Northampton General Hospital NHS
NHS Trust

AGENDA AND PAPERS

Public Trust Board

Thursday 26 June 2014

09:30

Board Room NGH

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 June 2014
09:30 in the Board Room at NGH

Time		Agenda Item	Action	Presented by	Enclosure
INTRODUCTORY ITEMS					
09:30	**1.**	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 29 May 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 Quality Report	Assurance	Dr M Wilkinson	**E.**
	9.	Director of Nursing & Midwifery Care Report	Assurance	Mrs J Bradley	**F.**
	10.	Hard Truths Commitments regarding the publishing of staffing data	Assurance	Mrs J Bradley	**G.**
	11.	Personalised Care Plan for the Dying	Decision	Mr C Pallot	**H.**
10:25	**STRATEGIC**				
	12.	Organisational Effectiveness Strategy	Decision	Mrs J Brennan	**I.**
10.35	**OPERATIONAL ASSURANCE**				
	13.	Integrated Performance Report and Quality Scorecard	Assurance	Mrs D Needham	**J.**
	14.	Finance Report Month 2	Assurance	Mr S Lazarus	**K.**
	15.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**L.**
	16.	Workforce Report	Assurance	Mrs J Brennan	**M.**

Time		Agenda Item	Action	Presented by	Enclosure
11. 35	**GOVERNANCE**				
	17.	TDA Self-Certification	Decision	Mr C Pallot	**N.**
11:45	**18.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting will be held at 09:30 on 31 July 2014 in the Board Room at NGH

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).

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 29 May 2014 at 09:30 in the Board Room at NGH

Present		
	Mr P Farenden	Chairman (Chair)
	Mr C Abolins	Director of Facilities and Capital Development
	Mrs J Bradley	Interim Director of Nursing, Midwifery & Patient Services
	Mrs J Brennan	Director of Workforce and Transformation
	Mr G Kershaw	Non-Executive Director
	Mr D Noble	Non-Executive Director
	Mr N Robertson	Non-Executive Director
	Mrs L Searle	Non-Executive Director
	Dr M Wilkinson	Interim Medical Director
	Mr P Zeidler	Non-Executive Director (Vice Chair)
In Attendance		
	Mrs R Brown	Care Group Director, Surgery
	Mr J Cornett	External Auditor, KPMG (Item 18)
	Mrs S McKenzie	Committee Secretary
	Mr C Sharples	Head of Corporate Affairs
	Mrs K Spellman	Deputy Director of Strategy and Partnerships
Apologies		
	Mrs D Needham	Chief Operating Officer
	Mr C Pallot	Director of Strategy and Partnerships
	Dr S Swart	Chief Executive Officer

TB 14/15 001 **Introductions and Apologies**

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

Apologies for absence were recorded from Mrs Needham, Mr Pallot and Dr Swart.

TB 14/15 002 **Declarations of Interest in the Proceedings**

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

TB 14/15 003 **Minutes of the meeting held on 24 April 2014**

The minutes of the meeting of 24 April 2014 Board meeting were presented for approval.

Subject to the following amendments the Board resolved to **APPROVE** the minutes of the 24 April 2014 as a true and accurate record of proceedings.

TB 13/14 197 Patient Story

Mr Abolins requested that the Patient Story be amended to read that the letter referred to the patient's relative writing about her satisfaction with the care and good treatment that her husband had received.

TB 13/14 205 Workforce Report

Mrs Brennan requested an amendment to the fourth paragraph
'An audit on the quality of appraisals undertaken would commence in May 2014'.

TB 13/14 205 Workforce Report

Mrs Brennan requested that penultimate paragraph should read
'Dr Swart responded that the root cause of this would be addressed through the Organisational Effectiveness strategy'

TB 14/15 004 Action Log and matters arising from the 24 April 2014 Board Meeting

The Board considered the action log.

The Board **NOTED** the Action Log and Matters Arising from the 24 April 2014.

TB 14/15 005 Patient Story

Mr Abolins presented a letter to the Board from a patient's relatives who thanked the staff on the Holcot ward for the care given to their late mother. They further thanked staff for the care given on arrival at A&E, on EAU and then on Holcot ward. They gave particular mention to Dr Clarke for his interaction and compassion. They advised that in lieu of flowers at the funeral, donations to Holcot were requested and that £850 had been received. Mr Abolins reported that Dr Swart had written a thank you to the staff involved in the care of the patient and also wrote a thank you to the patient's relatives for the kind donation.

The Board **NOTED** the Patient Story

TB 14/15 006 Chief Executive's Report

Mr Abolins presented the Chief Executive's Report.

Mr Abolins reported that the NGH safety education initiative had been shortlisted for a national award. 'Aspiring to Excellence' a training course designed and developed by Dr Jonny Wilkinson, NGH consultant anaesthetist, intensivist and patient safety lead, had been designed to help doctors of tomorrow become more safety aware. The programme had ben been recognised by the University of Leicester who have funded a Senior Lecturer post in Quality Improvement and Acute Medicine. The team had been invited to attend the awards ceremony in London on 15 July 2014.

Mr Abolins reported that in celebration of the Friend of NGH's 25th anniversary, the Friends of NGH had invited NGH departments and services to bid for a proportion of £25,000 funding. The three successful departments were, Cardiology investigations team £12,000, Surgical services £10,000 and Child physiotherapy £3,000and they were presented with the funds on 22 May 2014 at the Friends Annual General Meeting.

Mr Zeidler requested that the Charitable Funds Committee reviewed the unsuccessful bids to see if they could be supported in other ways.

Action: Mr Abolins

Mr Abolins reported that the regeneration of the Willow Tree Garden had now been completed. Clare Topping, Energy and Sustainability Manager had managed the project with free advice from a local landscape designer. 750 plants had been carefully selected. Mr Abolins commented that the garden would provide a healing environment for patients and a relaxing area for staff. A formal opening of the garden, by the Chairman, would take place in two weeks' time.

Mr Abolins reported on the progress for the planned improvement work to the lay out of the Accident and Emergency Department. The work had been divided into two main phases. Phase 1 was currently out to tender and it was envisaged that work would commence in late June. Phase 1 involved construction of an extension housing the new GP unit and consultant's offices and the conversion of the current Fracture Clinic into a new Resuscitation Unit to create 8 additional cubicles. Phase 2 involved the creation of an Emergency Observation Unit and new Ambulatory Care unit and would follow immediately from Phase 1.

Mr Abolins reported that following the CQC inspection, work had been brought forward, ahead of the main schemes of work, on the improvement of facilities for children and parents in the paediatric area in A&E. He reported that work had been expected to be completed by the end of June.

Mr Abolins reported that a formal report on governance and organisational development from Deloitte had been discussed at the last Board Development away day. The approach would now be developed in more detail and an implementation plan would be presented to the Board in the near future.

Mr Abolins informed the Board that the NGH Charity is about to launch an appeal with the Northampton Chronicle & Echo in order to raise £350,000 for the refurbishment of the Chemotherapy Suite.

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

TB 14/15 007 CQC Action Plan

Mr Abolins presented the CQC Action Plan.

Mr Abolins reported that three action plans had been developed, namely a high level overview focusing on short term improvements on immediate issues. The second action plan included compliance actions and more detailed operational matters identified by the CQC and the third action plan remained dynamic and changed on a daily basis as actions progressed and was managed by the Governance Team.

Mr Abolins confirmed that a weekly Programme Management Board, chaired by the Chief Executive, was in place to lead and have oversight on the corporate response to the CQC Report and hold officers to account to deliver the activities and milestones within it.

The NHS Trust Development Authority (TDA) agreed that an oversight forum would be established to provide oversight of the Trust's response to the CQC Report. The Oversight Group consisted of colleagues from the TDA, Commissioners and Healthwatch. The group felt that the Trust had demonstrated good progress how they had addressed the findings of the CQC report.

Mrs Brennan commented that the table on page 19 under Appraisals should be amended to reflect 3 green actions and 2 amber actions.

Mr Farenden comment that he felt assured that the Trust had demonstrated a robust approach in its response to the CQC findings.

The Board **NOTED** the CQC Action Plan

TB 14/15 008 Medical Director's Quality Report

Dr Wilkinson presented the Medical Director's Quality Report.

Dr Wilkinson provided a detailed overview of the content and reported that there had been a sustained improvement in HSMR and SHMI. Dr Wilkinson reported that 12 new serious incidents were reported, of which 9 were pressure ulcers. 10 Serious Incidents had been submitted for closure and there had been no requests for extensions and all Serious Incident reports had been submitted within the 45 day timeframe.

Dr Wilkinson informed the Board that NRLS Data published April 2014 had shown that NGH was just below the top quartile of reporters with a reported rate of 8.27 per 100 admissions compared to the median reported rate for medium acute organisations of 7.23 per 100 admissions. 0.5% of incidents reported by NGH resulted in severe harm or death compared to just under 1% nationally.
Dr Wilkinson commented that this represented a positive risk profile with a high number of patient safety incidents being reported and a low number of severe harm incidents.

Dr Wilkinson presented the revised Corporate Scorecard which had been made more user-friendly and incorporated outcomes from the CQC report and the TDA Accountability Framework. Dr Wilkinson explained that every red would have an exception report which provided more assurance to the Board.

Mr Farenden commented that members should acknowledge the significant improvement and offered thanks to all involved.

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

TB 14/15 009 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 following the report of the Francis Inquiry and the Berwick Review into Patient Safety. NICE had been asked by the Department of Health and NHS England to produce guidelines on safe staffing capacity and capability in the NHS.

It was noted that the milestones that had been achieved were; Capability which had been reviewed and reported to board six monthly using an evidence based tool; Staffing deployed for each shift compared to what had been planned was displayed at ward level and was visible by patients and carers.

Mrs Bradley confirmed that as of July 2014 a monthly report 'Hard Truths Commitments' would be presented to the Board. This report would contain details of planned and actual staffing on a shift by shift basis at ward level for the previous month.

Mrs Bradley informed members that the staffing data published on the Trust website would be written in a format that was accessible and understandable to patients and public.

Mr Noble questioned the wording of the second bullet point in the recommendations and the following amendment was agreed: 'Approve subject to the proposed format and information that will be will be published to support the Hard Truths Commitments '

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

TB 14/15 010 Patient Experience Report

Mrs Bradley presented the Patient Experience Report.

In summarising the report Mrs. Bradley reported that no Friends and Family Test (FFT) data was contained within this report as data would now be reported one month retrospectively. April's data would be contained within June's report.
A decision had been made to change the name from the Patient and Public Involvement (PPI) to the all-encompassing term Patient and Public Engagement

(PPE). The aim was to align PPE to the 10 key components of good engagement as identified by the NHS confederation.

It was noted that the previous 'Patient and Public Involvement Steering Group' had been disbanded and replaced with a Patient and Public Engagement Network (PPEN) which consisted of patients, carers, public, members, volunteers and governors, and would act as a 'pool' of representatives that would become engaged in various activities throughout the organisation.

Mrs Bradley informed the members that the revised strategy had been renamed the Patient Experience and Engagement Strategy and that the previous PPI strategy had been disbanded and the aims of the organisation with regards to engagement would be represented within the new strategy.

Mrs Bradley confirmed that five areas had been identified in which improvements were required, namely Noise at Night, Discharge, Communication, Pain Management and Mealtime Experience. However due to the magnitude of the work required to make improvements within these areas the decision had been made to focus on Noise at Night.

The Board **NOTED** the Patient Experience Report.

TB 14/15 011 Infection Prevention Performance Report

Mrs Bradley presented the Infection Prevention Performance Report.

Mrs Bradley reported that the main issues to highlight were that the total C diff ceiling for 2013/14 was 26, bringing the Trust under trajectory as the annual target had been 29. The CDI objective for 2014/15 had been set at 35 with an internal stretch target of 24.

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. **Action: Mrs Bradley**

It was noted that the Care Quality Commission (CQC) report highlighted that the hospital environment was clean and infection prevention had been good.

The Board **NOTED** the Infection Prevention Performance Report.

TB 14/15 012 Same Sex Accommodation Audit and Update

Mrs Brown presented the Same Sex Accommodation Audit and Update.

