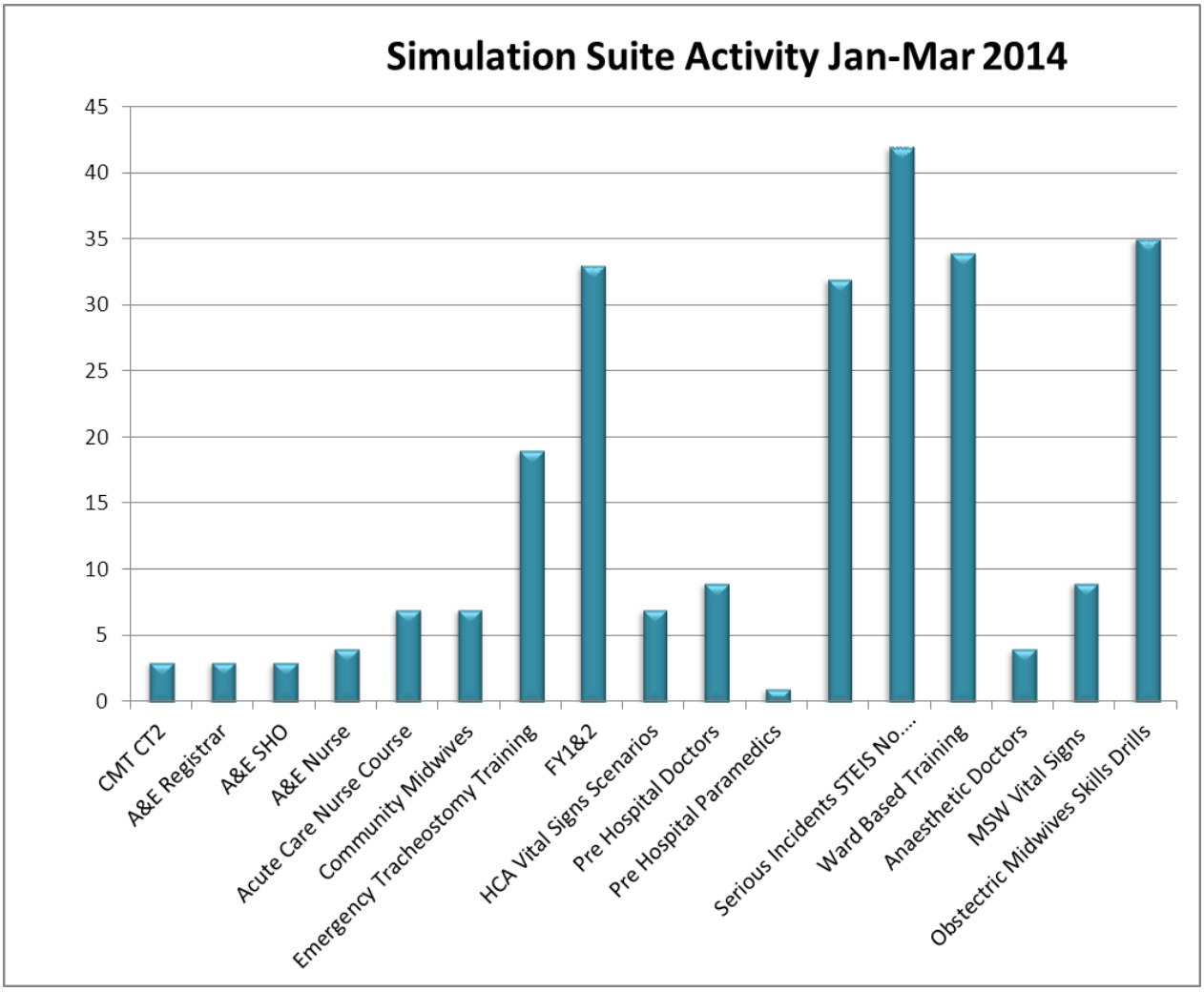
					possible. The main focus to date have been patient safety and training issues and all forums are formally minuted with a set format.			
Surgery was reported to offer good training with lots of support from Consultants and seniors. The trainees reported good access to theatres and ample opportunity to meet their competencies particularly within Vascular Surgery.	6	Core Trainees	Surgery	Green				Green
Trainees confirmed that they had been allocated supervisors at the start of their posts but had experienced issues in attending teaching due to heavy rota commitments, however the team were informed the rota is due to change in August to address this issue. The trainees also confirmed that they had been advised that they were unable to claim	5	Core Trainees	Surgery, Emergency Med	Amber	See 1.3	Amber	See 1.3	Green

expenses for travelling to teaching. The team would advise the Trust to confirm the guidance for expenses and communicate this to trainees.								
The trainees were keen to receive feedback on SUIs and Datix reports and whilst meetings had been arranged to discuss specific incidents, these were sometimes cancelled and no further feedback received. The visit team understands that a number of developments are being undertaken by the Trust to collect and disseminate information concerning incidents of this nature. Trainees appeared to be keen to be informed of / involved in these discussions and therefore the Trust may wish to engage further with trainees whilst developing the process. The LETB look forward to hearing more at the next meeting.	1	Core Trainees	Surgery, Medicine	Green				Green
Ward Visits								
Emergency Admissions Unit - The visit team were impressed by the enthusiasm of the staff and the description provided of their interactions with trainees. However, the description of the types of patients on the ward and the lengths of stay varied somewhat between what the team were told in sessions with trainees and what they heard on the ward.								

The Trust may find it beneficial to provide clarity on the role of the Emergency Admissions Unit and the patients whom should be admitted onto that ward.								
Beckett Ward - The visit team were pleased to have the opportunity to visit the Respiratory Medicine ward and meet some members of staff on that ward. The team were interested to hear how the ward integrated with the Hospital at Night system there appear to be opportunities for greater integration of the medical on-call team with the H@N supervisor that could lead to enhanced treatment and care. The Trust may wish to explore these opportunities.								
Hawthorn Ward - The team found the staff on this ward enthusiastic and keen to develop the service they provided and the opportunities presented to their staff.								
A&E - The trainees were positive about the training arrangements within the department, and about the educational and clinical support they received from all staff. This was being provided even during a period of increased throughput.								

Appendix 2

Simulation Activity



N

Appendix 3

NORTHAMPTON GENERAL HOSPITAL

Medical Teaching Faculty Development 2014

FEEDBACK SUMMARY

27th June 2014
13.00 -14.00h

Identifying the Trainee at risk or in Difficulty

Cripps Postgraduate Medical Centre, NGH

Number of attendees: 20
Number of completed questionnaires: 19

The consultants were asked to rate the teaching for:

Topical relevance:	100% of the attendees rated the sessions as 'very good' or 'excellent'
Style of session:	100% of the attendees rated the sessions as 'very good' or 'excellent'
Time/Duration: 1 did not rate the session	89% of the attendees rated the sessions as 'very good' or 'excellent'
Knowledge/Skills conveyed: 2 did not rate the session	84% of the attendees rated the sessions as 'very good' or 'excellent'

Comments and suggestions

Topic Relevance

- Important topic. A must for all consultants.
- Very useful.
- Very useful topic.
- Relevant to all clinical and educational supervisors.
- Good engagement with audience.
- Relevant.
- Yes, very relevant as I recently had to deal with a trainee in difficulties.
- Will there be a follow up session?

Style of session?

- Appropriate in style, content and time.
- Good style. Good use of group/lecture.
- Informal.
- Informal and easy to contribute.
- Very much liked interactive session.
- Worked very well.
- Informal. Good opportunity to express/discuss.
- Very useful.
- Appropriate.
- Good, interactive.
- Group discussion was useful.
- Very interactive.
- Very open, allowed us to let down our guards.
- Good balance of reflection and direct teaching.

Time/Duration

- Just right.
- Fine.
- An hour is about right- can concentrate for that long.
- Right.
- 1 hour.
- Could be longer.
- Not too long- well engaged.
- Kept attention, useful session.
- Just right- wouldn't mind if longer or more frequent.
- Goodtime management. Topic could have filled a longer session.

Knowledge/Skills Conveyed

The most important thing I learned:

- Be aware of the cultural differences!
- Importance of cultural considerations/conflict of own culture vs other doctor.
- Importance of cultural differences which may lead to misinterpretation.
- Good structure for review meeting of our level of concerns.
- How to record a conversation with trainee? Cultural differences.
- Think more about cultural contexts. Keep records of all conversations.
- Identifying the early signs of a failing trainee.
- Thinking about different cultures. Interview record.
- To treat as a diagnostic exercise.
- Take care to investigate/diagnose the problem. Don't go in 'cold' to discuss issues. 'Record it'.
- Keeping record of initial meeting of concerns.
- Structured, documented interview. Cultural awareness.
- Taking into consideration different backgrounds, cultural differences etc.
- Record and verify conversations with or without presence.
- Cultural differences could be perceived as difficulty.
- To be aware of cultural effects.
- Recording of the meeting of a trainee in difficulty- Cover all aspects to find out the problem early. Getting information before meeting be well prepared.
- Structure of a discussion of trainee in difficulty- probably what I felt least confident about.
- Structure and way to approach the issue that is safe.

General Comments

- Very good. Made compulsory for all consultants.
- Good to meet colleagues in other specialties.
- Great first in a series.
- It's great to meet up with colleagues- we don't do it enough.
- Short and sweet session.
- Very good interactive session. Overall very good.
- Very good session.
- Very good session.
- Useful to have drop in sessions.
- Structured questionnaire very helpful too.
- Very good. Thanks.
- Very good overview of dealing of a trainee in difficulty.
- Do not be prejudiced or judgmental.
- Very helpful.

Suggestions

- More please.
- More of these types will be useful.
- More time would be useful.
- To have regular sessions to cover all modules required for educational supervisors.
- To use examples for future sessions and mock interviews.
- Possibly examples- even if would need to be fictitious.

.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**A Framework of Quality Assurance for Responsible Officers and Revalidation - Annual Board Report**
Agenda item	18
Sponsoring Director	Dr Mike Wilkinson, Interim Medical Director
Author(s) of Report	Ms Johanne Anthony, Associate Medical Director/Interim Responsible Officer Ms Susan Jacobs, Project Manager
Purpose	To provide assurance to the Trust Board that local systems and processes concerning medical appraisals and revalidation are in accordance with The Medical Professional (Responsible Officers) Regulations 2010 as amended in 2013 and The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012.

Executive summary

Medical revalidation was formally launched by the General Medical Council (GMC) in 2012.
The purpose of medical revalidation was to strengthen the way doctors are regulated with the aim of improving the quality of care provided to patients, improve patient safety and increase public trust and confidence in medical systems - aiming to give extra confidence to patients that their doctor is being regularly checked by the employer and the GMC.

This report aims to provide assurance to the Trust Board that that robust effective local governance systems and processes are in place to support medical appraisal and revalidation and that the Interim Responsible Officer can discharge their statutory duties.

For the reporting period 1 April 2013 – 31 March 2014 Northampton General Hospital NHS Trust (NGH) had 257 doctors with a prescribed connection to the organisation

Revalidation:

- positive recommendations have been made for 50 doctors;
- there have been 8 deferrals and 0 non-engagement.

Appraisal:

- 208 appraisals were undertaken;
- 9 appraisals were not started;
- 7 appraisals were in progress;

- 20 new starters joined the Trust during the cycle;
- 2 sick;
- 11 left the Trust and have now disconnected as a prescribed connection.

Issues

- Resource for undertaking appraisals;
- Co-ordination of appraisal information prior to joining Trust;
- Compliance of prescribed connection;
- Connections for doctors on short term contracts.

Related strategic aim and corporate objective	Improve our core clinical standards to provide a high quality environment for our patients
Risk and assurance	Effective governance to support medical revalidation
Related Board Assurance Framework entries	BAF 14
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (N)
Legal implications / regulatory requirements	The Medical Professional (Responsible Officers) Regulations 2010 as amended in 2013 and The General Medical Council (Licence to Practice and revalidation) Regulations Order of Council 2012.

Actions required by the Trust Board

The Trust Board is asked to:

- Receive the annual report on the implementation of revalidation;
- To note the required 'statement of compliance' to confirm that the Trust, as a designated body, is in compliance with the regulations; **Appendix I**
- To note the statutory responsibilities which the NGH Trust has to ensure all prescribed doctors keep up to date and that they remain fit to practise – Letter to Trust Chairman from GMC, **Appendix II**

Public Trust Board
31 July 2014

A Framework of Quality Assurance for Responsible Officers and Revalidation - Annual Board Report

1. Executive summary

'Revalidation is something that the public expect their doctors to undertake and, if implemented sensitively and effectively, is something that will support all doctors in their professional desire to improve their practice still further'

Andrew Lansley CBE MP, Secretary of State for Health

Medical revalidation was formally launched by the General Medical Council (GMC) on 3 December 2012. It is a process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

The purpose of medical revalidation was to strengthen the way doctors are regulated with the aim of improving the quality of care provided to patients, improve patient safety and increasing public trust and confidence in medical systems aiming to give extra confidence to patients that their doctor is being regularly checked by the employer and the GMC.

1.1 Revalidation

For the period 1 April 2013 – 31 March 2014 Northampton General Hospital NHS Trust (NGH) had 257 doctors with a prescribed connection to the organisation for revalidation purposes. The Trust's Interim Responsible Officer (Interim RO) has made positive recommendations for 50 doctors, all have been approved by the GMC. The majority of licensed doctors are expected to be revalidated for the first time by the end of March 2016.

Recommendation Type			TOTAL
Revalidate	Defer	Non-engagement	
50	8	0	58

To defer is a neutral act and is predominantly to give more time for the doctors to compile their evidence.

1.2 Appraisal

The appraisal cycle runs from 1 April to the 31 March each year. For the period 1 April 2013 – 31 March 2014 of those doctors with whom NGH Trust, the designated body, had a prescribed connection (257), the Trust undertook 208 appraisals.

Appraisal rate			TOTAL
Consultants (permanent)	Staff grade, associate specialist, specialty doctor (permanent)	Temporary or short-term contract holders	
165/178	12/18	31/61	208/257

2. Purpose of the Report

The purpose of the report is to provide assurance to the Trust Board that robust effective local governance systems and processes are in place to support medical appraisal and revalidation.

The purpose of medical appraisal is to:

- Enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in the GMC document Good Medical Practice and thus to inform the Responsible Officer's revalidation recommendation to the GMC.
- Enable doctors to enhance the quality of their professional work by planning their professional development.
- Enable doctors to consider their own needs in planning their professional development.
- Enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

Medical appraisal is an integral part of the revalidation process. All licensed doctors are required to revalidate, every five years, by committing to an annual appraisal with the employer based on the GMC core guidance for doctors, *Good Medical Practice (April 2013) guide.*

3. Background

In October 2010 a commitment was made by the UK health departments and the GMC that, subject to an assessment of readiness, medical revalidation would start across the UK in late 2012, subject to an assessment of readiness to be considered by the Secretary of State for Health.

The GMC launched Medical Revalidation on 3 December 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their respective Responsible Officer in discharging their duties under the Responsible Officer Regulations[1]. It is expected that provider Boards will oversee compliance by:

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The Francis report highlighted the importance of Trust Boards to pay close attention to the quality of care delivered by their organisation. Medical revalidation is a critical tool for patient safety. The purpose of this report is to provide the Trust Board with assurance that the Trust has effective systems in place to monitor and support our medical staff.

The Department of Health published the Framework of Quality Assurance for Responsible Officers (FQA) in April 2014. The FQA has been designed to provide assurance to the Board, that doctors working for the organisation are up to date and fit to practice. Assurance will be provided through a range of reporting mechanisms; the Annual Organisational Audit (AOA); the annual report culminating in a statement of compliance signed off by the Chairman or Chief executive.

Each designated body (e.g. Primary Care Trust, NHS Trust, Deanery, Armed Forces) has an appointed Responsible Officer (RO) who has statutory responsibilities indemnified by the NHS. The RO must have been a licensed Medical Practitioner for 5 years and is accountable to the Board.

The Trust implemented a new electronic appraisal/revalidation management system, Equiniti, in April 2013. Equiniti RMS supports permanent staff appraisals/revalidation (non-permanent staff are managed using an Execl spreadsheet). Benefits include one electronic repository for all doctors' appraisal portfolios and revalidation data plus management reporting functionality.

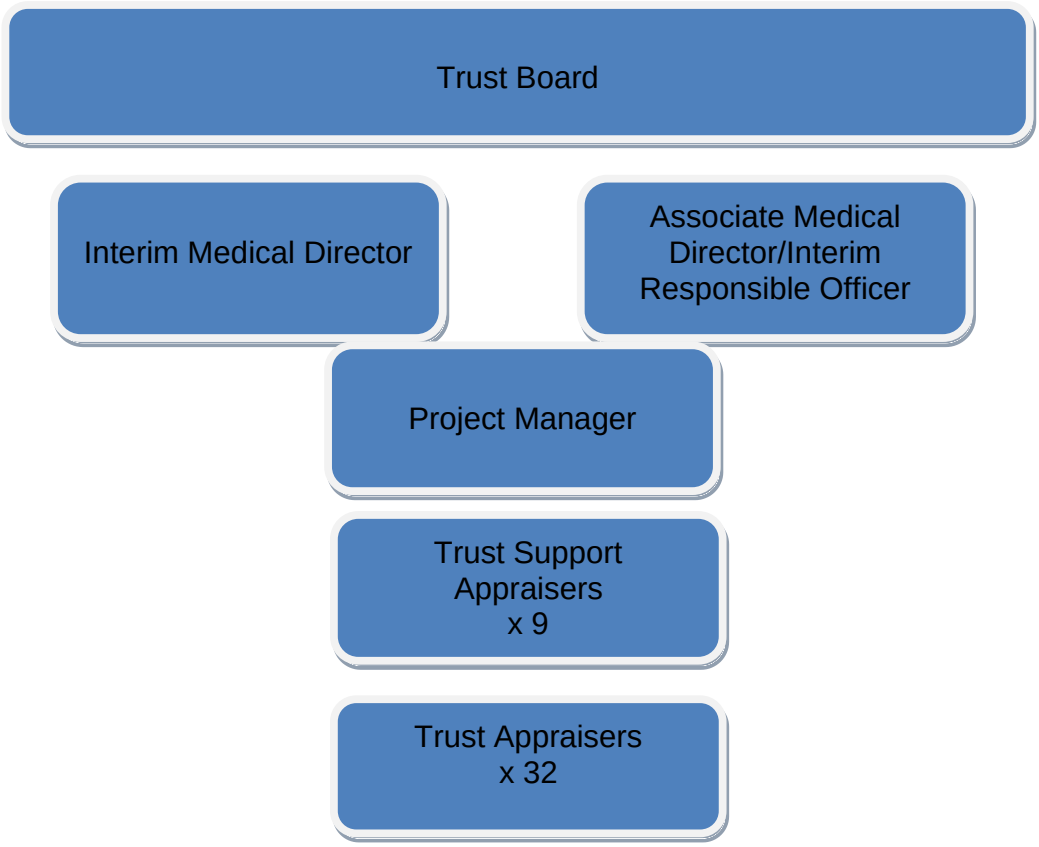
4. Governance Arrangements

The Trust Interim Medical Director together with the Trust Associate Medical Director/Interim Responsible Officer have an overarching responsibility to ensure that the Trust complies with the legislative requirements of Medical Revalidation.

The Trust recruited a substantive Project Manager in March 2014 who attended the Responsible Officer training in June 2014 designed by the Revalidation Support Team and NHS England. The training was facilitated by a trainer provider, MIAD, with input from NHS England and expert speakers including the GMC and NCAS.

The Interim Responsible Officer considers a range of information to support the evaluation of a doctor's fitness to practise and to obtain reasonable assurance that there are no unaddressed concerns about the doctor's fitness to practise. It includes a review of a doctor's appraisal portfolio and outputs of local systems and processes that supports revalidation:

- a doctor's record of participation in annual appraisals of their whole practice, where the doctor is not in a training programme
- completeness of a doctor's supporting information, ensuring the full scope of work have been included and covered within the supporting information
- intelligence arising from other sources, for example, systems of clinical and corporate governance that are in place
- patient and colleague multi source feedback
- a doctor's compliance with GMC conditions or undertakings that have applied to their registration during the current revalidation period
- a doctor's compliance with any locally agreed restrictions on their practice



In undertaking the Responsible Officer duties support is provided as follows:

- **Interim Medical Director** – evaluating fitness to practice and monitoring conduct and performance.
- **Associate Medical Director/Interim Responsible Officer** – improving the quality of care and patient safety through rigorous clinical governance. Accountable for ensuring the Trust carries out regular appraisals; establishes and implements procedures to investigate concerns; refers concerns about the medical practitioner to the GMC; monitors compliance with GMC conditions or

undertakings; makes recommendations to the GMC about fitness to practice; maintains records of practitioners' fitness to practice evaluations, including appraisals and any other investigations or assessments. Accountable for the day to day running and management of the appraisal system for doctors, including the development, update and implementation of policy and developing guidance and training for the appraisal system, monitoring of appraiser performance and quality assurance (QA) of appraisals.

- **Project Manager** – manages the appraisal process liaising with doctors and appraisers. Ensures allocation of an appropriate appraiser and appraisal month and monitors commitment and compliance, issuing reminders approximately 6 weeks prior to the allocated appraisal. Training and supporting doctors and appraisers with regard to Trust tools used and ensuring the Trust intranet site is up-to-date with appropriate information. Responsibility for ensuring effective monitoring and governance of revalidation recommendations and reasons for deferrals recorded. Ensures the list of prescribed connections is maintained. Supports the Interim Responsible Officer in policy development. Provides monthly reports on compliance with the appraisal process and number of doctors recommended for revalidation.

- **Support Appraisers** – responsibility for supporting the Associate Medical Director/Interim Responsible Officer in delivering a high quality appraisal system, including participation in the quality assurance processes, training and development of appraisers and wider support for all doctors within the appraisal process. Undertaking approximately 7 appraisals during the appraisal cycle.

- **Appraisers** – responsible for delivering high quality appraisals for the Interim Responsible Officer in keeping with the Trust Medical Appraisal and Revalidation policy, including participation in quality assurance processes, and for maintaining their skills and professional development in the role. Undertaking approximately 7 appraisals during the appraisal cycle.

  The Trust recognises that being an appraiser is a specific, professional role and after appropriate training it must be carried out to specified standards.

- **HR/Medical Staffing** – 100% compliance with pre-employment checks **Appendix III;** ensure that GMC registrations are in place prior to doctors commencing in post. Any issues relating to GMC registrations are raised to the Interim Responsible Officer. Exit interviews are requested upon notice of resignation from those staff who fall into this bracket.

- **Doctors** – Trust doctors with a prescribed connection to an NGH Responsible Officer are individually professionally accountable for their engagement with the medical appraisal process.

The Trust has in place a robust process for the allocation of appraisers and the scheduling of appraisals, ensuring fairness and equity free from appearance of bias. All Trust appraisals are undertaken according to professional standards as laid out in *Providing a Professional Appraisal (NHS Revalidation Support Team 2012).*

Should a conflict of interest of appearance of bias between a doctor and their appraiser arise the Trust adheres to the national guidance: *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint an Alternative*

Responsible Officer (NHS Revalidation Support Team, 2014).

Reporting is captured on a quarterly basis and Trust statistics reported to the higher officer using the NHS England required template.

Internal reporting is undertaken on a monthly basis and reported to the Interim Medical Director and Associate Medical Director/Interim Responsible Officer with quarterly reporting to the Appraiser Network Forum.

The Interim Responsible Officer and Project Manager ensure that an accurate record of prescribed connections is maintained. The Appraisal office receives, from HR, on a monthly basis, a schedule of Trust doctor starters and leavers for the preceding month. The office contacts each individual starter to ascertain previous details, if the Trust is the prescribed connection and ensures arrangements are in place to undertake an appraisal. The Trust uses the Medical Practice Information Transfer form (MPIT) to ascertain information about a doctor's medical practice from the previous Responsible Officer, introduced in April 2014. Regular monitoring is undertaken via GMC Connect and checked against the Trust database to ensure accurate connections.

To support the Interim Responsible Officer when reviewing a doctor's portfolio mid appraisal cycle, for revalidation purposes, the Trust has implemented a mid year declaration form for any significant events, complaints or other investigations/processes.

4.1 Policy and Guidance

The Trust has in place a Medical Appraisal & Revalidation policy with core content which is compliant with national guidance:

- Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2013);
- Supporting Information for Appraisal and Revalidation (GMC, 2013);
- Medical Appraisal Guide (NHS Revalidation Support Team, 2013);
- The Role of the Responsible Officer: Closing the Gap in Medical Regulation;
- Responsible Officer Guidance (Department of Health, 2010); and
- Quality Assurance of Medical Appraisers (NHS Revalidation Support Team, 2013).