Mrs Brown reported that Northampton General Hospital underwent significant redevelopment in 2010 to ensure that Same Sex Accommodation had been provided in clinical areas. The Trust now had separate male and female admission areas for urgent care. Within 2013/14 there had been 3 reported occasions when same sex accommodation within critical care had not be maintained. However this was due to the clinical needs of the patients and as such met the exception criteria. Therefore upon validation these patients were not classified as having experienced a Same Sex Accommodation breach.

Mrs Brown reported that due to the challenges of the urgent care pathway during the last year escalation areas had been opened with every care taken to ensure Same Sex Accommodation breaches had not occurred. If the requirement had been due to clinical need only, a datix report would be submitted and a root cause investigation undertaken to ascertain the reason.

Mr Noble asked how the Trust compared against other Trusts and Mrs Brown advised that a benchmarking exercise would be undertaken. **Action: Mrs Brown**

Mrs Brown reported that a further audit would be repeated in 12 months' time and reported to the Trust Board.

The Board **NOTED** the Same Sex Accommodation Audit and Update and **AGREED** the Declaration of Compliance.

TB 14/15 013 Operational Performance Report

Mrs Brown presented the Operational Performance Report.

Mrs Brown reported on the standards that the Trust had not achieved in April. However, significant improvement had been demonstrated throughout May 2014.

She reported that there had been one case regarding cancelled operations rebooked within 28 days. The number of patients who had waited over 26 weeks without initiation of treatment and not on a waiting list for a procedure remained at 49, no patients had waited over 52 weeks.

Mrs Brown reported that the Trust had not achieved the 62 day cancer standard from urgent 2ww referral to start of first treatment and two other cancer standards; 2ww referral and 31 day first treatment.

Mrs Brown advised that work had started on the enhancement of the Cancer Board and the introduction of a weekly operational meeting to review each patient pathway which included a review of current breaches across organisations and understanding the issues with capacity for MRI and CT.

Mrs Spellman advised that the ongoing Oncology partnership work with University Hospital Leicester would support the delivery of the cancer standards. Mr Kershaw commented that this was an area of concern and would continue to be monitored at the Integrated Healthcare Governance Committee.

Mr Farenden welcomed the increased focus on cancer targets.

Mrs Brown reported that the Trust had achieved 18 week RTT across all specialties and that all diagnostic procedures had been undertaken in less than 6 weeks. All stroke targets had been achieved.

The Board **NOTED** the Operational Performance Report.

TB 14/15 014 Urgent Care Report

Mrs Brown presented the Urgent Care Report.

Mrs Brown reported that the Trust had not achieved the Urgent Care 4 hour standard for April 2014 therefore a highlight report had been presented to Integrated Healthcare Governance Committee in May 2014.

Mrs Brown informed the members that safety huddles were occurring twice a day and that non-executive members were invited to observe. Re-introduced rapid assessment and treatment in the ED; additional support had been received from partners and leadership had been strengthened. This week the Chair of the Urgent Care Board had focussed on admission avoidance and complex discharge.

Mrs Brown presented to the Board the findings received from Mott McDonald and Emergency Care Intensive Support Team (ECIST), two external partners, who

had evaluated the urgent care programme and produced a series of recommendations. ECIST would be invited back to carry out further reviews and the Trust would continue to provide focus and momentum on the urgent care programme to build on the positive progress made. Mrs Brown commented that the focus would now be to ensure that the treatments implemented were sustained and the highest level of patient care, safety and performance was maintained.

The Board **NOTED** the Improving Urgent Care Report.

TB 14/15 015 Finance Report

Mr Lazarus presented the Finance Report for Month 1.

Mr Lazarus reported that the position for M1 reported a £2.2m deficit, compared to a planned deficit of £1.1m which gave rise to an adverse variance of £1.1m for the month of April. He reported early concern in relation to achievement of the plan for 14-15.

He advised that the M1 position included a number of one-off significant expenditure items, including management consultancy which was over plan by £180k together with additional unplanned income provisions for fines and penalties which may not arise in future months. A report had been submitted to the TDA on 16 May 2014 in accordance with the national reporting timetable.

Mr Lazarus reported that non-elective admissions had exceeded plan in April which gave rise to a potential increased 70% MRET penalty. There had been little indication to date that the CCG QiPP schemes had been effective in the first month of the financial year although some downturn in planned activity had been evident compared to plan. Mr Lazarus informed the members that the Chief Executive would be writing to the CCG explaining the current position, making a formal bid for transformation monies and asking for further clarification on the allocation of remaining MRET funding.

Mr Lazarus reported that a report on outsourced activity would be presented to the next Finance Committee, which would detail the planning cycle, capacity and potential efficiency gains. The report would be led by the Surgery Care Group with Finance in support.

Mr Lazarus reported that the cash flow position remained positive although action would need to be taken to ensure loan applications with the TDA would be progressed in June.

Mr Zeidler questioned whether the recruitment programme had progressed as quickly as first indicated. Mrs Brennan responded that a need to understand bank and agency staff better was required. Mr Lazarus confirmed that a detailed report on use of agency and locum staff costs and associated targets for reduction would be presented to the next Finance Committee. Mrs Bradley informed the members that workshop development courses had been set up for staff with budget responsibilities giving them the necessary financial skills and support to manage their budgets and booking bank and agency staff.

Mr Farenden commented that the Board had been assured in the past and therefore the situation needed to be addressed and managed tightly.

The Board **NOTED** the Finance Report.

TB 14/15 016 Workforce Report

Mrs Brennan presented the Workforce Report.

Mrs Brennan reported a decrease in sickness absence for April but still below the Trust target.

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.

Action Mr Lazarus and Mrs Brennan

Mrs Brennan reported that mandatory training stood at 76.91% against the revised target of 80% which had to be achieved by October 2014 and 85% by the end of March 2015. Role Specific Essential Training stood at 63.69% against the target of 70% which had to be achieved by October 2014.

Mrs Brennan informed the members that appraisal rates rose to 62.81% against the trust target of 85% which had to be achieved by March 2015. Mr Robertson commented that the quality of appraisals would be addressed at the next Audit Committee.

The Board **NOTED** the Workforce Report.

TB 14/15 017 Improving Quality and Efficiency Report

Mrs Brennan presented the Improving Quality and Efficiency Report.

Mrs Brennan reported that the latest thinking forecast at M1 was £12.136m, against the target required of £12.668m. The Trust was below plan by £532k. The plan submitted to the TDA required delivery of £513k in the first month and actual delivery had been £437k, therefore £76k below plan. The main drivers for the deficit were a shortfall in recurrent delivery of the 2013/15 CIP programme, 50% MRET non reinvestment and essential quality investment.

Mrs Brennan advised that we had around £7m worth of plans with completed Quality Impact Assessments (QIAs) but more work would need to be done in order to develop the remainder of the outstanding QIAs. Mrs Brennan reported that a number of high priority next steps had been identified in order to rapidly progress the programme and ensure delivery. The completion of QIA of all schemes identified was in progress and a report would be submitted to IHGC.

Mr Farenden noted the improvement from last year, but that further work and improvement was still needed.

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

TB 14/15 018 Approval of the 2013/14 Annual Report and Accounts and Quality Account

Mr Lazarus presented the 2013/14 Annual Report and Accounts and Quality Account.

Mr Cornett presented the Draft Management Representation Letter to the Board and asked the Board for approval.

Mr Lazarus informed the Board that the annual accounts would be signed off on 2 June 2014 and submitted to the Department of Health by KPMG on 9 June 2014 along with the Quality Account. The Quality Account deadline was 30 June 2014.

The Board noted this was the last year Mr Cornett would audit the Trust's annual accounts and thanked him formally for his support over the previous years.

The Board **APPROVED** the 2013/14 Annual Report and Accounts and Quality Account and the Draft Management Representation Letter.

TB 14/15 019 TDA Accountability Framework

Mrs Spellman presented the TDA Accountability Framework.

Mrs Spellman reported that the Framework articulated how the Trust expected the Trust Development Authority (TDA) to hold it to account during the course of the year, the processes by which this would happen and the key indicators that must be met.

Mrs Spellman explained that the indicators were grouped in the six ways; Caring, Well led, Effective, Safe, Responsive and Finance. The Trust would be managed via the monthly Integrated Delivery meetings with the TDA which may alter based on any escalation level that was in place.

Mrs Spellman commented that the Framework also described the approval framework for aspiring Foundation Trusts and the process for agreement of significant capital investments in excess of £50m.

Mr Zeidler asked what development support would be available from the TDA. Mr Farenden commented that this would be addressed at the monthly TDA meetings. Mrs Spellman commented that a final submission of the planning process was expected to be with the TDA in September 2014 and this would include a Development Support Plan which would be developed together with the TDA.

Mrs Brennan commented that the under Workforce Assurance, Trusts had been mandated to actively use the national workforce assurance tool which would mean a significantly increased workload which would need evaluating.

The Board **NOTED** the TDA Accountability Framework.

TB 14/15 020 Developing a 5-Year Plan

Mrs Spellman presented the Developing a 5-Year Plan Report.

Mrs Spellman informed the members that this report described the process to deliver the Clinical Strategy and the 5-year strategic business plan for Northampton General Hospital as well as describing the recent history with regard to some of these pieces of work.

The process to define the Trusts Integrated Business Plan was complex and had been influenced by many external factors. The approach had been to review each clinical service against a range of metrics, including external strategic initiatives to ensure future sustainability. This approach would result in a number of completed reviews ready for inclusion in the TDA submission on 20 June, but not all would be finalised. The submission would map the path to completing the reviews which would also enable the Trust to incorporate the outputs of the Challenged Health Economy work.

Mrs Spellman summarised the approach being taken to produce the Trust 5 year plan with a particular focus on the financial aspects. It had been proposed to present the plan to the Finance Committee on 18 June for discussion just ahead of the 20 June submission date to the TDA. The plan would then be revised and updated to be aligned to the outputs from the Challenged Health Economy work

currently being undertaken by Deloitte and due to report at the end of June 2014. Mr Noble asked if Mrs Spellman could ascertain how many members of staff were involved in the Healthier Northants Programme Management Office.

Action Mrs Spellman

The Board **NOTED** the Developing a 5-Year Plan Report.

TB 14/15 021 Corporate Objectives 2013/14 Report

Mrs Spellman presented the Corporate Objectives 2013/14 Report.

Mrs Spellman provided an update to the members on the progress made in relation to the 2013/14 corporate objectives.

After discussion it was agreed that the Stakeholder Engagement Strategy would be reviewed. **Action: Mrs Spellman**

The Board **NOTED** the Corporate Objectives 2013/14 Report.

TB 14/15 022 TDA Self-Certification Report

Mrs Spellman presented the TDA Self-Certification Report.

Mrs Spellman 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 April 2014 were discussed and subject to some areas of amendment were approved.

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

TB 14/15 023 Any Other Business

Mr Noble reported that he had attended the Championing Procurement 'Asking the Right Questions' event and commented that it was important to get procurement on the Board agenda. Mr Abolins commented that he would put together a briefing and some recommendations for the July meeting and schedule a 3 monthly report. Mr Abolins welcomed the need to have a non-executive as a procurement champion. **Action: Mr. Abolins**

Mrs Brennan informed the Board that at the Partnership Forum, Unite and Unison advised that they were balloting for industrial action regarding the national pay award.

Date of next meeting: Thursday 26 June 2014 at 09:30 in the Board Room at NGH

Mr Farenden called the meeting to a close at 11:35

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 19/06/2014

Ref	Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of Completion/Reason for Slippage
27	27/03/2014	TB 13/14 188	Workforce Report	It was requested that outcome measures for appraisal compliance be reported to the Board monthly from June 2014.	Mrs J Brennan	Jun-14	On Track	
28	29/05/2014	TB 14/15 005	Chief Executive's Report	Mr Zeidler requested that the Charitable Funds Committee reviewed the unsuccessful bids to see if they could be supported in other ways.	Mr C Abolins	Jun-14	On Track	
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	Jul-14	On Track	
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	Jun-14	On Track	
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	Jun-14	On Track	
32	29/05/2014	TB 14/15 019	Developing a 5-year Plan	Mr Noble asked if Mrs Spellman could ascertain how many members of staff were involved in the Healthier Northants Programme Management Office.	Mrs K Spellman	Jun-14	Completed	
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	29/05/2014	TB 14/15 022	Any other business	Mr Noble reported that he had attended the Championing Procurement 'Asking the Right Questions' event and commented that it was important to get procurement on the Board agenda. Mr Abolins commented that he would put together a briefing and some recommendations for the July meeting and schedule a 3 monthly report. Mr Abolins welcomed the need to have a non-executive as a procurement champion.	Mr C Abolins	Jul-14	On Track	

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Chief Executive's Report
Agenda item	6
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer
Author(s) of Report	Dr Sonia Swart, Chief Executive Officer
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 Trust Board is asked to:

- note content of the report

Enclosure C

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26 June 2014

Chief Executive's Report

1. Medical director appointment

Following a rigorous appointment process we were fortunate to have appointed Dr Michael Cusack, a consultant cardiologist, to the post of Medical Director. He will join our executive team at the end of September but will be visiting the Trust over the summer and meeting with key individuals. Mike was closely involved with reconfiguration of cardiac services across sites, led the Black Country Cardiovascular Network from 2008-2012 and has been involved in various aspects of pathway redesign from this time. He has a longstanding interest in medical management and has been a Clinical Director and more recently a Divisional Medical Director of a large surgical division at Royal Wolverhampton Hospital. His responsibility there included all Surgical Specialities, Anaesthetics, Theatres, Support services and Maternity in a medically led management model.

Mike is a very patient-focused doctor with a broad range of experience and is very much looking forward to joining our team. He shares our vision and values and is committed to and excited by the prospect of helping us to develop our services to deliver excellent clinical outcomes in a new clinically led structure.

I am grateful to Mike Wilkinson, who will continue to act as Interim MD until we have our new MD in post. The role of MD is an increasingly broad and challenging one and the need to focus on clinical leadership and clinical standards in service redesign will be of increasing importance.

2. Governance and assurance

As part of our response to the CQC, and following the Board's support of the recommendations from Deloittes, who were commissioned to undertake a review of our governance structures we will be starting the work needed to 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 aim is to increase the clinical voice and clarify reporting structures. Once this work is complete we will need to embed the way our corporate governance, performance management and assurance systems work and to that end will be recruiting a director of corporate development and assurance. This will be a vital role which will 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 will be developed and an outline paper be presented to the Board in July. We will also be consulting with key members of staff to develop this work.

3. Additional funding

Like most the UK we have been struggling with all the targets, particularly the 18 week, A&E and some cancer targets. Of these the emergency are standards continue to cause us the most difficulty and, of course, also have an impact on the other main elective targets. I 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.

Since that meeting It has since been reported that £250m has been allocated to help NHS providers clear their planned care waiting list backlogs. The DH also said that in 2014-15 there will be a £400m fund for 'winter pressures, £250m of which was announced last year by NHS England. This money is aimed at addressing pressures in accident and emergency departments. We do not yet know what amount of funding will be allocated to NGH, but the overall aim will be to ensure we continue to provide safe, high quality care for our patients.

4. Smaller hospitals

A report recently published by Monitor, 'Facing the Future: Smaller Acute Providers' finds 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.

I have recently had two meetings which were about the future of smaller hospitals and, along with seven CEOs of smaller hospitals across the UK, I met with Jeremy Hunt to provide a personal perspective and contribute to the Foundation Trust Network view on what measures could be taken to support smaller hospitals.

5. NHS Confederation annual conference

I attended the NHS Confederation annual conference in early June, when it was affirming to listen to some exceptional leaders and feel that, for the most part, we are on the right track with our plans to empower more managers and clinicians to take forward quality improvement centred on the needs of the patient - and with our recognition that we need to put great store on a way of rewarding those members of staff who work to our values and put in that extra mile. There were some other key themes from the conference including and emphasis on local leadership as the way in which we secure the gains we need. This will be welcome to many, if we can secure a national framework that is flexed to support rather than constrain us all. The Dalton review which is about securing sustainable models of provision for the future is likely to include a number of options that move away from centralisation and towards configurations that go from groups and chains to joint ventures and full mergers. This fits in well with our local approach in Northamptonshire which is built on forming and supporting strategic partnerships across the health and social care economy in order to provide patient centred care in a sustainable financial framework.

6. Strictly NGH

The first-ever Strictly NGH was enthusiastically supported by a lively audience. Thanks to all and particularly to Sally Watts who was the organiser and also, when it came to the judges' decision, the very deserving winner of the competition. Through sponsorship the dancers taking part have already raised almost £10,000 for our charitable fund.

The whole experience of the Strictly NGH effort reminded me again of the importance of teamwork and working together in ways that teach us about our common humanity and each other. It was great exercise and hopefully we will be able to keep something going as part of a staff health and wellbeing campaign – quite a few people have already volunteered for next year's competition.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 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 Craig Sharples, Head of Corporate Affairs
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, NGH received a number of recommendations and together with other areas the Trust identified created a number of CQC action plans (Appendix 1-3) to evidence compliance against those recommendations.

A number of the actions were completed immediately and some actions have longer term plans. The Governance Department are supporting the executive and action owners to collate the evidence and are providing constructive challenge.

There is a deadline of 30 June 2014 with which the Trust must be compliant in respect of the CQC High Level Compliance Actions. At the time of this report (17 June 2014) there are some minor gaps in evidencing compliance as specified within the report.

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 as sustained and evidence is available on an ongoing basis to demonstrate this.

In addition there is a comprehensive action plan in place to address the Compliance notices. These have longer timescales to demonstrate compliance and are being managed using the same process.

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 Committee

The Board is asked to:

- note the up to date position in relation to the action plan and have assurance that action is being taken to address the issues highlighted by the CQC and other recommendations and further be assured there will be robust evidence to demonstrate compliance.

Northampton General Hospital NHS
NHS Trust

Trust Board
26 June 2014

CQC Action Plan

1. Introduction

The Care Quality Commission Report into services at Northampton General Hospital NHS Trust was published on 27 March 2014 following the Chief Inspector of Hospital visit in January this year.

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.

This report is presented to the Board to summarise the findings of the report, 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

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

A number of the actions were completed immediately and some actions have longer term plans. Of particular concern is ensuring robust processes are not only developed but embedded as "business as usual" throughout the Trust. It is important that, through local team meetings and regular trust-wide communications, the CQC action plan and the work being carried out, is disseminated to all staff and that this communication is consistent and a regular occurrence.

With regard to the three strategic issues articulated in the CQC report; Urgent Care, Governance and Leadership, the trust has committed to a programme of improvement which accelerates and augments existing programmes of work that have been in place over recent months. The summary treatment plan – Appendix 1 - 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.

To underpin the strategic plan, a more detailed action plan has been developed – Appendix 2. This plan 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.

The third action plan is the most detailed and presents the Board with a snapshot of the detail management actions that are ongoing. This plan remains dynamic, changing on a

daily basis as actions progress, and is managed by the Governance Team. The plan can be found at Appendix 3 of this report.

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, the Trust's Internal Auditors are currently reviewing the action plans and the supporting evidence and will be visiting wards to review how the action plans and the actions have been embedded throughout the Trust.

3. Exceptions

There remains a risk that the action plan and evidence have 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.

Of the 8 highly significant points issued by the CQC a total 32 individual actions have been put in place to ensure compliance. A breakdown of their ratings and comparison on the position in May is presented in the table overleaf:

Point	Green Actions		Amber Actions		Red Actions		Total	
	May '14	*June '14*	*May '14*	*June '14*	*May '14*	*June '14*	*May '14*	*June '14*
1 – TTO's	3	**6**	3	**0**	0	**0**	6	**6**
2- Mandatory training	4	**6**	4	**2**	0	**0**	8	**8**
3 -Transfers at night	2	**3**	1	**2**	2	**0**	5	**5**
4 - Stroke imaging pathway	1	**3**	0	**0**	2	**0**	3	**3**
5 -ITU Core Standards	0	**1**	0	**0**	1	**0**	1	**1**
6 - Emergency Care (ECIST)	0	**0**	2	**2**	0	**0**	2	**2**
7 - Action Plans	1	**3**	1	**0**	1	**0**	3	**3**
11 - Appraisals	3	**4**	1	**0**	0	**0**	4	**4**
TOTAL	14	**26**	12	**6**	6	**0**	32	**32**

In addition there are some specific actions where currently there are gaps in compliance despite the actions implemented and evidence reviewed:

- Mandatory and Role specific Training compliance
- Appraisal compliance

A more detailed breakdown of the amber rated actions, including up to date progress reports and indicative completion dates can be found in the table overleaf.

Amber Actions as at 18.6.2014

Recommendation	Action	Progress	Reason for Amber	Target Date	Expected Date for completion
Patient Flow – Transfers at Night H1.1	Ward Transfer Records to include the time of transfer. This is included in the Nurse Handover Safety Checklist	Completed checklist to be sent and confirmation of how monitored	Clarification on monitoring of information required	March 2014	End June 2014
Patient Flow – Transfers at Night H1.1	Use of 4Cs and 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. Comments received and leaflet updated. Version 2 circulated Expected to be submitted to the Patient Information Group - June 2014	Require copy and NGV no	June 2014	End June 2014
Urgent Care - Emergency Care (ECIST) H2.1	Review October 2013 report and identify any additional actions	Actions resulting from the review have been incorporated into the Urgent Care Programme	Awaiting Board minutes from June 2014	May 2014	End June 2014
Urgent Care - Emergency Care (ECIST) H2.1	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 ECIS meeting info Autumn/ Dec 2013	Awaiting Board minutes from June 2014	May 2014	End June 2014
Mandatory Training H7.1	Provide a variety of options to ensure that staff are able to access mandatory training.	Updated TNA & Course outline onto trust intranet (planned by end of June 2014)	Require most up to date on intranet	April 2014	End June 2014
Mandatory Training H7.2	Role Specific: Scope out what is deemed to be role specific training in each	The T&D department are working on specific training for specific job roles. Templates are being	Require ESR /OLM to reflect the specific job role requirements to	May 2014	End Sept 2014

Recommendation	Action	Progress	Reason for Amber	Target Date	Expected Date for completion
	area and staff group Ensure correct information regarding role specific training is available on the intranet	updated by T&D however the issue is the uploading into the system which will require McKesson who will do the mass upload Role Specific identification of Job roles has been completed. 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	ensure accuracy of data		

4. Next Steps
The CQC will revisit the Trust, possibly during the summer months this will be an unannounced visit. They will be looking at the actions taken to address the high level issues identified and the evidence that supports the actions. They will also be looking at whether the actions have been embedded across the Trust and if can staff verbally, provide confirmation that processes that have been evidenced are in place.

The next CQC Oversight meeting will take place with the TDA and health economy partners on 9 July 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.