The Interim Responsible Officer ensures that handling of information for appraisal and revalidation complies with information governance, confidentiality and data protection requirements.

The Trust Medical Appraisal & Revalidation policy is currently under review and will be presented to the Procedural Documents Group for ratification.

Equality and diversity are at the heart of the NGH Trust Medical Appraisal & Revalidation policy. Due regard to eliminate any discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it, has been given throughout the development of the policy.

5. Medical Appraisal & Revalidation

A doctor's revalidation runs over a 5 year cycle and the doctor is required to revalidate once during the cycle. Revalidation is set by the General Medical Council (GMC). Each doctor is aligned to a local Responsible Officer, the Trust has appointed the Associate Medical Director as Interim Responsible Officer until the commencement of the substantive Medical Director later this year. The Interim RO assesses a doctor's portfolio of evidence and makes a recommendation to the GMC on the doctor's fitness to practice.

The key to revalidation is a structured appraisal based on the Good Medical Practice guidance. This sets out four domains of good medical practice:

GMC Standards of Good Medical practice:

Knowledge, skills and performance	• Make the care of your patient your first concern.
	• Provide a good standard of practice and care.
	  • Keep your professional knowledge and skills up to date.
	  • Recognise and work within the limits of your competence.

Safety and quality	• Take prompt action if you think that patient safety, dignity or comfort is being compromised. • Protect and promote the health of patients and the public.

Communication, partnership and team working	• Treat patients as individuals and respect their dignity.
	  • Treat patients politely and considerately.
	  • Respect patients' right to confidentiality.
	• Work in partnership with patients.
	  • Listen to, and respond to, their concerns and preferences.
	• Give patients the information they want or need in a way they can understand.
	  • Respect patients' right to reach decisions with you about their treatment and care.
	  • Support patients in caring for themselves to improve and maintain their health.
	  • Work with colleagues in the ways that best serve patients' interests.

Maintaining trust	• Be honest and open and act with integrity. • Never discriminate unfairly against patients or colleagues. • Never abuse your patients' trust in you or the public's trust in the profession.

All doctors are personally accountable for their professional practice and must always be prepared to justify their decisions and actions.

A doctor's appraisal covers the whole scope of their practice. If a doctor practices in

more than one organisation, they are required to collate supporting information that covers their practice in each of those places.

The Trust has established systems to support this process, specifically:

- The introduction of a revised Trust policy for Medical Appraisal and Revalidation.
- A review of resources with the appointment of an Interim Responsible Officer and substantive appointment of Project Manager.
- Appraisal process 100% compliant with GMC requirements.
- The establishment of a training program for appraisers carried out in accordance with the guidance of the national Revalidation Support Team, through which sufficient appraisers have been trained to meet the needs of the organisation.
- Movement to an entirely electronic system of appraisal using an on-line appraisal support system, Equiniti and Medical Appraisal Guide (MAG) Model Appraisal Form.
- The establishment of a Support Appraiser network.
- The establishment of an Appraiser network.
- Quarterly Appraiser Forums.

These systems have been used to support the revalidation of 50 doctors out of the 257 for whom NGH was the Designated Body for revalidation.

The uptake of appraisal has improved in comparison with the previous system. In 2013/14, the level achieved was in line with the national expectation but fell short of the 2014/15 target of 95%. Performance against this target will be more closely managed at Directorate level during this year and a system of quality assurance of appraisal will be established as national standards on this are published.

5.1 Appraisal Performance Data

• Number of doctors with whom the designated body had a prescribed connection as at 31 March 2014	257
• Number of completed appraisals	208
• Appraisals not started	9
• Appraisal in progress/not signed off	7
• New starters during 2013/14	20
• Sickness absence	2
• Doctors who left Trust	11

Appraisals must be signed off as complete by both the doctor and the appraiser within 28 days of the appraisal meeting having taken place. Failure to do so could be considered as a ‘missed appraisal’.

The Responsible Officer is informed of any reason for an appraisal not taking place and ensures appropriate action is taken.

5.2 Appraisers

The Trust currently has 9 Support Appraisers and 32 Appraisers all of which undertake Trust medical appraisals. All have been trained in accordance with the NHS Revalidation Support Team: Quality Assurance of Medical Appraisers.

The Trust employed the services of an external company, Edgecumbe for appraisal training. Edgecumbe provide blended learning options consisting of 5 hours of high quality online self-study, involving scenarios, activities and tests. This was followed by a full day skills workshop to build on the online learning with increased focus on the skills of handling the appraisal discussion. Content included, for example, giving feedback, being supportive yet challenging and discussing and agreeing the PDP.

The Trust offers a buddy system for new appraisers. Prior to a new appraiser undertaking an appraisal the buddy system enables the new appraiser to observe an appraisal, with the appraisees consent. The new appraiser is also linked to a Support Appraiser for mentoring and continued coaching and development.

In addition, appraiser meetings are held on a quarterly basis, offering support and guidance and sharing best practice.

The Interim RO attends a range of NHS England network meetings to share best practice.

5.3 Quality Assurance

5.3.1 Medical appraisals

The quality assurance of medical appraisals is undertaken by the Interim RO and Project Manager prior to revalidation. A review of the doctor's portfolio is undertaken to ensure that the doctor is fit to practise prior to making a recommendation to the GMC. The quality assurance of a doctor's appraisal portfolio includes:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate - by whom and sign offs.

- Review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard - by whom and sign offs.

- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs -by whom and sign offs

- Review of 360 multi source feedback from patient and colleagues to ensure their views inform the appraisal process.

5.3.2 Individual appraiser

The quality assurance of an individual appraiser is undertaken by the Interim RO for Support Appraisers and Support Appraiser for the Appraiser, to include:

- An annual record of the appraiser's participation in appraisal calibration events such as reflection on ASG (Appraisal Support Group) meetings.

- 360 feedback from doctors for each individual appraiser – undertaken electronically collated by the appraisal office with individual meetings between the Support Appraiser and Appraiser.

5.3.3 Organisation

Feedback from users of the Equiniti RMS system for permanent doctors and MAG documentation for Trust-grade doctors has been positive.

5.4 Access, security and confidentiality

All Trust appraisals are undertaken electronically. The Trust currently uses 3 systems:

- **Equiniti**: **Revalidation Management System (RMS)** – designed to ensure that doctors and their appraisers are acting in line with guidelines from the GMC and the NHS Revalidation Support Team. The system stores information about a doctor's whole practice and provides the Responsible Officer with a report on each doctor that can be used to form the basis of a revalidation recommendation to the GMC.

  The Revalidation Portfolio provides doctors with a quick and simple to use online tool for storing supporting information required for revalidation. Key features:
  - Clear instructions and reminders for both doctors and appraisers throughout the process

  - Ability for doctors to review reflective notes at any time with or without documents

  - The option of a fully managed filing and scanning service to record supporting information

  - Clear visibility for appraisers of each doctor's portfolio and their progress through one link

- A complete organisation of revalidation for Responsible Officer's including appraisal summaries with links to portfolios, outstanding concerns reporting and links to clinical governance

- **Model Appraisal Guide (MAG) model appraisal form** – an interactive pdf that allows doctors and appraisers to enter information and attach documents before and after the appraisal meeting. Designed with the appraisal meeting in mind, in a logical manner that mirrors how the appraisal conversation may flow.

  Doctors complete a proportion of the form and submit the package of information to the appraiser by a mutually agreed date. Further sections are completed during and immediately after the appraisal meeting by both the doctor and the appraiser.

  The MAG form is distributed from the appraisal office with Trust guidance on how appraisal is conducted within the Trust and how to use the form. Guidance includes; what information should be included, how much detail a doctor should go into and where particular items should be recorded. The guidance is clear on how the form should be used and passed between doctor, appraiser and the Interim Responsible Officer. The appraiser submits the final version of the form, in a locked down state, to the Interim Responsible Officer/Appraisal office. The appraiser also ensure that the doctor receives a copy of this version too as it is this version that is required to activate the form for use the following year

- **Equiniti 360° degree multi source feedback - an electronic** system collating colleague and patient questionnaires that facilitate the gathering of colleague or patient views about a doctors behaviour and performance. The system meets the standards set out by the General Medical Council and the 360° feedback for uses questionnaires developed in partnership with the Royal College of Physicians. The 360° feedback can be used:
  - to identify strengths and areas for improvement in a doctors practice so as to inform his/her professional development;

  - to provide reliable feedback on important qualities that can be difficult to obtain by other means, including communication skills, professionalism and interpersonal skills, assessed in the context of day to day practice.

- **Information security** – the Trust recognises the importance of information held electronically and manually and the need to ensure its safe storage. 2014/15 appraisal documentation is currently held electronically and by hard copy in individual personalised folders which are securely locked away. The Trust has in place plans to transfer all previous years appraisal documentation into a centralised electronic storage area.

5.5 Clinical Governance

The Trust uses a DATIX system for reporting and monitoring of complaints and serious incidents. Prior to appraisal the Trust makes available details of any relevant data to individual doctors.

Consultant outcome data is captured by doctors prior to their appraisal from the relevant national database.

All relevant national audits are completed by the Trust. The Trust has in place a programme of local clinical audits that are recorded on the annual clinical audit forward plan. Clinicians undertaking audit register their audit to provide the Trust with assurance that they are of high quality and in line with national and local priorities and that date held meets information governance requirements. Action plans are produced for audits that indicate a need for change in practice. Monitoring of the action plans is undertaken through respective Governance Managers and Facilitators, together with Clinical Audit, resulting in increased levels of assurance.

6 Revalidation Recommendations

The number of recommendations for the period 1 April 2013 and 31 March 2014, **Appendix IV:**

Recommendations completed on time	50
Recommendations completed not on time	0
Positive recommendations	50
Deferrals requests	8
Non engagement notifications	0

7 Recruitment and engagement background checks

HR Department undertake full clearances for all Medical Staff in-line with NHS Pre-employment check standards, including GMC registration, Right to Work, references and DBS clearance. GMC registration, DBS and Right to Work checks continue once staff are in post to ensure registrations are renewed, DBS remains valid and visa requirements are maintained.
Medacs ensure all clearances are completed for Medical Staff working through agency. At the point of sending candidates to the Trust for locum requirements, clearances are checked to ensure they are up to date. Medical Staffing carry out spot checks on agency staff files every 3 months to ensure clearance standards remain in place.

8 Monitoring Performance

The interim Medical Director is accountable to ensure that the performance of all doctors is monitored. Support is provided by Directorate Clinical Directors who take ownership and responsibility for doctors within their area.

The Trust has an Associate Medical Director for appraisal and revalidation who is undertaking the duties of Responsible Officer. Successful recruitment has taken place and a substantive Medical Director/Responsible Officer will be in place in the autumn 2014.

For doctors in training their performance is managed by the Educational Supervisor and Trust Education lead.

9 Responding to Concerns and Remediation

The Trust has in place Case Managers and Case Investigators and in addition uses external agency support as appropriate. Training for Trust personnel was provided by NCAS in conjunction with the Revalidation Support Team. The Trust has, in addition, used the services of Hempson Solicitors on an ad hoc basis. A Responding to Concerns policy is required to be implemented. **Appendix V** - audit of concerns about a doctor's practice.

10 Risk and Issues

10.1 Risks

- Doctors not undertaking their appraisal during the month of allocation.
  Mitigation: the Project Manager issues an e.mail reminder to doctors 6 weeks prior to the appraisal month

- Trust not being aware of any issues relating to doctors when recruited.
  Mitigation: For new starters declaration form under revision.

- Insufficient number of appraisers to meet demand
  Mitigation: review of appraiser contingency planning, undertake recruitment campaign

10.2 Issues

- The Trust has in place an Interim Responsible Officer.
  Mitigation: the Trust Interim Medical Director and Interim Responsible Officer jointly discuss any issues or concerns that arise. This will be resolved with the commencement of a substantive Medical Director in September 2014.

- Capture of previous appraisal data; revalidation date and previous Responsible Officer for new starters
  Mitigation: Strengthened process for checking doctors information prior to commencement

- Relevance of data on exit interview template for doctors on short term contracts
  Mitigation: Review of exit form and process to be undertaken to ensure appropriate data capture

11 Corrective Actions, Improvement Plan and Next Steps

The following areas have been identified for development and improvement:

- Establish a systematic approach to undertake quality assurance audit of appraisal inputs and outputs.

- Strengthen fluidity of data flow into appraisal office following appointment, establishing system to ensure data capture of doctors previous RO and appraisal date prior to commencement.

- Undertake review of data held ensuring compliance with information governance.
- To review and strengthen clinical governance data availability to doctors prior to appraisal.
- To implement a responding to concerns policy.
- Administrative resource to support governance and monitoring.
- To review the Medical Appraisal and Revalidation policy in line with NHS England guidelines.
- Undertake appraiser recruitment campaign.
- Arrange an external quality assurance review of the Trust revalidation systems and processes.

12 Recommendations

- The Board is asked to accept the report, noting it will be shared along with the annual audit, with the higher level Responsible Officer.
- To consider any needs/resources.
- To note the requirement to approve the ‘statement of compliance’ confirming that the Trust, as a designated body, is in compliance with the regulations.

Designated Body Statement of Compliance

The board/executive management team – [delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

From the Chief Executive and Registrar

General Medical Council

5 June 2014

Regent's Place
350 Euston Road
London NW1 3JN

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: 0161 923 6602
Fax: 020 7189 5001

Mr Paul Farenden
Chairman
Northampton General Hospital NHS Trust
Northampton General Hospital
Cliftonville
Northampton
NN1 5BD

Dear Mr Farenden,

Effective governance to support medical revalidation

We are writing to ask if you would draw to the attention of your Board the statutory responsibilities which your organisation has to ensure all your doctors keep up to date and that they remain fit to practise.

As you know, the Secretary of State for Health commended the legislation for medical revalidation in December 2012. The process is now up and running. The aim is to improve patient safety by making sure all doctors are part of a managed system of clinical governance, which includes robust and regular appraisal of their practice.

Revalidation is dependent on local systems and, as a designated body under the legislation, you are required to ensure these systems are in place and operating effectively.

However, as well as being a statutory responsibility, we believe the systems to support medical revalidation can provide a powerful lever to help drive improvements in the quality of professional practice.

For this to work effectively board members should:

- monitor the frequency and quality of medical appraisals in their organisations
- check there are effective systems in place for monitoring the conduct and performance of their doctors
- confirm that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.

The Francis Inquiry highlighted once again the importance of board members paying close attention to the quality of care delivered by their organisations – we believe medical revalidation is a critical tool for patient safety. It is therefore important that all Boards satisfy themselves that they have effective systems in place to monitor and support their medical staff.

Revalidation and the CQC's new inspection methodology

CQC is transforming the way it monitors, inspects and regulates health and social care. Its new methodology focuses on ensuring providers deliver safe, effective, responsive, compassionate high quality care and treatment, that is well led.

The delivery of high quality care relies on having staff that are appropriately qualified, experienced, up to date and fit to practise. The training, professional development, supervision and appraisal that doctors (and other staff) receive will provide valuable evidence to support CQC in awarding a rating on its four point scale (outstanding, good, requires improvement, inadequate) to a provider and its services. During inspections they will speak with the responsible officer and a range of doctors and you should expect that this may include asking about their experience of the revalidation process, the support they receive and how this helps them keep up to date and able to deliver evidence based care and treatment that delivers the best outcomes for people.

CQC is exploring how it might use the information from the Organisational Readiness Self-Assessment (ORSA) exercise that was run by the NHS Revalidation Support Team, and any subsequent assurance processes, in its Intelligent Monitoring model.

Revalidation and NHS foundation trusts

NHS foundation trust condition 4 of the provider licence ("the FT governance condition") requires FTs to establish effective systems and processes to ensure compliance with all applicable legal requirements. This includes The Medical Profession (Responsible Officers) Regulations 2010 (as amended), which require designated bodies, including all NHS foundation trusts, to appoint a responsible officer to oversee the evaluation of doctors' fitness to practise, conduct and performance. They further require designated bodies to provide the responsible officer sufficient funds and other resources to enable the responsible officer to discharge their responsibilities.

Consequently, ineffective evaluation or appraisal of doctors could lead to regulatory action by Monitor.

Revalidation and NHS trusts

Revalidation is an important tool for Boards to ensure that doctors are being appraised, and are receiving appropriate training and professional development to enable them to continue to improve the care that they deliver to patients. The Trust Development Authority (TDA) will ensure as part of its oversight of NHS trusts that Boards are assured about the processes in place to fulfil this important aspect of quality governance.

Further information

Together with systems regulators and quality improvement bodies in Wales, Scotland and Northern Ireland we have produced a handbook for boards and governing bodies which their members may find useful. It can be accessed at www.gmc-uk.org/revalgovhandbook.

Yours sincerely,

Niall Dickson
Chief Executive & Registrar
General Medical Council

David Behan
Chief Executive
Care Quality Commission

David Bennett
Chief Executive
Monitor

David Flory
Chief Executive
NHS Trust Development Authority

This letter is copied to:

- Dr Sonia Swart, Chief Executive
- Dr Johanne Anthony, Responsible Officer

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	531
Permanent employed doctors	15
Temporary employed doctors	304
Locums brought in to the designated body through a locum agency	185
Locums brought in to the designated body through 'Staff Bank' arrangements	17
Doctors on Performers Lists	6
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	4
TOTAL (please note that the Doctors on Performers List are classed as coming through the 'Staff Bank' arrangements but have been separated to show that they are also on the Performers List)	**531**

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	DBS	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	15	15	15	15	15	15	15	-	-	15	15	15	-	-	-	-
Temporary employed doctors	304	304	304	304	304	304	304	-	-	304	304	304	-	-	-	-
Locums brought in to the	185	185	185	185	185	185	185	-	-	185	185	185	-	-	-	-

designated body through a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements	17	17	17	17	17	17	17	-	-	17	17	17	-	-	-	-
Doctors on Performers Lists	6	6	6	6	6	6	6	-	-	6	6	6	-	-	-	-
Other (independent contractors, practising privileges, members, registrants, etc)	4	4	4	4	4	4	4	-	-	4	4	4	-	-	-	-
Total (these cells will sum automatically)	531	531	531	531	531	531	531	-	-	531	531	531	-	-	-	-

For Providers – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

NB: this section may change as a result of the SCL Project

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	57	403	11	816	1230
Medicine	113	549	252	1115	1916
Psychiatry	-	-	-	-	-
Obstetrics/Gynaecology	31	-	-	92	92
Accident and Emergency	34	7	-	942	949

Anaesthetics	63	2	-	33	35
Radiology	18	124	-	-	124
Pathology	-	-	-	-	-
Other	-	25	12	156	193
Total in designated body (This includes all doctors not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	525	525			
3 days to one week	105	105			
1 week to 1 month	46	46			
1-3 months	26	26			
3-6 months	6	6			
6-12 months	1	1			
More than 12 months					
Total	709	709			

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2013 to 31 March 2014	
Recommendations completed on time (within the GMC recommendation window)	58
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	58
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	N/A
New starter/new prescribed connection established within 2 weeks of revalidation due date	N/A
New starter/new prescribed connection established more than 2 weeks from revalidation due date	N/A
Unaware the doctor had a prescribed connection	N/A
Unaware of the doctor's revalidation due date	N/A
Administrative error	N/A
Responsible officer error	N/A
Inadequate resources or support for the responsible officer role	N/A
Other	N/A
Describe other	
TOTAL [sum of (late) + (missed)]	0

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months				2
Conduct concerns (as the primary category) in the last 12 months				5
Health concerns (as the primary category) in the last 12 months				0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2013 and 31 March 2014 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All DBs				0

TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	N/A
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	0
For investigation	0
For assessment	3
Number of NCAS investigations performed	0
Number of NCAS assessments performed	3

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**Equality Delivery System 2 (EDS2) Final Self-Assessment June 2014**
Agenda item	19
Sponsoring Director	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Andrea Chown, Deputy Director of Human Resources
Purpose	Assurance to the Trust Board that the Trust has carried out a full and comprehensive Equality Delivery System Self-Assessment following the launch of the updated system in November 2013.

Executive summary

This paper (appendix 1) provides a summary of the consultative process carried out for the EDS2 self-assessment and demonstrates the grades that were awarded for each of the 18 outcomes following consultation with staff side colleagues and representatives from service user groups.

In addition, the paper provides a detailed report of the work that has been carried out for each outcome and gives an explanation to the reasons why the self-assessment resulted in the grading awarded.

Related strategic aim and corporate objective	
Risk and assurance	Of the 18 outcomes the Trust has self-assessed as achieving 3 and developing in 15. The Equality and Human Rights Steering Group will discuss the areas that have been graded as developing at their next meeting in October 2014 to determine which outcomes pose the greatest risk/s and these will form part of the Trusts Four Year Action Plan.
Related Board Assurance Framework entries	All
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)

Legal implications / regulatory requirements	NHS Constitution Public Sector Equality Duty Equality Act 2010

Actions required by the Trust Board

The Board is asked to endorse the content of the EDS2 Self-Assessment.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
31 July 2014

Equality Delivery System 2 (EDS2) Final Self-Assessment June 2014

1. Introduction

The Equality Delivery System (EDS) for the NHS was made available to the NHS in June 2011. It was formally launched on 11 November 2011. Following an evaluation of the implementation of the EDS in 2012, and subsequent consultation with a spread of NHS organisations, a refreshed EDS was launched as EDS2.

The main purpose of EDS is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

EDS2 is made up of 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals:

- Goal 1 – Better Health Outcomes
- Goal 2 - Improved Patient Access and Experience
- Goal 3 – A Representative and Supported Workforce
- Goal 4 – Inclusive Leadership

These outcomes relate to issues that matter to people who use, and work in, the NHS. They also support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions.

The self-assessment requires that one of the following grades is applied to each outcome:

Undeveloped	Developing	Achieving	Excelling
People from all protected groups fare poorly compared with people overall OR evidence is not available	People from only some protected groups fare as well as people overall	People from most protected groups fare as well as people overall	People from all protected groups fare as well as people overall

2. Body of Report

Appendix 1 provides the full self-assessment carried out. Pages 2 to 3 give a summary of the self-assessment grades that were awarded for each of the 18 outcomes, by the following groups:

- Care Group and Equality Leads (Managers Self-Assessment)
- Staff (Staff Side)
- Local interests (PPI).

Pages 4 to 36 address each of the 18 outcomes in detail and gives an explanation to the reasons why the self-assessment resulted in the grading awarded.

3. Assessment of Risk

Of the 18 outcomes the Trust has been self-assessed as achieving 3 of them and developing in 15 of them.

This self-assessment is an improvement on the previous one of 2011 whereby we were graded as underdeveloped in 2 outcomes, developing in 14 and achieving in 2.

4. Recommendations

The Board is asked to endorse the content of the EDS2 Self-Assessment.

5. Next Steps

Following the endorsement of the EDS2 Self-Assessment at the Equality and Human Rights Steering Group in June 2014 it was agreed that this group will discuss the areas that have been graded as developing at their next meeting, in October 2014, to determine which outcomes pose the greatest risk/s and these will be built into the Trust's Four Year Action Plan. At each subsequent meeting the action plan will be looked at to assess the progress that has been made against it.

Northampton General Hospital NHS
NHS Trust

P

EQUALITY DELIVERY SYSTEM

EDS2

Final Assessment June 2014

Northampton General Hospital

Summary of EDS2 Self-Assessment Final Approved June 2014

Goal	EDS Outcome	Care Group and Equality Leads assessment	Staff (Staff Side)	Local interests (PPI)	Overall rating
1. **Better Health Outcomes**	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	**G**	**A**	**G**	**A**
	1.2 Individual people's health needs are assessed in appropriate and effective ways.	**G**	**G**	**G**	**G**
	1.3 Transitions from one service to another for people on care pathways, are made smoothly and with everyone well informed.	**A**	**A**	**A**	**A**
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	**A**	**A**	**A**	**A**
	1.5 Screening, vaccination and other health promotion services reach and benefit all local communities.	**G**	**G**	**G**	**G**
2. **Improved patient access and experience**	2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.	**G**	**G**	**G**	**G**
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care.	**A**	**A**	**A**	**A**
	2.3 People report positive experiences of the NHS.	**A**	**A**	**A**	**A**
	2.4 People's complaints about services are handled respectfully and efficiently.	**A**	**A**	**A**	**A**
3. **A representative and supported workforce**	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.	**A**	**A**	**A**	**A**

	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.	**A**	**A**	**A**	**A**
	3.3 Training and development opportunities are taken up and positively evaluated by all staff.	**G**	**A**	**G**	**A**
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.	**A**	**A**	**A**	**A**
	3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.	**A**	**A**	**A**	**A**
	3.6 Staff report positive experiences of their membership of the work force.	**A**	**A**	**A**	**A**
4. Inclusive leadership	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.	**A**	**A**	**A**	**A**
	4.2 Papers that come from the Board and other major Committees identify equality related impacts including risks and say how these risks are to be managed	**A**	**A**	**A**	**A**
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**A**	**A**	**A**	**A**

EDS2 Outcome 1.1 (EDS2 Goal 1 – Better Health Outcomes)

Services are commissioned, procured, designed and delivered to meet the health needs of local communities

Northampton General Hospital (NGH) delivers services which are commissioned by the Care Commissioning Groups across Northamptonshire.