Appendix 1
CQC Report – Strategic Treatment Plan and Progress

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	**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	**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	**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'.	**Completed**		**DELIVERED**

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	**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	**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**		**DELIVERED**
We must improve arrangements for children's care in the A&E department	**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	**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'.	**August 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	**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	**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'.	**May 2014**		**DELIVERED**
We must ensure that the findings of the Emergency Care Intensive Support Team are explicitly acted upon	**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	**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'.	**May 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

Appendix 2

CQC Inspection – Action Plan June 2014

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

1. TTOs and Taxis

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 however some transfer of medication by Taxi to other hospitals still continues	Chief Operating Officer	April 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	The arrangements for the trail need to be taken through the medicines management committee and agreed.	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
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 May 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 - awaiting minutes	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. Added the requirement to report from Directors down through their teams as well as the bottom up approach.	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	Agree & implement performance management dates when the trust target will be met	Workforce discussed at IHGC & Trust Board monthly	Director of Workforce	May 2014	Workforce reports to IHGC and Trust Board	IHGC	
2.6	Ensure accuracy of data including minutes	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	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	June 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	June 2014	Up to date information regarding role specific training requirements needs to be available to all staff	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
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	March 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	Monitoring process needs to be agreed	Chief Operating Officer	March 2014	Description of process Evidence of roll out	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	March 2014	Draft of Patient leaflet Consultation emails	IHGC	

4. Stroke Imaging Pathway

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	Complete	Medical Director	April 2014	Copy of pathway	IHGC	
4.2	Ensure communication of pathway to all staff	Complete	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	Complete	Medical Director	April 2014	Evidence required for: monitoring of pathway e.g. how many specialist Nurse requested CT's have taken place. Outcome of SSNAP audits to ensure trust maintain above National average compliance	IHGC	

5. Intensive Care Society Core Standards for intensive care units

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

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	Monitor the progress through Health Assure	Chief Operating Officer	May 2014	Report to IHGC	IHGC	

7. Follow-Up of Action Plans

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 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 Governance 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 action plans with RAG rated progress Meeting minutes HealthAssure Reports	Clinical Quality and Effectiveness Group	

7.3	Ensure all 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 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. 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 **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.	Completed. At 30 April 2014, compliance rate was 71%	Director of Workforce	May 2014	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	May 2014	Papers & Minutes IHGC Papers of Trust Board & Minutes Trust Board	IHGC	
8.3	Agree and implement performance management dates when the trust target will be met	Agreed.	Director of Workforce	April 2014	Review Trust target (May) - 85% - Report to IHGC in June2014	IHGC	
8.4	Continue to embed the new appraisal process aligned to incremental progression	Ongoing	Director of Workforce	March 2015	Ongoing compliance reporting	IHGC	

9. Do Not Attempt CPR Paperwork **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. 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	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 **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	March 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	A gap analysis to be completed by 31st May 2014	Director of Facilities	May 2014	For inclusion in compliance report to CQEG Minutes and report to Risk Group	Medical Equipment Group	

11. Capnography Machines
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	Business Case	Medical Equipment Group	
11.2	Where a shortfall is identified, carry out a risk assessment for inclusion on Risk Register	Business Case developed showing sufficient capnographs in the system		May 2014	Business Case	Medical Equipment Group	

12. Dispensing Medication after Patients are Discharged
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 **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 **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. Group consists of Consultants, Service managers and Matrons from each area	Director of Nursing, Midwifery and Patient Services	June 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 Shortlisting for both adult and children's nurses have taken place and interviews are planned for 9th and 13th May 2014. 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	June 2014	Copy of advert Copy of job description VCP confirmation Copy of roster	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	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	June 2014	Protocol	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.	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.	Medical Director	June 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	June 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

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	Clinical Quality and Effectiveness Group	
15.4	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	Evidence in report detailing the impact on patient	Clinical Quality and Effectiveness Group	
15.5	Develop a method of capturing patient experience	A patient transfer leaflet is being developed and will be available for patient and will promote timely feedback	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' Expected to be submitted to the Patient Information Group w/c 5th May 2014	Director of Nursing, Midwifery and Patient Services	May 2014	Draft of Patient leaflet Consultation emails	Clinical Quality and Effectiveness Group	

16. Maternity Labour Ward Entrance

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. 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

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	Medical Director	July 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	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 end of April / first week in May	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.	Medical Director	May 2014	Copy of SOP Ward minutes to demonstrate discussion	Clinical Quality and Effectiveness Group	

18. Emergency Call Alarms

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	June 2014	Completed action plan	Strategic Management Board	

19. Complaints

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 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 - July 2014	Director of Nursing, Midwifery and Patient Services	May 2014	HealthAssure process plan Dissemination to Care Groups/Directorates CQEG reports Directorate Governance Reports	Clinical Quality and Effectiveness Group	
19.2	Progress of all action plans monitored on HealthAssure		Director of Nursing, Midwifery and Patient Services	May 2014		Clinical Quality and Effectiveness Group	
19.3	Ensure all action plans are signed off by the accountable committee in a timely manner		Director of Nursing, Midwifery and Patient Services	June 2014		Clinical Quality and Effectiveness Group	

20. Records **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	Work is taking place with IT to establish a detailed report that can be monitored monthly by both Medical Record Group and the Service Managers	Director of Strategy and Partnerships	April 2014	Copy of audit results as evidence Monitoring	Medical Records Group	

20.4	Book OPAs prior to the 2 day cut-off within medical records. Review utilising Infoview report	Work is taking place with IT to establish a detailed report that can be monitored monthly by both Medical Record Group and the Service Managers	Director of Strategy and Partnerships	April 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	Development of the Web page and also further publicity of the process for requesting notes required in short timescales	Director of Strategy and Partnerships	April 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	Development of the Web page and also further publicity of the process of training. Link with T&D about making tracking of notes a role specific for Admin & Clerical staff.	Director of Strategy and Partnerships	April 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	A risk assessment is being carried out on the lack of porters for the tasks to ensure timely collection of notes.	Director of Strategy and Partnerships	April 2014	Monitoring Evidence	Medical Records Group	
20.8	Stronger monitoring of Datixs by undertaking RCAs and reporting back to all concerned	This is now monitored on a monthly basis and outcomes monitored to establish what the root cause of the unavailability of notes is.	Director of Strategy and Partnerships	April 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
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	This is now addressed by the implementation of stock rotation	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.	Director of Nursing, Midwifery and Patient Services	April 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 **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	Training programme Attendance at training records	Nursing & Midwifery Board	
22.3	Monitoring of compliance via monthly QuEST audits	Awaiting QuEST data	Director of Nursing, Midwifery and Patient Services	May 2014	QuEST audits	Nursing & Midwifery Board	

23. Care Record Templates and Audits **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 **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 **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 **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' Sustained delivery of the 4 hour transit time target Reduced number of patient moves	Trust Board	

27. End of Life Care

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.	The Lead attends Regional and County Wide Steering Group meetings and will disseminate best practice.	Director of Strategy and Partnerships	May 2014	Audit of records	IHGC	
27.2	To lead the implementation of the National Principles replacing the Liverpool Care Pathway.	Clarification awaited around Liverpool Care Pathway or the National Principles	Director of Strategy and Partnerships	June 2014		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 is to be rolled out in May 2014	Director of Strategy and Partnerships	June 2014		IHGC	
27.4	Provide ward based education in relation to DNAR and TEP with respect to End of Life care planning.	Development of initial training compliance by ward	Director of Strategy and Partnerships	June 2014		IHGC	
27.5	Support clinicians to identify patients with unmet needs, ensuring they are referred to the Specialist Palliative Care Team.	Further training available to staff	Director of Strategy and Partnerships	June 2014		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.	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.	Director of Strategy and Partnerships	December 2014	Job description and Job Plan	IHGC	
27.7	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	Identify a specific team of individuals whose responsibility it is for delivering EoLC leadership.	Business case being developed for a dedicated team	Director of Strategy and Partnerships	June 2014		Clinical Quality and Effectiveness Group	
27.9	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	July 2014		Clinical Quality and Effectiveness Group	
27.10	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	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	July 2014		Clinical Quality and Effectiveness Group	

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 Actions point 6 Summary action 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 and monitoring	Mar-14	Completed checklist to be sent and confirmation of how monitored		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 inc 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, Summary ref 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	Audit provided - further audit required		1. Patient Flow\W1.3\W1.3.2 Audit of Taxis		100% compliance	
			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	Medicines Management Committee
											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			
			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	

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
H1.6	CQC High Level Compliance Notice Point 8 Summary action 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 not 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	May-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	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
											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			

Enclosure D

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		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 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, Summary action 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 3. Responsiveness to Care\W3.3\ROM Minutes 11th March 2014 .doc 3. Responsiveness to Care\W3.3\SSDG Minutes 24 April 2014.docx		Appropriate staff are aware and utilised the correct pathway	
			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 & Course outline (planned by end of June 2014)		7. Mandatory Training & Appraisal\7.1\7.1 Mandatory Training NGH-PO-306.pdf	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
											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			
											7. Mandatory Training & Appraisal\7.1\W7.1 review of TNC on the street.msg			
											7. Mandatory Training & Appraisal\7.1\update of TNA and Course outline email 16.6.2014.msg			
			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		Improve numbers of A&C staff	CQEG
											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			
			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			CQEG
											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 %			
											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				External review of OLM/ESR data (McKesson) Reports to CQEG	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. 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		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.docx			
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			

COMPLIANCE UPDATE ACTION PLAN V4

Appendix 1.
1. COMPLIANCE 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				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				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		May 94.6 June >95%					
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
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			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			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			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		Andy Daly		Process for capturing patient experience following ward moves	Jun-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	May-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. COMPLIANCE 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	Jun-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	Jul-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		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	Jun-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.				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?		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. COMPLIANCE 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"	Jun-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	Jun-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	Jun-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				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	Awaiting copy of checklist and confirmation of sign		2. Urgent Care\C2.6\RE CQC evidence - senior nurse checklist and resus trolley.msg			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. COMPLIANCE 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		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			
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
			Matrons must check the stock in their areas to ensure it is in date				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		A process for stock control is established	

3. COMPLIANCE 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
CS3.4	CQC Should point 5, summary action 21	The CQC found food supplements and nutritional drinks were not monitored to ensure consumption within expiry dates.	Ensure nurses responsible for administering these are aware of the need to fully check the labelling including the expiry date before administering to patients.	DoN	Bill Wood / Natalie Green	Chris Ainsworth	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	SAFE - Identify, monitor and manage risks to people who use, work in or visit the service. (outcome 16)		Nursing & Midwifery Board
			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.	Apr-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.		3. Responsiveness to Care\C3.4\Key Information for Huddles - Nutritional Supplements.docx			
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$\Matrons Dashboards\Dashboards 2014-15\Weighing Audits 3. Responsiveness to Care\C3.5\Adult Admission Discharge - ADL Mar 14 NGV1580.pdf	CARING - Patients Care and treatment is delivered in accordance with the care plan to ensure healthy living choices (outcome 4)		Nursing & Midwifery Board
			Provision of extensive training by the practice development team for the whole Admissions & Discharge documentation		Bill Wood / Natalie Green		Training programme Attendance at training records	May-14	The Practice Development Team disseminated the reviewed nursing documentation on 25th April to all the adult inpatient wards. Prior to this the ward sisters were sent details of the reviewed documents and copies to share with their staff during daily huddles and ward meetings in preparation. The on call sisters and night practitioners were requested to speak to staff and raise any issues with the PD team – none received. The PD team are keeping a log of staff who have been spoken to in respect of the revised documentation. Details of contact numbers were left with the wards if they had any concerns of questions The PD Team went out again on the 30th April to all the wards to speak with staff.		3. Responsiveness to Care\C3.5\Evidence regards new nursing documentation (3).docx			
			Monitoring of compliance via monthly QuEST audits				QuEST	May-14	Awaiting QuEST data		\\srv-filer-001\Nursing_Indicators$\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			

3. COMPLIANCE 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
CS3.8	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. COMPLIANCE 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	Mar-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		4. Medical Equipment\CM4.1\NORTHAMPTON GENERAL HOSPITAL MEDICAL DEVICE MAINTENANCE KEY PERFORMANCE INDICATORS.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)	Properly maintained and safe for use	Medical Equipment group
											4. Medical Equipment\CM4.1\Document 4 - Context of Medical Equipment Maintenance.docx			
			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		Trust are aware of which equipment has not been tested and plans are in place to rectify and omit the risk	
											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			
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	Sue Cross		May-14	Emailed information from Jeremy Stone		4. Medical Equipment\CM4.2\FW Capnographs email MW 17.4.2014.msg	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
			Where a shortfall is identified, carry out a risk assessment for inclusion on Risk Register					May-14	Managed and monitored through the risk register		see Datix for information			
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	Jun-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.			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. COMPLIANCE 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	Jul-14	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		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					
			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					
			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	May-14	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.		5. Governance\C5.2\SOP - 10 Standing Agenda.doc			
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			

COMPLIANCE UPDATE ACTION PLAN V4

5. COMPLIANCE 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
			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 Progress of all action plans monitored on HealthAssure Ensure all action plans are signed off by the accountable committee in a timely manner	DoN	Lisa Cooper	Chris Ainsworth	HealthAssure process plan Dissemination to Care Groups / Directorates CQEG reports Directorate Governance Reports	May-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		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

6. COMPLIANCE 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		End of life Strategy Group / IHCG
								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		
									Add as a rolling quarterly agenda item to the End Of Life Risk Strategy Group to ensure compliance is monitored after quarterly submission				
									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 to be provided				
									Ensure Core compliance of training is 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				
									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		
									Monitoring of compliance to be reviewed at EOLSG		6. End of Life\C6.1\6.1.3 Training compliance\EOL Strat Group 6th May 2014.docx		
			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 Screening tool post safety huddles	June 2014	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 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		
									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		6. End of Life\C6.1\6.1.4 Clinical safety huddles\Mac Spec		
		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.				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 COC action plan		6. End of Life\C6.2\6.2.2 EOL Strat Group 6th May 2014.docx		

6. COMPLIANCE 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			DoS&P	Liz Summers	Sue Cross	Plan		Group delivering the CQC action plan. Business Case submitted to CCG for identification of funding		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 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		End of life Strategy Group / IHCG
											6. End of Life\C6.3\6.3.1 Business case for SPC CNS Version 2.doc		
							Job plan and description for Speculative Palliative Care Nurse Appraisal documentation		Job plan etc will not be produced until go ahead for funding has been established				
							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 Presentation to Matrons and Sisters in June 2014 (awaiting minutes) Newsletters circulated twice a year Macmillan meetings monthly		6. End of Life\C6.3\6.3 High level meetings		
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 Strategic Management Board / CQEG				Minutes of meetings where this has been discussed		CQEG and SMB reporting				
			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 circulated for consultation April 2014		6. End of Life\C6.4\C6.4.3 EOL Annual Work plan		
		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				Increase in the use of the LCP in May and June	Jul-14	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		
									Amber care pathway Heat Map		6. End of Life\C6.5\Amber Care Bundle- Final Report- v11 (2).pdf		
									Reporting of results?				