NGH is working collaboratively with the CCG and neighbouring Providers, including HealthWatch, to develop service specifications that are tailored to accommodate the growing requirements of our local community. All three service reviews are linked in with the NHS Outcomes Framework indicators, re: ensuring a positive experience of care, and to treat and care for people in a safe environment. The model that has been discussed at length is a tiered system that integrates primary and secondary care, whereby community-based "hubs" shall seek to deliver Consultant-led intermediate models, with more rapid access to the most appropriate healthcare professional. Patient self-management has been mapped out, including functions to signpost patients to charities and self-help support groups where appropriate, and with an emphasis on health promotion.

Commissioners provide national best practice guidance and the Trust delivers through NICE guidance, national service specifications, quality outcomes and clinical networks. In addition the Trust considers Royal College Guidelines and delivers best practice tariff. The Trust is monitored and delivers on these national and local quality standards.

EDS Grade:	
Comments:	Staff Side comments: 1.1 Staff side feel this should be amber as we are not able to demonstrate contact with some minority groups. Trust Response: For some minority groups the contact is through Health-Watch and the Health Equality Group. The Trust recognises that further work is required to link in with the commissioners. Trust Grade: Now Amber

EDS2 Outcome 1.2 (EDS2 Goal 1 – Better Health Outcomes)

Individual people's health needs are assessed in appropriate and effective ways

The Trust has introduced a new comprehensive nursing assessment documentation which gives prompts regarding patients with complex needs, eg:- sensory disabilities, learning disabilities, dementia. The Trust provides the tools for patients, wherever possible, to have informed choice in their decision making. The Trust has developed or has access to leaflets in an easy read format which are helpful for patients with learning disabilities or where their first language is not English. Telephone and face to face interpreters are available and used in all areas of the hospital. Bedside communication folders and pictocomm pictorial folders are available on all wards.

The Trust has a 'flagging' system in place to highlight patients who may require extra support, eg:- Butterfly care, learning disability. This enables reasonable adjustments to be made from the first contact with the hospital in OPD to POA, admission, theatre and discharge. In addition to the generic nursing admission documentation, the Trust has introduced additional processes to help staff interact with patients with additional needs, eg:- Patient Passport for patients with LD, Butterfly Profile for patients with a diagnosis of dementia. These documents which are completed by the nurse with the patient and carer, enables nursing staff to understand the patient's needs and their behaviour and therefore helps with the patient needs assessments. The Trust has developed and introduced a pain assessment tool which is suitable for people with learning disabilities or patients with communication issues.

The Trust has introduced monthly QuEST (Quality, Effectiveness Safety Team) audits to monitor compliance with a comprehensive variety of quality issues on all wards and these are reported via the Nursing and Midwifery Board, to the Trust Board. Patients or their relatives / carers can raise issues via the 4C's process and where appropriate, action plans are developed and positive changes made.

NGH aims to improve patient experience in the hospital through patient feedback including that received via the national annual patient survey.

Throughout the NGH transformation plans and service reviews, the impact of changes on both quality and equality are assessed and documented. Although no longer required by legislation, the Trust continues to impact assess all policies as part of the ratification process to ensure that due regard is given to the impact on protected groups.

EDS Grade:	
Comments:	Staff Side comments: 1.2 Staff side feel this should be amber as although we have these systems in place some are not utilised by staff which leads to disadvantages. Trust Response:

	Systems are in place to promote appropriate assessment and monitoring takes place to identify when systems are not adhered to and appropriate action is taken when necessary. Grade: Remains Green

EDS2 Outcome 1.3 (EDS2 Goal 1 – Better Health Outcomes)

Transitions from one service to another for people on care pathways, are made smoothly and with everyone well informed

The Trust recognises that the hospital discharge process and poor communication regarding discharge are two of the main issues raised by patients and relatives in complaints and effective patient discharge is a Trust Quality Priority 2014/15.
The discharge processes are in place to try to enable a smooth transition for patients moving from the acute setting to the community, however, there can be delays due to either external factors or factors such as hospital patient flow.

The discharge team, based in the Operation centre, have a direct communication with the Borough council with regard to homelessness / housing needs and can direct patients who are homeless with no care needs to the one stop shop at the Guildhall, Northampton. We inform the Gateway team that they will be attending before they arrive to give them time to check on their previous and current circumstances and can direct them to Oasis House and hostels depending on their need.

For more in depth housing and homeless issues we have a specific referral system which has been agreed for use by all councils in the county. We also have direct contact and referral with Stepping Stones, which is an interim service that can be used in the transition of a patient needing either housing or adaptations to current dwelling. It is planned that we have a couple more dwellings coming on line soon in Northampton. The other dwellings in this scheme are around all areas of the county.

We have just started to have one of our discharge facilitators based in each assessment units to identify any complex discharge issues, on admission, therefore documenting and highlighting them for the accepting wards. If they are complex then they will have a plan outlined and documented in the notes and on the ward workspace system, which will follow the patient to whatever ward they are sent. The ward should then work in liaison with MDT members towards the patient's expected date of discharge.
We are working towards **3 levels** of discharge.

- **Levels 1 & 2** - the ward will be responsible for patient's discharge.
- **Level 3** - the more complex discharges, will be followed closely by the discharge facilitation team in conjunction with the ward to enable a more timely, effective and safe discharge.

The Trust recognises issues with the urgent care admissions and discharges and has introduced a 6 week project entitled ' Breaking the Cycle' to understand the root causes of the issues with the emergency pathway and align internal and external stakeholders to improve the way we work together. This will enable us to implement operational changes that deliver a step change in performance and agree the performance metrics and how we can sustain impact. The Deep Dive escalation that has been driven by the Trust when the Trust has seen significant demand for beds, has seen some close collaboration with partners in expediting discharge. Work is ongoing to improve the timelines of these discharges, with a demand and capacity analysis being carried out by the CCG regarding shortfall of social care beds.

The dementia beds during the winter funded by winter monies proved very successful these are being re looked at as to whether they should be made substantive. Additional Avery beds have been procured from the Autumn 2014.

There are good examples of excellent transitions from one service to another, eg:- where patients with learning disabilities are assessed to identify levels of support required and NGH agree to fund regular carers from the support provider whilst the person is in hospital. An ongoing project in A/E regarding the working in partnership with AGEUK, enables older patients' needs on discharge to be assessed 'at the front door' and, where extra support is required, to avoid admission where appropriate.
There are however, issues on some occasions regarding the transition from child to adult services.

The Safeguarding Adults lead supports the wards and the discharge team (Health Partnership Team) with discharges of patients who are vulnerable. Patient pathways have been developed for patients with Learning Disabilities and those with Dementia. Working in partnership with the commissioners, the Trust temporarily opened beds at Favell House to enable suitable patients with dementia to be 'stepped down' from the acute beds and to facilitate a timely discharge.

All referrals for an outpatient consultation come into the Trust by GP's by the Choose and Book system, in the minority some patients are referred by letter. The management of these referrals is via the Elective Patient Access policy which is populated form National guidance regarding Access targets and !8 week referral to treatment times. In addition referrals via the 2ww system are by Choose and Book or 2 week wait office. .

EDS Grade:	
Comments:	Staff Side comments: 1.3 Agree amber

EDS2 Outcome 1.4 (EDS2 Goal 1 – Better Health Outcomes)

When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

NGH prioritises the safety of patients and this is assured through a number of mechanisms predominantly through the clinical governance structure and framework.

The results of the 2013 National Inpatient Survey, identified that NGH had a high mean rating score of 96 (100 being perfect) regarding the response to the question 'Did you feel threatened during your stay in hospital by other patients and visitors?' The improvement in the Trust score has is partly due to ensuring that all wards are single sex and the reconfiguring of its bed base to ensure our patients are cared for in the right bed, in the right place, at the right time.

The Security Management team is responsible for the operational provision of security services within the Trust and they work closely with both Trust staff and the police to ensure that patients' safety is assured. The Trust's Local Security Management Specialist (LSMS) reports all incidents involving physical restraint to the Trust's Health and Safety Committee on a quarterly basis and high level restraint incidents are reported and discussed at the Patient safety Learning Forum to encourage and support learning at a Trust wide level. All public facing staff receive conflict resolution training as part of their mandatory training.

The introduction of the '4Cs' policy in 2010 (comments, concerns, complaints and compliments) has improved our ability to resolve more complaints, comments and concerns without the need for formal complaint to be raised. The complaints department currently collect data regarding complainants (this does not include all the protected characteristics) and is coded to include 'attitude and behaviour' which encompasses much wider issues than those detailed in this outcome.

The Trust Safety Academy and their associated work streams have been developed as a result of reducing avoidable harm and there are 34 safety improvement projects in place.

The Patient Safety Strategy 2012-2015 articulates the aims of the Patient Safety Improvement Programme and supports the Trust quality strategy. The overall aim of the Patient Safety Strategy is to increase staff engagement in a programme of quality and improvement projects related to Patient Safety thereby bringing positive changes to clinical processes and practices which will ultimately improve patient care, patient experience and clinical outcomes. The positive improvements in clinical processes and the delivery of care will improve the safety culture whilst reducing avoidable harm in hospital.
The vision at Northampton General Hospital Trust is to provide the very best care for all of our patients. This requires NGH to be recognised as a hospital that delivers safe, clinically effective acute services focused on the needs of patients their relatives and carers. These services may be delivered from our acute or community hospital sites or by NGH staff in the community.
The Trust Safety Academy and their associated work streams have been developed as a result of reducing avoidable harm and currently there are 31 Metrics with 127 separate measurements.

The five safety work streams are:

- Reducing harm from Failure to Rescue
- Reducing harm from Failure to Plan
- Reducing harm from Failures of Care
- Learning and Sharing from Successes and Failures
- Human Factors safety science

The above work streams were identified as the five main themes that the majority of safety concerns and avoidable harm could be attributed to. The projects within the work streams were identified and can be attributed to lessons learnt from serious incidents, audit results from case note reviews or areas for improvement identified by operational staff employed at NGH.
The safety improvement work dovetails and compliments mandatory assurance standards. The refined reporting methodology from the Safety Academy will make progress to date and current challenges more transparent, providing status at a glance.
A high level safety progress report will be provided to the Trust Board quarterly and bimonthly to Strategic Management Board.

NGH is a designated 'Keep Safe' location. The Trust has 3 guide desks and 48 volunteers have been trained by members of the Learning Disability Partnership Board regarding communication and roles as keep safe ambassadors. NGH has signed up to a rights charter for individuals with Learning Disabilities.

The hospital has an established Dignity Forum where staff from all staff groups meet and discuss good practice and areas for improvement. The Complaints and PALs department present letters and highlights issues raised by patients and relatives and actions are agreed to take back to all wards and departments. A carer was invited to talk to the group regarding his experience at the hospital from the perspective of a carer in a same sex relationship.

The Head of Safeguarding and Dementia leads a team of staff to ensure that vulnerable patients, both adult and children, are free from mistreatment and abuse and leads investigations where this is applicable.

EDS Grade:	
Comments:	Staff Side comments: 1.4 Unsure of this amber rating due to the recent external whistle blowing. Trust Response: There is a lot of work to do and it will be ongoing but processes are in place to highlight issues and learn from the mistakes.

EDS2 Outcome 1.5 (EDS2 Goal 1 – Better Health Outcomes)

Screening, vaccination and other health promotion services reach and benefit all local communities

NGH can demonstrate that it actively engages with different protected groups in some of the screening and vaccination programmes it undertakes, eg:- in breast screening where the department requests GPs to inform them of any ladies with disabilities in order that reasonable adjustments can be made, information and letters are available in different languages, easy read and Braille. A health promotion radiographer attends a Bangladeshi Group who do not have a written dialect and health promotion days are held in various locations. Canal boat travellers are sent appointments via contacts with GPs and post box and moorings addresses.