6. COMPLIANCE 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	summary outcome 27		Liaise with the Countywide group to develop guidelines based on the National Principles for End of Life Care	DoS&P	Liz Summers	Sue Cross	County wide guidelines for Care of the Dying	Jul-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		End of life Strategy Group / IHCG
									Learning and development of Junior Doctors and Registrars understanding of the End of Life process - Currently being escalated to EOLSG as still an issue				
							Local EOL process developed	Jul-14	Local tool developed for use after 14th July onwards - Risk Assessment of withdrawal of national tool completed				
									Task and finish group developed for new process				
									Care plan developed and circulated for consultation				
			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 booket. App 7.pdf		
									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				
									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		
									Reporting results from Audits				
			Review Trust policy to ensure it reflects current practice				Six monthly real time audit built into the Clinical Audit Programme across the Trust	Jun-14	New End of Life Strategy is currently out for consultation and incorporates an update of current practice etc.		6. End of Life\C6.5\End of Life Strategy Review		
								Jul-14	EOL Policy to be updated to reflect the new local care tool that is being developed				
								Sep-14	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	Jun-14	Discussions have taken place with Dr Riley however no formal SLA as no funding available. Is there any evidence of a courtesy agreement				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				
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				
			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		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)				
			Prevent the movement of patients at End of Life unless in their best interest					Jan-15	Ward huddles information and movement - awaiting further assurance of info from Wendy Smith when meeting		6. End of Life\C6.7\Ward Huddles		

6. COMPLIANCE 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
									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				
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)		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 - WS is chasing Karin currently. A discussion has taken place at NMB		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 and is currently with MOC for approval prior to PIG & Med Illustrations				
			Palliative opioid management to be incorporated into medicine administration assessments										
			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				

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.					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	May-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
			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	Jul-14	Reduced number of records awaiting collection in departments. Proposal to be developed and submitted to the HRG for approval 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.					Health Records Committee
			Stronger monitoring of Datixs by undertaking RCAs and reporting back to all concerned		Tracey Harris		Process for Medical Records to monitor Datix Reports / Minutes	Apr-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		Chris Ainsworth							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									
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	May-14			9. Workforce. Leadership\C9.2\Head of Mid 9. Workforce. Leadership\C9.2\Visibility Plar 9. Workforce. Leadership\C9.2\Lead Nurse \ 9. Workforce. Leadership\C9.2\Lead Nurse \		Nursing & Midwifery Board
			Develop visibility plan for Execs and Non Execs	COO	COO	Simon Hawes		Jun-14			9. Workforce. Leadership\C9.2\TRUST BOAR 9. Workforce. Leadership\C9.2\ward visit boardv1.pptx		
			Develop visibility plan for Senior Managers										
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 2.	DoN		Chris Ainsworth							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	Jo Dilley	Simon Hawes	Risk Assessment	Jun-14			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		Caroline Corkerry							IHCG
			Business case to be developed to meet any shortfall identified										
			Annual consultant job plan to ensure 24 hour on call Consultant cover										

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Medical Directors Quality Report
Agenda item	8
Sponsoring Director	Dr Mike Wilkinson, Interim Medical Director
Author(s) of Report	Dr Natasha Robinson, Associate Medical Director Mrs Christine Ainsworth, Senior Quality, Risk & Litigation Manager Mr Sean McGarvey, Head of Information and Data Quality
Purpose	Assurance

Executive summary

- Due to public concerns regarding the use of 'big data' derived from healthcare sources, HSCIC has delayed its transfer of SUS data to Dr Foster and there is therefore no further update since the previous report
- The latest Trustwide notes review looking at deaths in June 2013 is attached as an appendix. This reveals a number of areas previously identified and has been fed back to the Patient Safety Academy
- The next review looking at December 2103 has now commenced
- 12 new Serious Incidents were reported & 10 were submitted for closure
- There were no requests for extensions and all Serious Incident reports were submitted within the 45 day timeframe
- All action plans produced during the reporting period have been reviewed by the Serious Incident Group and uploaded to HealthAssure. Actions are being monitored by the Care Group Governance Managers

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
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**

Enclosure E

	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 contract.

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
26 June 2014

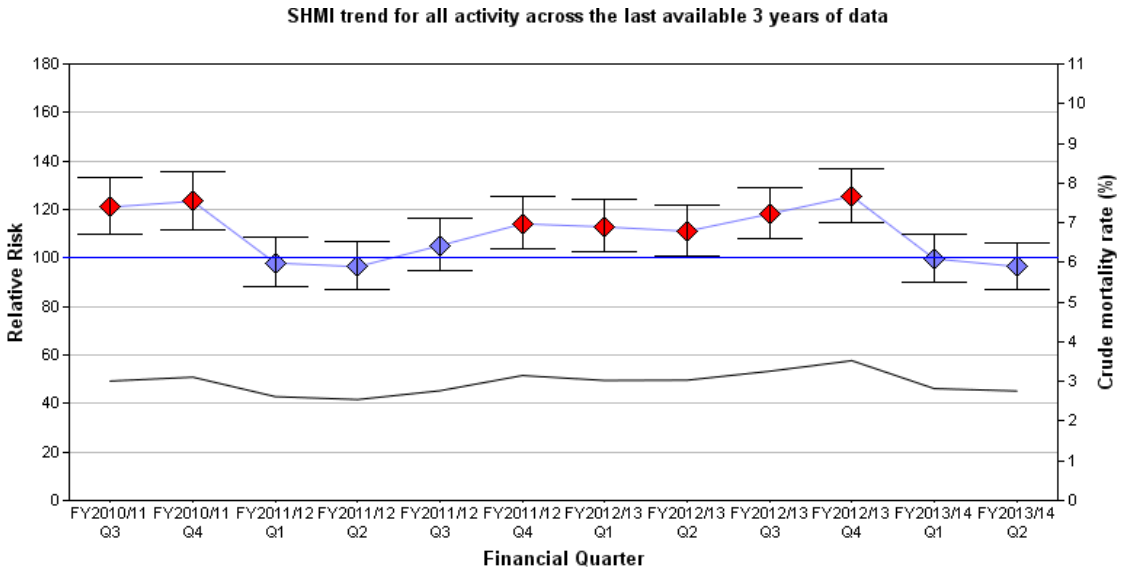
Medical Director's Quality Report

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

Due to public concerns regarding the use of 'big data' derived from healthcare sources, Health and Social Care Information Centre (HSCIC) has delayed its transfer of SUS data to Dr Foster and there is therefore no further update since the previous report. The next update is expected to take place as normal, and is due 1 July 2014 when it will update 2 months [March and April 2014].

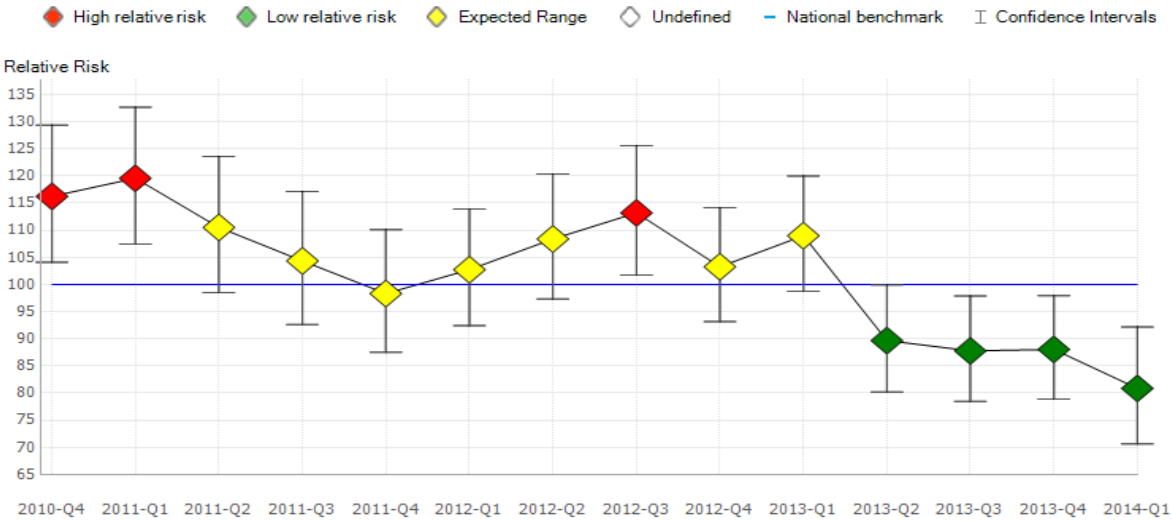
2. Standardised Hospital Mortality Indicator (SHMI)

The previous month's SHMI data release has now been made available to Dr Foster, enabling quarterly progress to be tracked. SHMI for Q2 2013-2014 was **96,** and is expected to remain at approximately that level in the next 2 quarters based on the assumption that it will track Hospital Standardised Hospital Mortality Ratio (HSMR) 100 [see below]. The reason for this very significant change from the previous year is not clear, and has also occurred previously in 2011. Improvements in areas such as stroke and hip fracture can be attributed to changes in care delivery and will have contributed, but this does not account for the magnitude of the overall fall in mortality. The possibility must therefore exist that it will increase again without an obvious cause.



Enclosure E

HSMR 100



3. 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.

4. Trustwide Notes review

The final report following the Trustwide notes review (50 deaths in July 2013) is included with this report as an appendix. This is in summary form to avoid possible identification of individual doctors and patients. Themes identified include some of those noted in previous reports, and include:

- Organisation and quality of content of the notes is still problematic and also makes clinical coding difficult
- The majority of patients who die present without contacting primary care
- Inappropriate admission of patients at end of life continues
- Analysing and learning from deaths occurring in A&E is more difficult [new]
- Early consultant review and diagnosis is important in ensuring prompt treatment
- Discontinuity of consultant care may potentially adversely affect patient care
- There is good evidence of interdisciplinary and multidisciplinary working in some areas [eg Stroke]
- Prescribing in the elderly has additional risks

Due to the small sample size no robust conclusions can be drawn about trends in standards of care.

The findings will be looked at in detail by the Patient Safety Academy to inform projects over the coming year. The summary report will be received by the CCG, and widely distributed within the Trust for discussion at directorate/specialty level.

The next review [50 deaths in December 2013] has started and includes senior nurses, trainee and specialty doctors, and 20 consultant volunteers across all specialties.

5. Specialty Mortality and Morbidity Review

In accordance with the 2014-2015 CQUIN requirements, a programme of mortality review meetings is being developed across all specialties. Terms of Reference for meetings are being finalised and agreed with CCG to ensure a structured approach to case note review and identification of learning points. This is already well established in those directorates with <5 deaths/month, but in the Directorate of Medicine the large numbers [average 75/month] mean developing a different approach. The emphasis in all areas is on case review, presentation, challenge and learning points. It is planned to collect information centrally from all specialties to understand trends and identify themes. The biannual review of 50 deaths will provide some quality assurance of the directorate process.

6. Consultant Outcomes Publication

Following last year's pilot publication by NHS England of consultant outcomes in 10 clinical specialties, the scope has been increased to include additional elective orthopaedic procedures, urogynaecology, lung cancer treatment [and also specialties not provided at NGH]. All consultants at NGH whose data was available through the national audit programmes [the source of the information] had performance outcomes within the expected range in 2013, but there was a considerable amount of work required to validate the data and ensure correct attribution of cases. It is likely that this will be the case again this year but perhaps to a lesser extent as awareness of the importance of accurate data collection is increasing in all areas. The data validation period closes on 14 August 2014.

7. Serious Incident Review

Within the reporting period 01 – 30 April 2014, 12 new Serious Incidents have been reported.

The following table illustrates the Serious Incidents by Datix category:

Category	Number	Comments
Implementation of care	9	9 x Hospital acquired Pressure Ulcers, all of which occurred in April. The investigation(s) will determine whether the pressure ulcers are avoidable or unavoidable
Accident which may result in personal injury	2	1 x Fractured neck of femur – which occurred in March 1 x Fractured ankle - which occurred in April
Diagnosis, failed or delayed	1	Unexpected admission of maternity patient to ITU

Closed Serious Incidents
During the reporting period at total of 10 incidents were submitted to Nene and Corby Clinical Commissioning Group for closure as follows:

- 6 x Grade 3 Pressure ulcers deemed to be avoidable
- 3 x Grade 3 Pressure ulcers - The investigation found that the pressure ulcers were unavoidable and have therefore requested that the incidents be downgraded
- 1 X Fractured neck of femur

Active Serious Incidents
As at 30 April 2014 there were 27 on-going Serious Incidents investigations underway.

STEIS Extension Submission Requests
During the reporting period the Trust did not request any extensions and 0 Serious Incident Reports were submitted in breach of the 45 day timeframe.

Key Learning and Service Improvements
The systematic investigation of Serious Incidents results in important lessons being learned and improvements identified and implemented. These improvements support the embedding of an effective safety culture thus allowing the delivery of high quality, safe patient care.

Lessons learnt from submitted Serious Incidents will be shared at the Ward, Directorate and Care Group Governance Meetings and assurance that this has happened will be sought in the Directorate quarterly reports to CQEG.

Appendix 1

Mortality Case Note Review of 50 Consecutive Adult Deaths in July 2013

Introduction
Over the last 12 months, the focus of external regulators such as the Care Quality Commission (CQC) and Trust Development Authority (TDA) has been on strengthening mortality reviews. For 2014/15, Morbidity and Mortality Reviews will be the subject of a local CQUIN (at Directorate and Trustwide level).

This summary looks at a Trustwide review of 50 consecutive adult deaths in July 2013 and compares the findings to previous similar reviews carried out in 2011 and 2012. The team of reviewers was made up of 12 Consultants from a variety of specialties and 2 Specialty Doctors. Each reviewer was asked to review up to 4 sets of notes and attend a minimum of 2 meetings to present and discuss their cases. A standard dataset was completed and the data from all 50 completed proforma both quantitative and qualitative was collated to form the report. For the first time, some deaths in the Emergency Department were included (as this review was looking at care provided by NGH, out of hospital arrests were generally excluded unless the patient had recently been seen in the ED or recently discharged).

Aim

- **To provide a Trustwide forum for identification of learning from Mortality Case Note Review**

Objectives

1. To engage clinicians across the Trust in mortality review
2. To provide a forum for discussion of examples of notable care
3. To identify themes surrounding failures in care
4. To identify preventable deaths
5. To identify issues with clinical coding and hospital documentation
6. To identify and share areas for learning across the Trust

Demographic Results

	2013	2012	2011
Number of cases reviewed	50	50	222
Age range	31-99	39-98	35-99
Median Age	81 years	81 years	84 years
Gender	66% Male: 34% Female	54% Male:46% Female	48% Male:52% Female
Admitting Team (General Medicine)	64%	76%	76%

Objective 1 – To engage clinicians across the Trust in mortality Review:
The reviewing team was made up of a mixture of experienced reviewers (who had been part of the team on previous occasions) and new reviewers. A wide variety of specialties were represented including surgery, gynaecology, haematology, oncology, paediatrics, radiology, anaesthetics and ITU. Unfortunately there were no reviewers from the emergency department or medicine. Those who took part were very positive about the benefits of the review both in identifying learning points and improving their own case note review skills. As has been found previously, most reviewers were keen to take part again.

Objective 2 - To provide a forum for discussion of examples of notable care:
In 62% of admissions, at least one example of notable care was highlighted. Common reasons for the care being noted as very good were:

- Good documentation [16]
- Good discussion with the patient and/ or family and carers [12]
- Excellent input from either general or specialty consultant [9]
- Good initial assessment/ clear management plan [7]
- Good provision of end of life care either by admitting team or specialist palliative care team [2]

	2013	**2012**	**2011**
Care suitable for reviewers own family	72%	74%	78%

Objective 3 - To identify themes surrounding failures in care:

	2013	**2012**	**2011**
Failure to plan	32%	32%	21%
Failure to rescue	8%	10%	5%
Failure to communicate	16%	18%	8%

There is some overlap between the three categories and what constitutes failure in each category. The main examples for each category are shown below:

Failure to Plan	**Failure to Rescue**	**Failure to Communicate**
Failure to make a clear diagnosis or consider differential diagnosis	Failure to follow EWS protocol	Failure of discharge planning on previous admission
Failure to investigate fully on admission or follow up the results of investigations done on admission	Failure to request senior review when patient was deteriorating	General lack of communication between teams or members of a team
Delay in senior review		Failure of appropriate communication with surgical on call team
Failure to plan appropriate treatment		

Objective 4 - To identify preventable deaths:
The following classification was used to identify suboptimal care and therefore preventable deaths:

Suboptimal Care Question 2013 (n=50)	Number of patients	Percentage
No suboptimal care (grade 0)	31	**92%**
Suboptimal care identified but death not avoidable (grade 1)	15	
Possibly preventable death (grade 2)	4	**8%**
Probably preventable death (grade 3)	0	

	2013	2012	2011
Optimal Care Question (grade 2+3)	4 (8%)	3 (6%)	13 (5.9%)

4 deaths were identified as possibly preventable (grade 2). This is highly subjective and in at least 1 case may simply reflect the lack of notes available for review which made it impossible to follow the decision making process. 2 others were very elderly with significant comorbidities and although suboptimal care was identified, it is very likely that the deaths could not have been prevented.

This accounts for 8% of deaths reviewed but it is important to note that the change in percentage between 2012 and 2013 only represents 1 extra possibly preventable death. No grade 3 (probably preventable deaths) were identified.

Objective 5 - To identify issues with clinical coding and hospital documentation:
Clinical coding was reviewed alongside the clinical care. Coding of deaths is complex and is made more difficult if the notes are not clear, if the admission is very short or if there are multiple transfers of care between consultants. There was a very clear improvement in the quality of the coding between 2011 and 2012 with a reduction in the number of cases requiring recoding from 38% to 22% (primary code). In addition, between 2011 and 2012 the accuracy of secondary coding (comorbidities) improved with only 28% in 2012 requiring further additions compared to 56% in 2011. This improvement was sustained in 2013 however further improvement was not demonstrated.

Objective 6 - To identify and share areas for learning across the Trust
Reviewers were asked to identify any learning points for sharing across the Trust.

Category	Learning
Documentation	• Stickers are very useful if they are completed fully. • Junior doctors are now regularly recording GMC number but consultants are still not doing this very often. • Badly organised, incomplete notes make it difficult to follow the course of events and be confident that the correct management plan was followed. Poor notes make it difficult to assess the quality of care given. • The admission clerking and examination is vital both for establishing the diagnosis and also for providing information to the clinical coding team.

Category	Learning
	• It is important to review old notes as soon as they become available.
End of Life Care*	• Senior input is vital in the early recognition of dying and provision of good end of life care. • The Liverpool Care Pathway (LCP) was generally well used and gave evidence of good quality end of life care. • Lack of end of life discussions in the community is still leading to inappropriate admissions.
Consultant Review	• Regular consultant review does not guarantee continuity of care. • Delayed consultant review leads to delayed decision making and potentially delayed discharge. • Consultant review is important for reducing delayed or missed diagnoses.
Team work	• Multi-Disciplinary Teams were used well to provide good quality care. • The Stroke team are a model for consultant led care. • Communication between ITU teams and specialty teams was generally very clear from the notes. • Outreach review is helpful but is not a substitute for continued care from the ward team.
Medication	• The dose of paracetamol should be reduced in the frail elderly population. • The use of warfarin in the elderly should be reviewed carefully to ensure the benefits outweigh the possible complications.
Investigations	• Investigations that are requested must be followed up to ensure they are done in a timely manner and that the results are reviewed and documented clearly in the notes.
Coding	• The coding can only reflect what is documented in the notes. • Consider a weekly summary for long admissions.
Miscellaneous	• Pressure sores can develop very quickly so it is important to consider this complication as soon as the patient is admitted. • Nutrition in the elderly is very important to consider and often overlooked. • NGH does not have enough High Dependency Unit beds.
Avoidable Admissions	• Patients self-presenting to A&E without apparently contacting primary care first is still an issue. • Better end of life care planning in the community is needed to try and reduce acute admissions (particularly admissions at end of life from nursing homes). • Community teams do not pick up or respond to all patients in a timely manner therefore precipitating unnecessary emergency admissions (eg ICT, Heart Failure Team).

Category	Learning
Deaths in the Emergency Department	• This is an important group for review but for the majority, the review of the hospital notes only helps in understanding a small part of episode. Information from primary care will be vital in enhancing the review of this group of patients.
Post Mortem Rates	• Post mortem rate remains constant and lower than the team felt was desirable at 14%.

*There was a fall in the use of the LCP in July 2013. The dates for patient selection for this review coincide with the publication of the report on the use of the LCP and recommendation that it should be phased out. It is therefore not surprising that there was confusion over the use of the LCP amongst relatives and carers and that although NGH policy was to continue to use the LCP until the replacement standards had been agreed, it was clear that relatives and carers did not always agree to this. Comments were made by reviewers that when the LCP was used, the quality of end of life care was good and worry was expressed that without the framework, it was more difficult to deliver all aspects of end of life care and also to make an assessment of the quality of care delivered.

What next?

- Learning from this review will be shared with:
    - Trust Board
    - Clinical Commissioning Group (as part of CQUIN for 2014/15)
    - Patient Safety Academy (to form part of the Patient Safety Work Stream)
    - Clinical Directors
    - Governance Leads (for discussion at directorate/ departmental governance meetings)
    - Governance Managers and Facilitators

- Identify volunteers from Medicine and ED to take part in the next round.
- Extend the review group to include senior nurses and doctors of all grades.
- Repeat the review in June/ July 2014 for 50 consecutive adult deaths from December 2013.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

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

Executive summary

This report provides a detailed update on a number of clinical projects and improvement strategies that the nursing & midwifery team are working upon. It is proposed that a shortened version of this report, that gives an overview of the key quality standards, will be shared on the Trusts website as part of the Open & Honest Care report that will include the Trusts data for our 'Hard Truths' commitment.