NGH works with the Public Health Department and the local authority to deliver public health, vaccination and screening programmes and is aware that there remains variation in access to these services from different protected groups. An example of good practice at NGH concerns abdominal aortic aneurysm (AAA) screening for men age 65. Since April 2012, we have screened approximately 8000 men with our national data showing an 89% uptake. To promote AAA screening, the team have attended golf and rotary clubs, held a display in the Grovenor Centre as well as displays within the hospital. Posters and information have been sent to all pharmacies and libraries in Northamptonshire and the Maple Access clinic (a clinic with special interest in people who are homeless, travellers, mental illness, asylum seekers, substance abuse and vulnerable people). The group are identifying trends for men who do not attend and will hold clinics in areas identified eg at village halls or working mens' clubs.

The Trust regularly holds education sessions for the public regarding issues relating to diabetes care. NGH also holds a public session regarding dementia care and has utilised the Hospital open day for Health education stands etc.

As part of our Quality Schedule, we record the health status of all our patients regarding their smoking and alcohol habits (Making Every Contact Count). The target is 85% of all patients and for those who smoke and drink, we should then provide appropriate advice regarding the impact that smoking and drinking has on the person's health. This is monitored every quarter and in Q4, 96% were asked about their smoking and alcohol habits and 50% of those requiring 'brief opportunist intervention' were offered ongoing support. This will be an ongoing focus for the Trust in the future.

The Trust' Occupational Health department annually provides staff with the opportunity to have influenza vaccinations. This year there was a proactive campaign to ensure as many staff as possible were vaccinated. Communications took place through the Trust- wide communication channels including screen savers and the weekly bulletin. In addition the uptake was reported in the HR Bulletin. The final percentage rate reported for Northampton was 58%. The national vaccine uptake for healthcare workers from September to January 2014 was 54.8%.

EDS Grade:	

Comments:	Staff Side comments: 1.5 Agree Green

EDS2 Outcome 2.1 (EDS2 Goal 2 – Improved Patient Access and Experience)

People, carers and communities can readily access hospital, community health or primary care services and should not be denied Access on unreasonable grounds There are some physical limitations presented by the older buildings within NGH, e.g. steep ramps in some of the corridors. However, the Trust receives very few complaints regarding its accessibility largely due to the services provided to overcome some of the shortcomings, eg:- electric visitor 'buggy' to transport patients around the hospital. As part of larger scale improvement works, new lifts, ramps, automatic doors and larger bathrooms are generally provided where required. NGH has worked with patient groups to review physical access to services and incorporated their views in capital developments and ongoing programme of dedicated schemes intended to provide equality in access, eg:-following issues highlighted at the NGH Disability Advisory Partnership Group, Deafconnect were commissioned to complete an audit of the audiology department and Northampton Association for the Blind an audit of the Eye department. As a result of the audits, changes have been made both Trust-wide and within the departments.

In order to provide good accessibility information to patients and visitors, the Trust commissioned a comprehensive access survey and its findings are annually updated published on the Trust's website via DisabledGo. The survey identifies areas where there could be improvements and these are being addressed as part of a rolling programme. The introduction of the use of pictorial signage will benefit those with learning disabilities, those confused by illness or effects of their condition and those who do not have English as their first language. As a result of the site wide access survey hearing loops have been installed at all departmental receptions and portable units are available that can be taken into consulting rooms etc.

There are no ceiling track hoist systems in place to help transfer patients to the toilet or bath; access is usually by means of mobile hoist. Specialist equipment is available for Bariatric patients and staff are trained in its use. To further improve facilities for severely disabled adults and their carers, the Trust has installed a specialist toilet / changing facility or 'Changing Place'. This changing facility is accessible to patients and visitors alike and is located on the main hospital corridor. This facility has an electric hoist with track system as well as adjustable height changing table.

In order to maintain patients' and visitors independence, the Trust has developed a Policy for Assistance Dogs on Trust Premises and has installed signage to indicate where Guide dogs are welcomed within the Trust. A Patients' Carers Policy and Carer's Charter has been developed to ensure carers can continue to work with NGH staff to deliver care if they so wish.

Cultural and faith belief information is available on all wards and departments via a Chaplaincy folder. This includes information on spiritual care and health provision, religious and cultural belief systems, NGH calendar of religious festivals and the care of the patient after death. In order to recognise the needs of some religious groups, The Trust has purchased single use 'Religious Consideration' theatre gowns which were developed in conjunction with Muslim women to provide complete body coverage.

The Trust recognises that patients who have a first language which is not spoken English, have the right to professional language support. The contracted supplier to NGH of interpreting and translating services offer services incorporating 24 hour/ day telephone interpreting, face to face interpreting (including sign language) and written translation including Braille. The Trust also has contracted Deafblind UK to provide a communication support service for dual sensory impaired patients at hospital appointments.

In order to communicate effectively with patients with learning disabilities, those who first language is not English and patients who have communication difficulties caused by medical conditions such as stroke or dementia, the Trust has developed easy read leaflets and pictorial signage. All wards have pictorial communication folders.

The Trust has a robust system for ensuring impact assessments are carried out on all polices before being ratified at the Procedural Document Group. In addition all business cases are required to complete a quality and impact assessment for services and functions.

People from all communities can readily access the hospital. A/E is open 24/7 and is often the area utilised instead of primary care for people from some communities or those who are not registered with a GP. The Trust has worked with the local BME community via the Trust BME User group to try help address this: ensuring that the different ways of accessing healthcare are available. Presentations to the group are available on the BMESRP website for the public to access.

Patients have access to the Choose and Book system for hospital appointments to enable patients to choose convenient appointment times. GPs can directly book appointments for patients where this is appropriate, ie:- where the GP acts as the patient's advocate where a patient is unable to use the 'choose and book' facility.

The Trust access framework for outpatient's appointments and elective admissions is followed in a timely fashion with date order and clinical priority for all patients. This is monitored through the weekly performance framework meetings and is reported to the Trust Board. The Trust abides by the local priority treatment policy which is developed by the commissioners.

The Trust has a texting reminder service regarding out patient appointments but this is not suitable for all patients and is not used in all departments. The Trust has worked with the Disability Advisory Partnership Group and the BMESRP to produce a clear template for appointment letters which has been introduced as a pilot. Currently, patients are unable to text or e-mail into the hospital regarding appointments due to information governance issues. However, the Trust is aware that the telephone service is not suitable for all patients and is investigating ways to address this.

There is an ongoing problem within the Trust regarding car parking and the lack of parking spaces on some occasions. Patients are advised via their invitation to OPD that there are limited spaces on site and also a map is enclosed to show the nearest car park and the local bus stops. Disabled car parking spaces are available near each entrance and access to all areas is detailed via disabledgo on the hospital website. The hospital buggy is available via the telephone from all entrances to the hospital but this service is not available at weekends.

In addition volunteer driver information leaflets are displayed within the Trust for contact by patients/carers, particularly in areas where patients are requiring frequent attendances and are particularly frail such as in the chemotherapy outpatient areas.

A directorate of services is available for the public via the internet site and there is a pathfinder on the central server for GP access.

EDS Grade:	
Comments:	Staff Side comments: 2.1 Agree Green

EDS2 Outcome 2.2 (EDS2 Goal 2 – Improved Patient Access and Experience)

People are informed and supported to be as involved as they wish to be in decisions about their care

The results of the inpatient survey 2013 indicate that NGH did involve patients as much as they wanted to be and there was an improvement from the previous year score regarding this question. The demographics for the survey indicates that the survey responses were received representative of protected groups:-

- 47% male
- 84% age> 50
- 15% deaf or severely hearing impairment
- 6% Blind or partially sighted
- 25% long standing physical condition
- 1% learning disability
- 3% Mental health conditions
- 34% long standing illness
- 58% long standing condition
- 24% problems with physical access
- 1% gay/lesbian
- 1% bisexual
- The 'top 5' faiths were represented other than Muslim

The Patient Information Group ensures that written patient information is produced in an agreed format and EIDO clinical information is readily available for medical staff to give to patients as required. The Trust Interpreting and Translating service is readily available for all patients whose first language is not spoken English. Pictorial communication folders, Makaton cards, NGH developed easy read leaflets and information in alternative formats such as large print are available to aid communication with patients who may have specific communication needs. There is a link on the Trust intranet site to national available easy read leaflets.

The Learning Disability Nurse supports individuals on wards and at some outpatient appointments working with healthcare staff to explain the patient's treatment in easy to understand language. This helps and supports the patient to make informed decisions about their care.

Following involvement from representatives from some protected groups, information and advice folders are available for staff on all the wards regarding the care of patients with disabilities, from different cultural and faith backgrounds and for those patients with dementia. These act as aids to enable staff to help and support patients to make informed decisions.

The Mental Capacity Act puts the patient at the centre of all care and if the person assessed lacks capacity, a best interest decision process involving family and or carers that know the patient well is instigated. If the person has no family or friends to support decision making use of

Independent Mental Capacity Advocate (IMCA). Training in Mental Capacity is mandatory for all clinical staff. This ensures that all staff are aware of the principles of mental capacity regarding patients' decision making concerning their care/ treatment.

The Trust has access to an advocacy service to support complainants, which is funded through the local authority. Details as to how this service can be accessed are included within the 4C's leaflet, on the website and through direct referrals by the complaints team where indicated. Interpreting and translating services are also available for service users should they require support and assistance when raising a complaint or an informal concern about any aspect of their current and future care. This information is also included within the 4C's leaflet and through both the complaints and PALs teams on request.

NGH monitor real time Patient Experience using the Friends and Family test. Wards and departments are able to address wherever possible, the issues which are raised. This will potentially encompass feedback from patients from all protected groups.

The Trust use opportunities to inform and educate patients regarding health issues, treatment and care via displays and presentations, both within departments but also within the Trust such as skin sun damage, the effect of smoking on medication and length of stay. The Trust holds a variety of specialist clinics to enable patients to make informed decisions about their care, for example, Birth after Caesarean Section clinics for consistent advice and evidence based information sharing to increase women's confidence in requesting a vaginal birth after a previous caesarean section.

The important role which carers play is recognised by the Trust and where patients agree, carers are encouraged to be involved in the care of the patient whilst they are in hospital with Carers Policy given full guidance. Carers are signposted to extra support and care, for example the development of the NGH Carers of Patients with Dementia leaflet.

There are a range of diagnosis specific patient support groups active within the Trust. One such example is the 'Haematology Happy Days Support Group'.

EDS Grade:	
Comments:	Staff Side comments: 2.2 Agree amber

EDS2 Outcome 2.3 (EDS2 Goal 2 – Improved Patient Access and Experience)

People report positive experiences of the NHS

The Trust has recruited into a new post, Patient Experience Lead who leads on all aspects of the patient experience and reports to the Trust Board via the Director of Nursing and the Patient Experience Board.

The Trust is now compiling quarterly triangulated analysis which includes all aspects of patient experience, looking at compliments such as those received in the complaints dept, PALs, through the Friends and Family Test and those handed in to wards and departments directly. This is currently work in progress but will be fully up and running in the financial year.

The 4C's process is designed to encourage members of the public to raise compliments as well as concerns, comments and complaints. There is a form available on all wards / departments, which staff complete with the public to capture this feedback. The information is then recorded in the complaints & PALs quarterly analysis which is reported to the Clinical Quality Effectiveness Group (CQEG).

The various Trust groups who represent people from different minority groups, (eg:- the Disability Partnership Advisory Group, the BMESRP) are forums for a patient's and public voice to report their experiences of the Trust.

The Matron carries out ward rounds to ask patients and relatives their opinion of the care and any concerns are acted upon and documented in the patient's records. Hourly care rounds have been implemented to ensure nursing staff communicate with patients on at least an hourly basis benefiting patients by involving them in care decisions. Part of the monthly QuEST inspections involves speaking with patients regarding their care and this is reported via the Nursing and Midwifery Dashboard to the Trust Board.

The Trust commits to listening and learning through complaints, comments and surveys and ensures appropriate action is taken. NGH aim to improve patient experience for those in the protected groups through normal learning from the '4Cs' and adverse event processes such as complaints, serious incidents, incidents and claims.

Any equality complaint received would usually be raised through PALs but may be raised directly to the Equality Lead for Patient Services who meets monthly with the PALS and Complaints Lead and any issues or trends raised is through the Director of Nursing. Furthermore these issues are raised with the Equality and Human Rights Steering Group.