Key points from this report:

- N&M Quality Dashboard (QuEST) shows a slight reduction in overall achievement this month of 79% against 83% last month. Due to the timeliness of the data further analysis is required to understand the detail behind this reduction. The N&M Quality dashboard is not available for this report this month, due to the timeframe for submission.
- Hard Truths staffing data has been submitted. This demonstrates the planned versus actual staffing on the wards during May. The registered staff were under the planned number of staff on all three shifts (Early, Late & Night) by 3-8%. The non-registered staff (HCA/MSW) were over the planned number of staff on all three shifts by 3-25%.
- Although extensive work continues there has 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 has not been achieved, we reported 11 avoidable grade 2 pressure ulcers against a target of 7.25, grade 3 pressure ulcers reported equated to 6 avoidable against a target of 3. There has been a decrease in the number of Grade 3 pressure ulcers and a greater percentage of the pressure ulcers identified are 'device related'. The Lead Tissue Viability Nurse is due to present the recent thematic review and on-going action plan that the Committee are asked to consider and support further initiatives planned.
- March reviewed data: FFT Decrease in the inpatient response rate from **47.81%** to **36.05%**
- March reviewed data: FFT Increase in the A&E response rate from **11.62%** to **11.87%**
- March reviewed data: FFT Decrease in the inpatient NPS from **74** to **69**
- March reviewed data: FFT Decrease in the A&E NPS from **63** to **59**
- April FFT: A&E obtained a response rate of **16.6%** - this is largely attributed to the high re-sponse rates seen in Eye Casualty (32.49%) and Ambulatory Care (42.40%) as A&E on their own had a response rate of 12.78%
- April FFT: Inpatients achieved a response rate of **33.27%** against a target of 25%
- 'Sleep Well' Campaign initiated to support patients with sleeping at night time. Eye masks and ear plugs being piloted on 4 inpatient wards.
- 'Ticket Home' project initiated with tickets first phase roll out to the assessment wards planned

Enclosure F

within coming weeks

- There have been 6 C. Difficile cases this year; this is above our monthly internal stretch target but within our national annual target of 35.
- National guidance has been published on the management of carbapenemase-producing Enterobacteriaceae (CPE), an action plan in response to the guidance has been prepared by the Infection Prevention & Control team.
- There has been a positive reduction in the number of falls/1000 bed days within the month, however the completion of paperwork associated with the re-assessment and on-going care of patients at risk of falling has deteriorated.
- The use of the Learning Disability Hospital Passport has been extended to Paediatric services addressing a concern raised through our recent CQC visit.
- Safety Climate Questionnaire for April has provided a baseline for future improvements

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 Board is asked to:

- discuss and where appropriate challenge the content of this report and to support the work moving forward, in particular the presentation by the Lead Tissue Viability Nurse
- support the publication of the Open & Honest Care Report on to the Trusts website which will include safety, staffing and improvement data

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26 June 2014

Director of Nursing & Midwifery Care Report

1. Introduction

The Nursing & Midwifery Care Report presents highlights from our key projects during the month of May and a quarterly update from our safeguarding and professional & practice development and safety team.

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 new '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 'Hard Truths' update (see section 3.0).

2. Body of Report

Nursing & Midwifery Quality Dashboard

The N&M 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 N&M Quality Dashboard for this month is not presented due to the timeliness of this report. The corporate nursing team are in the process of reviewing all the dash boards for nursing & midwifery as part of a wider review to refine and provide greater assurance to the Committee.

2.1 Nursing & Midwifery Quality Dashboard – Summary

The QuEST summary demonstrates an overall score of 79% for the wards. This is deterioration from April's data of 4%. Interestingly there was a drop in the scores when the last 'quarterly' QuEST was undertaken, this may be due to the external auditors who undertake the quarterly QuEST audit who may not be familiar with the tool. However, due to the timeliness of the data for this report further analysis will be undertaken to understand these issues. Allebone ward have recorded their highest score since the new audit in October began. Benham ward have seen a drop in their scores this month that will be investigated.

Enclosure F

Ward Names	Oct-2013	Nov-2013	Dec-2013	Jan-2014	Feb-2014	Mar-2014	Apr-2014	May-2014
Allebone	68%	61%	61%	71%	57%	69%	71%	76%
Becket	78%	78%	78%	79%	91%	94%	82%	83%
Benham	66%	75%	79%	84%	83%	91%	85%	65%
Brampton	78%	88%	82%	89%	81%	83%	95%	85%
Collingtree	68%	74%	76%	82%	72%	82%	91%	81%
Compton	82%	86%	86%	87%	90%	90%	82%	85%
Creaton	73%	68%	75%	87%	80%	86%	86%	88%
Dryden	68%	71%	78%	76%	76%	85%	84%	83%
EAU	69%	71%	79%	72%	71%	78%	86%	81%
Eleanor	72%	79%	81%	84%	76%	78%	91%	83%
Finedon	61%	81%	79%	85%	84%	83%	93%	77%
Knightley	73%	83%	74%	82%	86%	85%	93%	80%
Holcot	74%	78%	82%	79%	82%	82%	86%	79%
Victoria	69%	71%	83%	90%	85%	88%	78%	81%
Talbot Butler	65%	73%	79%	79%	89%	85%	87%	83%
Rowan	61%	75%	75%	62%	82%	88%	93%	85%
Willow	65%	73%	78%	73%	79%	86%	89%	77%
Head & Neck	76%	75%	85%	89%	85%	89%	93%	91%
Spencer	68%	70%	81%	87%	92%	94%	87%	81%
Abington	69%	59%	76%	77%	84%	96%	87%	83%
Cedar	53%	76%	79%	82%	81%	78%	86%	89%
Althorp	76%	84%	92%	93%	90%	83%	94%	88%
Hawthorn	61%	74%	81%	83%	90%	90%	77%	83%
General Wards	77%	74%	76%	82%	79%	84%	83%	79%

* The data is continually being validated / updated and may therefore be subject to slight change

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. June was the first month the Trust submitted data to NHS England and the Trust exceeded the revised submission date. The data submitted was for the month of May 2014 and there have been a number of challenges to provide the relevant information. It has been a very 'labour-intensive' process that we hope will improve over time but an electronic solution, that complements our current e-roster system, is being explored. 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.

During this month our 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.

Due to the timeliness of this report a summary of the planned and actual staffing data is presented in appendix 1. In the future further analysis will be provided.

In summary:

Early Shift

Across the month 97% of the planned registered staff levels were achieved. For non-registered staff (HCA & MSW) there was an increase above the planned number of 6%. The additional shifts were for 'specials', vacancies, escalation areas and short term sickness.

Late Shift

Across the month 92% of the planned registered staff levels were achieved on the late shift. For non-registered staff (HCA & MSW) there was an increase above the planned number by 3%. This was due to 'specials', vacancies, escalation areas and short term sickness.

Night Shift
Across the month 97% of the planned registered staff levels were achieved on the night shift. For non-registered staff (HCA & MSW) there was an increase of 25%. The additional shifts were again for 'specials', vacancies, escalation areas and short term sickness.

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 in place.

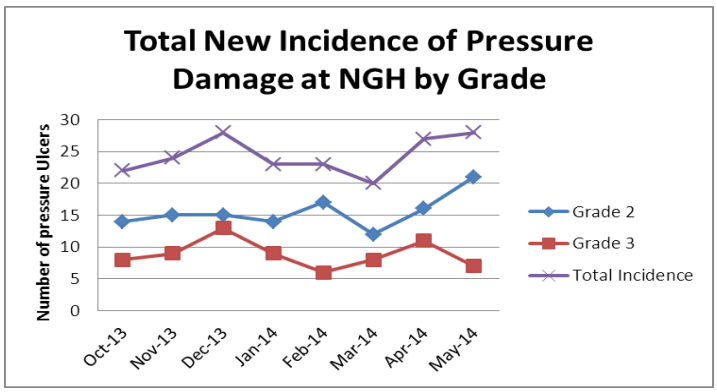
In May 93% of patients did not experience any of the four harms in this Trust which is comparable to the national average. The Trust is particularly focusing on the reduction of catheter-related urinary tract infections and pressure ulcers (see section 5.0).

Catheter-related Urinary Tract Infections: Four patients across the Trust experienced a catheter-related urinary tract infection in May which is one patient more than the national average. There is continued work to implement our new urinary catheter care plan, pilot the RCA tool and update our Link nurses to support the ward staff education programme. The action plan is monitored through the Safety Thermometer Strategy group and is reported to Nursing & Midwifery Board.

5. Pressure Ulcer Prevention

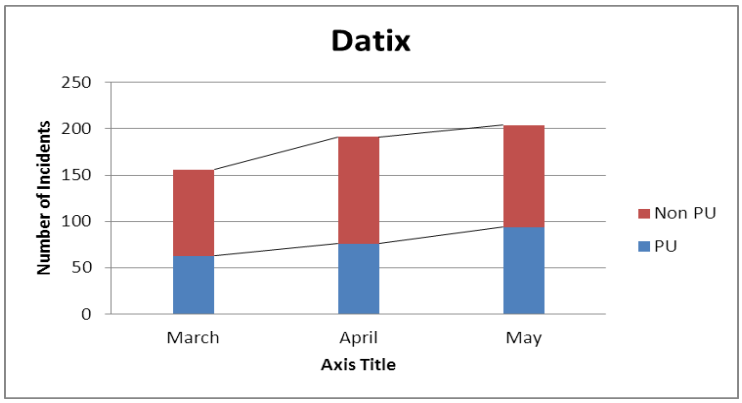
In May 28 new hospital acquired pressure ulcers (HAPU)'s were validated (fig 1). Of these 21 were validated as Grade 2 and 7 Grade 3/Grade 3 unclassified. It is interesting to note that of the 28 HAPU's 13, just under half were reported within the last week of the month. Further analysis of potential bank & agency increase, during this period, will be reviewed to understand this increase.

Fig 1



From an analysis of all datix (pressure ulcers including Grade 1, moisture lesions, duplications etc.) submissions over the last 3 months (fig 2), there has been a 25% increase in the number of incidents reported. The increase is also apparent in the number of pressure ulcers reported, this included both hospital acquired and those inherited to the Trust. The Tissue Viability Team issued wards with stickers in March to assist with documentation of all areas vulnerable to pressure ulcers and it is believed this has contributed to the increase in reporting as this has resulted in a more comprehensive and timely re-assessment of skin integrity.

Figure 2



Since the introduction of the documentation stickers the number of Device Related Pressure Ulcers (DRPU) has also increased. Of the 28 pressure ulcers reported 10 were device related. Prior to their introduction DRPU's were reported only by critical care, only 3 of the 10 ulcers occurred in critical care.

Fig 3

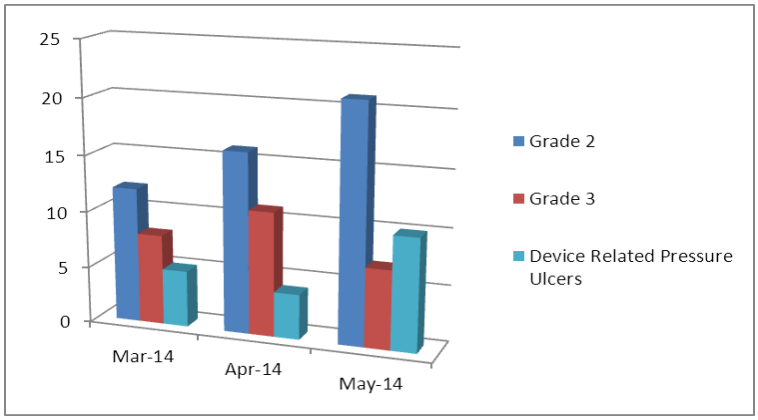
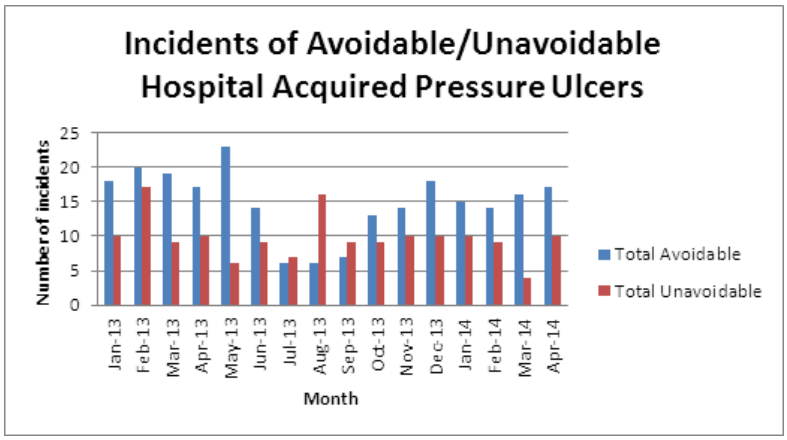


Figure 4



The RCA process –The RCA process is heavily scrutinised by the Tissue Viability Team at the Confirm and Challenge meetings held monthly, with Matron, Ward Sisters, and Lead Nurses. However, with the renewed focus on 'Back to Basics' there will be a revised accountability escalation process for those wards that are repeatedly attending. In view of the large numbers of pressure ulcers it has been agreed that this will now take place twice a month. This will assist with the reporting of outcomes (Avoidable/ Unavoidable) in a more timely and robust way.