The Trust is part of the national Friends and Family Test whereby every patient that is seen within A&E, Maternity services and Inpatient Services is offered the opportunity to feedback on their experiences. The Trust is investigating the introduction of a FFT technology solution to include additional languages.

There are many national surveys which run throughout the Trust. In particular the National Cancer Survey and the National Inpatient Survey

provide an opportunity for patients to feedback on their care. They provide a breakdown of the demographics of patients to ensure all patients are being given an equal opportunity to participate and give their views. For 2014/2015 the Trust has commissioned a number of additional surveys including a National Outpatients Survey, a National Neonatal Survey and we are currently taking part in a pilot study aimed at reviewing the sampling process.	
EDS Grade:	
Comments:	Staff Side comments: 2.3 Agree amber

EDS2 Outcome 2.4 (EDS2 Goal 2 – Improved Patient Access and Experience)

People's complaints about services are handled respectfully and efficiently

Formal and informal complaints that are raised are managed in a way that meets the need of the individual. It is often difficult to ascertain through general communication is a person is from one of the 'Inclusion Health' Groups. This is therefore achieved / identified through early contact with the patient / relative and is through a mutual agreement method, either verbally or in writing and including a third party for additional support where this need has been identified. The Trust is often reliant upon the individual being willing to disclose their status, which often they are not willing to do.

Each complainant is given a single point of contact within the complaints team to support and guide them through the process. Meetings are also offered, to take place with service users, where required, as an additional level of support, to their individual and specific needs appropriately. This is for all service users. The Trust aims to ensure that all services users who access complaints and PALs are treated with dignity and respect at all times.

The Trust has developed easy read 4C's leaflets and is developing an easy read Friends and Family questions so that people with learning disability can give their comments about their care and influence service changes.

The CQC NGH report March 2014 stated that there was a robust process of complaints management but there was no mechanism to ensure that recommended learning and actions resulting from complaints were achieved in an appropriate time frame. The Care Groups are working to address this issue as complaints are dealt with through Governance meetings and reported through Directorate dashboards.

Timescales for complaint responses are agreed with the complainant from the outset, the average being 30 days and where this cannot be achieved, the Trust has to request a time extension. The average compliance with this agreed timescale is 76%. The number of complaints, the response rate and the top 5 subjects of complaints are reported monthly using the corporate and directorate score cards. The information is also reported quarterly via the CQEG and Patient Safety reports, and annually via the Trust Annual Complaints Report, the Quality Account and to the Department of Health (KO41a).

In response to the Patient Survey 2103 question, *' Did you see/ were you given any information explaining how to complain about care received',* scored a low mean rating of 25.

The Equality Lead for patient services meets the Head of Complaints and PALs on a regular basis and raises any issues brought forward regarding the equality agenda.

EDS Grade:	

Comments:	Staff Side comments: 2.4 Agree amber

EDS2 Outcome 3.1 (EDS2 Goal 3 – A Representative and Supported Workforce)

Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

The Trust's recruitment and selection process is fair, inclusive and transparent in that all posts advertised through NHS jobs2 ensure the anonymity of individuals up to the point of interview. Therefore, appointing managers are not aware of any details regarding the individual applicants or candidates until after the decision has been made to interview them.

NHS jobs2 requests information on the protected characteristics so that monitoring can take place from the data received. The findings from this data are reported in the Equality and Human Rights Annual Report which is also published on the internet.

In addition, the Trust has an Equality and Human Rights Steering Group which oversees the Trust's equality agenda and this group receives sample reports based on the information provided through the recruitment and selection process on randomly selected posts advertised by bandings.

The latest report on the recruitment sampling went to the December 2013 steering group and the subsequent February 2014 meeting. Six recommendations from the report were accepted including; working with universities to encourage a greater gender mix; storing of recruitment data electronically so that reports can be analysed more robustly and taking steps to accurately capture disability monitoring data.

Due to the lack of data on some of the protected characteristics the Trust did carry out a data verification exercise for all staff in 2012 and whilst the response rate was good at approximately 60% there are still limitations to the data as individuals have confirmed that they do not wish to disclose certain protected characteristics.

The Trust does commission Access to Work to support staff when relevant reasonable adjustments are required.

The Trust does engage with Staff Side on many issues and when information is requested from Staff Side regarding any anomalies they may see in relation to recruitment and selection to posts the Trust is transparent in that it either provides the information requested or discusses the issues with the Staff Side.

A new initiative for individuals with learning disabilities is underway with the recruitment to a project worker for Learning Disabilities through a Service User. The initiative uses easy read application forms and job descriptions with support to complete the application if required.

The Trust is committed to supporting disabled people as it has retained the 'Two Ticks' symbol which provides recognition by Job Centre Plus that employers have made certain commitments regarding employment, retention training and career development of disabled people. The Trust believes that its' continued commitment will encourage disabled people to apply for the jobs within the Trust and the evidence from our annual reports suggests that the Trusts' Guaranteed Interview Scheme is being applied.

EDS Grade:	
Comments:	Staff Side comments: 3.1 Agree amber

EDS2 Outcome 3.2 (EDS2 Goal 3 – A Representative and Supported Workforce)

The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

The majority of staff in the Trust are on Agenda for Change terms and conditions of service and the medical terms and conditions apply for doctors and dentists. The Trust carries out monitoring of the Agenda for Change bands through the Equality and Human Rights Annual Report. An equal pay audit is due to be carried out and presented to the Equality and Human Rights Steering Group in June 2014. Depending on the findings an action plan will be drawn up to address any inequalities, where necessary. The Trust has a job evaluation process for all Agenda for Change posts which is fair and transparent as a panel of both staff side and management representative's band new posts or those where there are significant changes. The organisation does not carry out positive recruitment for any disadvantaged groups; however, the Trust does adhere to the NHS Employers employment standards. The Trust is currently harmonising all on-call, stand-by and out of hour's payments and consultation is due to end mid-April 2014. This harmonisation will mean all staff will be paid equitably for being on-call or stand-by and will receive the same pay for the band that the work has been evaluated at.	
EDS Grade:	
Comments:	Staff Side comments: 3.2 Agree amber

EDS2 Outcome 3.3 (EDS2 Goal 3 – A Representative and Supported Workforce)

Training and development opportunities are taken up and positively evaluated by all staff

All staff regardless of their protected characteristics are expected to have an appraisal and personal development plan (PDP) on an annual basis to support their training and development needs. The Trust has standardised paperwork which all staff will complete to identify their objectives for the coming year and the development needed to carry out their job. The KSF core dimensions are integrated into the appraisal paperwork which includes equality and diversity.

All new staff attend the Trust's induction within 3 months of commencing employment with the Trust and this provides individuals with the opportunity to complete level 1 of the majority of mandatory training subjects. In addition, it provides the individual together with their manager to set three key objectives within the first three to six months of employment. All staff are required to attend equality awareness training on a three yearly cycle.

Several methods of training are in place which include:

- Review of Knowledge – face to face
- Self-directed and workbook completion – individuals reading appropriate material and completing a test in their own time
- E-Learning course
- Cluster days – attendance at face to face teaching sessions

In addition, the Directorates enable staff to attend specialist courses and these are accessed following discussion at the individual's appraisal and through their personal development plan.

There is equity across the Trust in that all new clinical starters attend the clinical skills week. Existing members of the Trust are also able to attend the training.

The process for the evaluation of training and development subjects is as follows:
Corporate Trust Induction is currently evaluated and some subject leads such as Safeguarding evaluate their own specific courses. The Review of Knowledge (RoK) sessions evaluate prior learning. Learning & Development are also recommending a peer review process amongst Mandatory Training Leads, which includes the Learning & Development Manager and Trainer on a 6 monthly basis.

The Trust's Equality and Human Rights Annual Report provides evidence of access to training by protected characteristics and demonstrates that all staff are treated equally with regard to access.

The Trust subscribes to the East Midlands Leadership Academy. Emails are received by the Assistant Director of Workforce and widely

distributed to managers who cascade the information on courses to staff. There are a number of staff who currently access the different levels of the leadership courses provided by the Leadership Academy. One of the courses is via e-learning which is difficult to evaluate. The Trust currently has 5 staff attending the Mary Seacole Leadership Programme, 2 staff attending the Elizabeth Garrett Anderson programme and 2 on the Nye Bevan programme. There are 8 staff on the Nursing & Midwifery Leadership Programme.

The corporate preceptorship programme, which is for newly qualified registered nurses is a 6 month programme for which the ward/Dept sister nominates or even the individual nurse may nominate themselves. The programme is evaluated at the end and is generally evaluated well.

The table below identifies the numbers of apprentices and substantive staff across the different disciplines undertaking a NVQ:

	Clinical Health Care inc Periop and Maternity	**Business Admin**	**Customer Service**	**Support Service**	**Pathology**	**Pharmacy**
Apprentice		11	3	2	2	2
Substantive	32	1	2 (Domestic Supervisor and Ward Clerk)	1 (hostess)		3

The staff survey results for the 2013 survey confirm that the Trust is above average for Acute Trusts with 82% of staff receiving job-relevant training, learning or development in the last 12 months. This is a statistically significant improvement since 2012 (74%).

EDS Grade:	
Comments:	Staff Side comments: 3.3 Unsure if we can agree to amber rating as not all staff have equitable access to mandatory training. I/E A&C staff Trust Response: Currently the Trust's view is that this will continue as it is based on freeing up capacity for mandatory training leads to increase training for clinical staff due to a CQC Warning Notice. Needs to be a review within six months.

EDS2 Outcome 3.4 (EDS2 Goal 3 – A Representative and Supported Workforce)

When at work, staff are free from abuse, harassment, bullying and violence from any source

The Trust has a Harassment and Bullying Policy which is integrated to the Trust's Grievance Procedure providing staff with a procedure for raising allegations of harassment and bullying. The HR Department record and monitor all formal harassment and bullying cases and support managers to investigate all of those formal cases. The HR Department has produced detailed equality reports on harassment and bullying cases in relation to some of the protected characteristics to identify if there were areas of concern for disadvantaged groups. These were reported to the Equality and Human Rights Steering Group, however, due to the low numbers of formal cases it was difficult to evaluate statistically. The Staff Survey results for 2013 placed the Trust in the bottom 20% of Acute Trust's so work is required to make improvements. In response to the staff survey question: *'In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers/team leaders or other colleagues', 30%* of the sample of respondents said they had experienced this in 2013 but 29% confirmed this in 2012. The improvements required will be carried out through the organisational development work that the Trust will be doing in the coming years. In addition, it must be noted that harassment and bullying awareness is part of the Trust's induction. At the induction new staff are made aware of the policy and procedures to follow. It is evident that there has been an increase in the numbers of individuals raising concerns of harassment and bullying, in particular in the medical staff group and in some areas external mediation has been put in place to address the issues that have been raised. In relation to staff experiencing harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public 37% said they had experienced , whilst in 2012 36% confirmed they had. The Trust has developed a Violence and Aggression Policy and Training Needs Analysis for those staff requiring training but again improvements are required within this area.	
EDS Grade:	
Comments:	Staff Side comments: 3.4 Agree amber

EDS2 Outcome 3.5 (EDS2 Goal 3 – A Representative and Supported Workforce)

Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

The Trust has a Flexible Working Policy which through the consultation mechanism has staff side agreement and involvement. The policy is available for all staff to use regardless of their protected characteristics.

The Trust (at 1 June 2014) has a headcount of 4758 member of staff. 2965 are full time and 1793 are part time which equates to 38% of our staff working on a part time basis.

The types of flexible working options available are as follows:

- Part time working
- Job sharing
- Term time contracts
- Annualised hours
- Variable time working
- Compressed hours
- Career breaks
- Flexible retirement
- Home working
- Flexible working
- Time Off in Lieu

In addition, the Trust has an Annual Leave policy which enables all staff to 'buy-back' an additional week's annual leave through a salary sacrifice scheme.

The Trust does not monitor the number of flexible working requests received by protected characteristics nor does it monitor if there is equal access to flexible working requests but the flexible working policy is in the process of being revised so that this can be captured and future monitoring will take place.

EDS Grade:	
Comments:	Staff Side comments:

	3.5 Why do we not monitor requests for flex working and the reasons? Not equitable across the trust. Trust Response: The Flexible Working Policy is in the process of being reviewed and will include an element of monitoring by the HR Department. Needs to be reviewed once the policy has been embedded.

EDS2 Outcome 3.6 (EDS2 Goal 3 – A Representative and Supported Workforce)

Staff report positive experiences of their membership of the work force

Whilst the 2013 Staff Survey results have been disappointing the staff's most positive perceptions report:

- They are trusted to do their job
- Their role makes a difference to patients/service users
- They always know what their work responsibilities are
- Their organisation does not blame or punish people who are involved in errors, misses or incidents
- The Trust encourages them to repot errors, near misses and incidents
- They know who the senior managers are here
- They are satisfied with the quality of care they give to patients/service users
- Team members have to communicate closely with each other to achieve the team's objectives
- They are able to do their job to a standard they are personally pleased with
- They have clear, planned goals and objectives for their job.

In addition, in the survey 49% of staff reported that they would recommend the Trust as a place to work which is an improvement on previous year's results.

From 1 April 2014 the Trust is carrying out its staff Friends and Family test. We have designed a very simple online survey, which takes between 1 and 3 minutes to complete. Answers are submitted via the web and will not be identifiable to anyone. We are seeking the views of staff on how well we are doing as an organisation for our staff and for our patients. We will publish the results of the survey on our website. In addition, the Organisational Development team are going around the Trust's site with paper copies of the survey for those staff that do not have access to emails.

The Trust does have an exit interview process in place which is for staff that are leaving the Trust. Whilst the process is robust and designed to provide information on how to make improvements the numbers submitted for monitoring are low so work is required to improve the take up fro leavers but in addition monitoring needs to be improved.

In April, we launched our first Friends and Family Test to Staff, concentrating on the non-clinical support areas. When we asked you if you'd recommend us for treatment, 69% of you said it was likely or extremely likely, 25% weren't sure and 6% said it was unlikely or extremely unlikely. As a place to work, it was a similar story with 67% likely or extremely likely, 18% unsure and 15% unlikely or extremely unlikely.

There will be a strong focus on staff engagement across the Trust in the coming months and they will be some workshops to help us all to see how we can bring our values to life in our day to day work and how we can embed them in everything we do, starting with 'walking in the patients shoes'. We are also working on introducing questions around our values at recruitment and exit interview.

The IQE team is a new function within NGH with the responsibility for enabling quality and efficiency improvements and developing the capability of staff to identify and deliver their annual IQE programmes. Tuesday 3 June saw the launch of our 'Making Quality Count' development programme which puts ownership for improving the quality of the care we provide at the front line. Our new improvement methodology will be used within the Making Quality Count programme as well as being available for use by all teams so that, wherever people are working on quality and efficiency improvements, we will all be talking the same language and applying a consistent process of making those changes resulting in clarity and consistency for everyone.

Management and Leadership development will also be a big priority and you'll hear more throughout the summer about the opportunities that will be available.

All of the above and much more is part of our Organisational Development Strategy moving forward.

EDS Grade:	
Comments:	Staff Side comments: 3.6 agree amber

EDS2 Outcome 4.1 (EDS2 Goal 4 – Inclusive Leadership)

Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

The Trust Board recognises the importance of ensuring that the services it provides are relevant to the diverse communities we serve, and this is stated within our strategy and delivery plans. Examples whereby Executives have been involved or overseen initiatives of relevance are as follows:

Our Director of Facilities has ensured the following:

- Further fire alarm beacons throughout public areas and public WCs and also around Audiology. This helps persons who are hard of hearing know if there is a fire alarm activation
- New DDA standard reception desk to Main Theatres complete with hearing loop
- New DDA standard reception desk to Ophthalmic Department complete with hearing loop
- New DDA standard reception desk to Medical Out Patients complete with hearing loop
- The widening of a door to one of the exam rooms in Medical Out Patients for bariatric patients
- Further corridor upgrades. Colours to walls and floors aid partially sighted persons. Also grab bump rails give assistance to the frail and infirmed
- Decorations to wards to include colours, signage and clocks to help persons with dementia
- New bold signage across site to Eye Casualty
- Raised zebra crossing at the southern entrance to provide level wheelchair access and to slow traffic
- Level access showers, DDA grab rails and contract colour fittings to Shower/WCs to Sturtridge Ward
- Level access showers, DDA grab rails and contract colour fittings to Shower/WCs to Balmoral Ward
- Level access showers, DDA grab rails and contract colour fittings to Shower/WCs to Robert Watson Ward
- White toilet fittings, seats etc in Elderly Wards changed to dark blue to give visual contrast.

The Director of Nursing attends the following committees:

- Equality and Human Rights Steering Group
- NGH BME SRP
- NGH Disability Advisory Partnership Group
- NGH Dementia Care Action Committee
- NGH Dementia Focus Group
- NGH Dignity Forum
- SOVA Group (meeting Jan 8th, unable to access the minutes)

- Patient and Public Involvement Steering Group

In addition NGH are represented at the following external meetings:

- Equality and Inclusion Regional Leads meetings
- Health Equality Group
- NCC & NCG Dementia Strategy Group
- Dementia Action Alliance.

The Director of Workforce and Transformation attends and chairs the Equality and Human Rights Steering Group in the absence of the Chair of the Trust. The Director has revised the Board Paper and other document templates to address equality impact assessments. Furthermore the Director has developed values with the staff, one of which is regarding respect and support for others. This year the Director has commenced a programme of staff engagement which will encompass the development of a leadership framework. Oversees recruitment, in particular for nurses and doctors has been a feature in the recruitment activity across the Trust and an apprenticeship scheme is being rolled out.

The Trust's Equality and Human Rights Steering Group reports directly to the Board. Its membership includes executive directors, patient and public engagement representation, governors, senior managers and operational staff. The Board has adopted the Equality Delivery System 2 as its main tool to review its equality performance and to identify future priorities and actions.

The Board has a history over several years of requiring reports on progress towards its equality and diversity objectives, initially identified through the three original equality strands, subsequently against the single equality scheme, and now using the Equality Delivery System 2.

The Trust's annual report contains a section each year reporting on the Trust's commitment to equality and diversity, and listing the systems in place and progress towards its equality objectives during the year.

EDS Grade:	
Comments:	Staff Side comments: 4.1 Agree

EDS2 Outcome 4.2 (EDS2 Goal 4 – Inclusive Leadership)

Papers that come from the Board and other major Committees identify equality related impacts including risks and say how these risks are to be managed

All Trust Board papers and other Committees such as the Integrated Healthcare Governance Committee and the Clinical Effectiveness and Efficiency Group are required to have an assessment identifying equality related impacts and how the risks will be managed. This was revised by the Director of Workforce and Transformation. In addition, Quality Impact Assessments (QIA) are carried out on all new change programmes and this is monitored through the Improving Quality and Efficiency Group. Escalation mechanisms for QIAs is through the Integrated Healthcare Governance Committee. The Trust has an electronic system for carrying out equality assessments on all policies. There is a system in place through the Business Planning cycle to carry out equality assessments on functions but the Trust recognises that this is not as robust as the electronic system and therefore improvements do need to be made in this area. The Trust has a robust Risk Group through its Governance arrangements and individual departments risks are monitored through the Directorate Governance meetings and escalated to the Risk Group and Executives when appropriate.	
EDS Grade:	
Comments:	Staff Side comments: 4.2 The sharing of information does not always happen. Changes not always impact assessed Agree Amber Trust Response: Need to develop better monitoring of equality related impacts on functions.

EDS2 Outcome 4.3 (EDS2 Goal 4 – Inclusive Leadership)

Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

The Trust recognises that the staff survey results of 2013 have identified that support from line managers as very low. To address this issue the Director of Workforce and Transformation has developed an Organisational Development Strategy which incorporates a new leadership framework which is integrated into the Trust's appraisal process.

The Trust has in recent years had a good response rate to equality and diversity training through the Staff Survey results with the Trust rating in the top 20% of Trust's for carrying out the training for staff within the last 12 months. For the Financial year 2013/2104 the average percentage of staff having received equality and diversity training is 80.9%. This exceeds the yearend target of 75%. In addition, in February 2014 the Learning and Development department ensured that all staff received an equality and diversity awareness leaflet. This was attached to payslips.

In the last 12 months the Trust has carried out a number of international nursing recruitment campaigns which has given rise to the implementation of cultural programmes for international staff recruited. Both Spanish and Portuguese nurses have been provided this programme through their induction

With the increase of international recruitment taking place in the hospital, training programmes are being delivered to the cohort of staff coming into the Trust in large groups such as the recent recruitment to 30 Spanish nurses. This programme provides cultural awareness and support.

EDS Grade:	
Comments:	Staff Side comments: 4.3 agree amber

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 July 2014**

Title of the Report	**TDA Self-Certification**
Agenda item	20
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Craig Sharples, Head of Corporate Affairs
Purpose	Decision

Executive summary

At the beginning of April 2013, the NHS Trust Development Authority (TDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of 'Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.

In accordance with the Accountability Framework, the Trust is required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of these are attached as Appendix 1 and 2 for discussion and approval.

Related strategic aim and corporate objective	All
Risk and assurance	Compliance with performance targets and financial statutory duties
Related Board Assurance Framework entries	BAF 19-25
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Meeting financial statutory duties

Q

Actions required by the Trust Board

The Trust Board is asked to:

- approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for June 2014 at Appendix 1 and Appendix 2

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

April	May	June
July	August	September
October	November	December
January	February	March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).

2. **Condition G7** – Registration with the Care Quality Commission.

3. **Condition G8** – Patient eligibility and selection criteria.

4. **Condition P1** – Recording of information.

5. **Condition P2** – Provision of information.

6. **Condition P3** – Assurance report on submissions to Monitor.

7. **Condition P4** – Compliance with the National Tariff.

8. **Condition P5** – Constructive engagement concerning local tariff modifications.

9. **Condition C1** – The right of patients to make choices.

10. **Condition C2** – Competition oversight.

11. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

---

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Comment where non-compliant or at risk of non-compliance

1. Condition G4
Fit and proper persons as Governors and Directors.

Timescale for compliance:

2. Condition G7
Registration with the Care Quality Commission.

Timescale for compliance:

3. Condition G8
Patient eligibility and selection criteria.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

4. Condition P1
Recording of information.

Timescale for compliance:

5. Condition P2
Provision of information.

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

8. Condition P5
Constructive engagement concerning local tariff modifications.

Timescale for compliance:

9. Condition C1
The right of patients to make choices.

Timescale for compliance:

10. Condition C2
Competition oversight.

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Timescale for compliance:

Q

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

April	May	June
July	August	September
October	November	December
January	February	March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (supported by Care Quality

Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

Q

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate.

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans.

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

Q

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forwards.

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

Q

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Q

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 July 2014
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
INTRODUCTORY ITEMS					
09:30	**1.**	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 26 June 2014	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Dr S Swart	**Verbal**
	6.	Chief Executive's Report	Receive	Dr S Swart	**C.**
09:45	**CLINICAL QUALITY AND SAFETY**				
	7.	CQC Action Plan	Assurance	Dr S Swart	**D.**
	8.	Medical Director's Report	Assurance	Dr M Wilkinson	**E.**
	9.	Director of Nursing & Midwifery Care Report	Assurance	Mrs J Bradley	**F.**
	10.	Hard Truths Commitments and Nurse Staffing Review Update	Assurance	Mrs J Bradley	**G.**
10:20	**OPERATIONAL ASSURANCE**				
	11.	Integrated Performance Report and Quality Scorecard	Assurance	Mrs D Needham	**H.**
	12.	Finance Report Month 3	Assurance	Mr S Lazarus	**I.**
	13.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**J.**
	14.	Workforce Report	Assurance	Mrs J Brennan	**K.**
10.50	**ANNUAL REPORTS**				
	15.	Clinical Audit Annual Report	Assurance	Dr M Wilkinson	**L.**
	16.	Risk Management Annual Report	Assurance	Dr M Wilkinson	**M.**
	17.	Medical Education Annual Report	Assurance	Dr M Wilkinson	**N.**
	18.	Medical Revalidation & Appraisal Annual Report	Assurance	Dr M Wilkinson	**O.**

Time		Agenda Item	Action	Presented by	Enclosure
11. 35	**GOVERNANCE**				
	19.	Equality Delivery Stems 2 (EDS2)	Assurance	Mrs J Brennan	**P.**
	20.	TDA Self-Certification	Decision	Mr C Pallot	**Q.**
11:55	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting will be held at 09:30 on Thursday 25 September 2014 in the Board Room at Northampton General Hospital

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).