5.1 CQUIN Update
The CQUIN target for avoidable Grade 2 (7.25 ulcers) was not met in April, with 11 ulcers identified as avoidable. The target for Grade 3 (3 ulcers) was not met either with 6 ulcers validated as avoidable.

The continued increase in the incidents of pressure ulcers is a safety concern and patient experience issue. It is also a significant risk to the organisation in regards to reputation and achieving CQUIN. It is proposed that through the planned presentation by the Lead Tissue Viability Nurse that the actions identified will improve our patient experience and bring the Trust in line with other organisations regarding the number and severity of the pressure ulcers that are hospital acquired.

6. Health Care Associated Infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions. *Clostridium difficile* (C.difficile) and *Meticillin-Resistant Staphylococcus Aureus* (MRSA) bacteraemia are the most common. C.difficile is a type of bacterial infection that can affect the digestive system, causing diarrhoea, fever and painful abdominal cramps - and sometimes more serious complications. The bacteria does not normally affect healthy people, but because some antibiotics reduce the 'good bacteria' in the gut that protect against C.difficile, people on these antibiotics are at greater risk.

The MRSA bacteria is often carried on the skin and inside the nose and throat. It is a particular problem in hospitals because if it gets into a break in the skin it can cause serious infections and blood poisoning. It is also more difficult to treat than other bacterial infections as it is resistant to a number of widely-used antibiotics

We have a zero tolerance policy to infections and are working towards preventing and reducing them; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough.

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

	C.Difficile	MRSA
Number of infections this month	5	0
Improvement target for year to-date	35	0
Actual to-date	6	0

The Trust takes part in the national surgical site surveillance scheme of over 150 hospitals in England so that it can measure the rates of surgical site wound infection and be sure that patients are given the highest possible standard of care. The data below shows the total operations this month with no infections.

Limb amputation	11
Spinal	5
# Neck of femurs	14
Total hip replacements	22
Total knee replacements	26

The monthly May Beat the Bug; Stop the Clot, Save the Skin remains positive with feedback given at the end of the review in order to support staff to maintain standards. The reviews are still being seen as very positive by the staff on the wards where they have been undertaken and the support of these quality reviews is beneficial.

National Guidance has been published on the management of carbapenemase-producing Enterobacteriaceae (CPE) and in response to this; a plan has been produced for the early detection, management and control of CPE. This plan was presented at the May Infection Prevention Committee for approval and implementation; Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However these organisms are also some of the most common causes of urinary tract, intra-abdominal and bloodstream infections**.**

7. Falls Prevention

We calculate our falls rate 'falls/1000 bed days'. This allows us to monitor improvement over time, but cannot be used to compare us with other hospitals; whose staff may report falls differently and their patients may be more or less vulnerable to falling than our patients. For example other hospitals may have younger or older populations who are more or less mobile or who are receiving treatment for different illnesses.

In May our falls rate reduced from 5.37/1000 bed days to 4.42/1000 bed days
This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause.

This month we reported 4 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	0
Severe	4
Death	0

In order to reduce the risk of someone falling whilst in hospital staff perform a falls risk assessment. In order to monitor improvement, we regularly check patients notes each month to see if this has been completed through our internal QuEST audit process. This month our compliance with undertaking a falls risk assessment within 12 hours of admission was 88.4%. Further analysis is required to understand the QuEST data.

Once patients are deemed at risk of falling staff implement a plan of care to reduce this risk. The percentage of patients who had a care plan where all elements of the plan were implemented was disappointingly 48% which demonstrates poor compliance to documentation. This month's results have been poor and further investigation of the data is required to understand the issues which will be undertaken by our Falls Prevention Specialist.

8.0 Patient Experience
Revised March Friends and Family Test (FFT) Data
It has been identified that the FFT data provided to us by our external company was inaccurate for March. A full investigation into the data has been carried out by the Information Team and has highlighted an over reporting by the external company of 372 entries. This data was reported to the DoH through the UNIFY and action is now being taken to resubmit our revised position.

The change in the data does have a large impact on the response rates and score and earlier reported data in April should be dismissed with the revised data shown in. Although the change in the response rate led to the Trust achieving below the required 20%, the CQUIN is assessed as an overall monthly position for which the Trust had a response rate of **20.10%** meaning the CQUIN would still have been attained.

In summary:

- Decrease in the inpatient response rate from **47.81%** to **36.05%**
- Increase in the A&E response rate from **11.62%** to **11.87%**
- Decrease in the inpatient NPS from **74** to **69**
- Decrease in the A&E NPS from **63** to **59**

A further quality check has been implemented to ensure the data being received in the future is accurate.

April's FFT data
Response Rates:
Response rate national targets for Quarter 1 are:

Inpatient Services = 25%
A&E (inc Ambulatory care and Eye Casualty) = 15%

As Maternity do not have a national required target discussions with the service have identified the following internal targets;

Labour Ward/Birth Centre/MOW/Robert Watson/Balmoral = 25%
Community = 15%
Overall target = 20%

In summary:

- Inpatients achieved a response rate of **33.27%**
- Maternity services obtained a response rate of **36.68%**
- A&E just managed to reach their response rate target obtaining a response rate of **16.6%** - this is largely attributed to the high response rates seen in Eye Casualty (32.49%) and Ambulatory Care (42.40%) as A&E on their own had a response rate of 12.78%
- Day case areas obtained a response rate of **27.19%**
- Paediatrics achieved a response rate of **58.64%**
- 6 Inpatient wards achieved below the 25% target, Allebone, Brampton, Creaton, EAU and Spencer, however of particular concern are **Dryden (2.30%)** and **Victoria (5.13%)**

Net Promoter Scores (NPS)
Previously there have been no targets set for the NPS nationally, with a local target of 80 set internally. Work is currently underway to identify internal targets based on national scores obtained from organisations of a similar size to NGH. If approved, these will be circulated within next month's report.

In summary:

- Inpatient services obtained a score of **71**
- A&E (including Ambulatory Care and Eye Casualty) obtained a score of **57** showing further depreciation , March (59) February (74) January (72)
- Maternity services achieved a score of **80**
- Day case areas achieved a score of **83**
- Paediatrics continue to obtain scores below what is expected internally, obtaining a score of **67** for April

Free-text analysis
As FFT will now be reported a month retrospectively it is possible to provide a monthly breakdown of the positive and negative comments, and the common themes A&E are now considered as 1 department and are not split into Minors and Majors due to the IPads being moved.

Of most significance:

- Inpatient areas had 209 comments, **82.8%** of which were positive and **17%** were negative
- A&E had 108 comments, **88%** of which were positive and **12%** were negative
- Maternity services had 383 comments, **94.3%** were positive and **6%** were negative
- Eye Casualty received 170 comments, **93.5%** were positive and **6%** were negative
- Themes were only deduced from the areas where there was a substantial amount of comments to be able to draw common themes, these were, Inpatients, A&E and Eye Casualty. Themes were not compiled for Maternity as only **22** of the **383** comments were negative and therefore it was not considered that this would be an adequate representation of the service

Improvement Work
'Sleep Well' Campaign:
Noise at night has been identified as a problem for many years within the organisation and most recently the CQC National Inpatient Survey reported NGH as performing as within the 'worse' category for noise at night nationally. In addition to this, CQC within their inspection in January 2014 also highlighted the issues with noise during the night. A number of audits have been carried out over the past 2 years, and improvement work has taken place, such as changing bins the soft closing and ensuring doors do not bang/squeak. However, this has had little impact on the experience of the patient and it is becoming increasingly vital that we look at further ways to improve. What is also becoming evident is that it is not only noise at night time which is an issue, but also the light. For this reason the trust is moving away from just looking at noise, and is now looking at the overall sleep experience.

Many other organisations have faced similar issues, and with hospitals being 24 hour organisations it is evident that a combination of noise reduction and sleeping aids are the best way to help patients. Therefore a working group has been established to take forward the 'Sleep Well' Campaign.

Update

- A Patient Experience questionnaire has been carried out with volunteers attending every inpatient ward and asking an average of 5 patients for their views on key issue areas in the Trust. This included the issues with noise at night. These are in the process of being analysed and results will be reported at a later date. This survey will also act as a baseline for post-implementation evaluation.
- 'Sleep Well' packs are being piloted on 4 wards in the hospital (Allebone, Dryden, Finedon and Abington). These contain an eye mask and a set of ear plugs. They have been purchased from a social enterprise that runs in Leicester and if successful, the aim is to provide these throughout the hospital
- A questionnaire has been issued to night staff asking them for their views on the disturbances on the wards at night time. These are in the process of being analysed but early interpretations suggest staff are concerned with the noise levels from patients that are suffering with dementia/confusion.
- Currently exploring pen torches for nursing staff to use at night time.

Future Plans

- The aim is to create a 'Sleep Well' box for each inpatient ward in the hospital which will contain the 'Sleep Well' packs, a leaflet about night time, pen torches for nurses to use and guidance and expectations policy for staff on their behaviour during the evenings.

'Ticket Home' – improving communication around discharge

The 'Ticket Home' is a project which was initiated in Wales originally and has gone on to have success nationally and internationally. In summary, the Ticket is laminated sign which is placed at the patients' bedside and contains certain information related to their discharge. Of most significance is their 'Planned date of leaving hospital' which is completed the day they arrive in hospital. This is followed by a series of 'Goals' which they have to achieve to be able to go home. This will include such things as 'Physio discharged?', 'Medication arranged'. Results from formative evaluations have shown the Ticket has a significant effect on length of stay. One study found before the ticket home system was introduced average length of stay for hip replacement was 7.4 post-operative days, following the introduced of ticket home this dropped to 4.3 days, equating to a reduction of 3.1 days on average. NGH are planning to roll this out to the assessment wards within the following month, with a phased trust wide implementation after.

The project has been initiated by the care group Director and is being project managed by the patient experience lead and the specialist discharge nurse. A working group has been established including a representative from the Alzheimer's society and from the assessment units.

Assessment of Risk

- Risk of not meeting the CQUIN if A&E does not improve their response rates for the re maining quarter
- Large depreciation in the NPS for A&E over the past two months
- Data quality concerns with the data being provided from the external company for the FFT

9. Safeguarding Update

Following on from the previous quarterly update in May; the general themes in relation to safeguarding remain reasonably static. The work of the Improvement Board continues to drive change within the safeguarding children partnership and NGH as an acute provider plays a significant role in this. As previously reported, the embedding of the Common Assessment Framework [CAF] remains a strategic priority, with considerable emphasis on partner organisations [non council run] to maintain and improve the engagement with this.

As a Trust, NGH has taken a number of steps to support the internal processes around CAF:

- Increased training provision, in a variety of formats
- CAF 'clinics' – facilitated sessions to support completion

In addition, work is being undertaken to ensure that there are robust and appropriate outcome measures available to the Trust to assure the impact of the CAF. It is anticipated that these will be available through the next quarter.

In the coming month the Adult Safeguarding Board will publish a serious case review into the care and treatment of a patient with a Learning Disability. The committee should note that this review is significantly late in publication; the incident occurring in 2011. The Trust has made significant advances in the care provided to patients with a Learning Disability and there are now sufficient processes in place to enable challenges and difficulties to be identified early and proactively managed.

The recent CQC inspection made one recommendation in relation to Learning Disability patients in the paediatric setting. It had been observed by the Commission that 'hospital passports' whilst widely used in other services, were not in use in paediatrics. This has now been rectified. A formal audit of the use of these passports is scheduled for the second quarter of the year, in line with the safeguarding team audit plan to provide robust evidence and assurance.

9.1 Safeguarding – Training Compliance
The Trust is required to ensure that staff are afforded the appropriate training in relation to safeguarding adults, Mental Capacity Act, Prevent, and Safeguarding Children. The latter two are statutory requirements and all four areas are part of the Trust's Quality Schedule.

The current training position is indicated below,

	Level One		Level Two		Level Three	
	April 14	May 14	April 14	May 14	April 14	May 14
Safeguarding Children	95.9%	95.8%	68.7%	68.2%	63.9%	60.6%
Safeguarding Adults	78.2%	79.1%	66.82%	67.9%		
MCA	74.6%	74.6%				
Prevent	60%	60%				

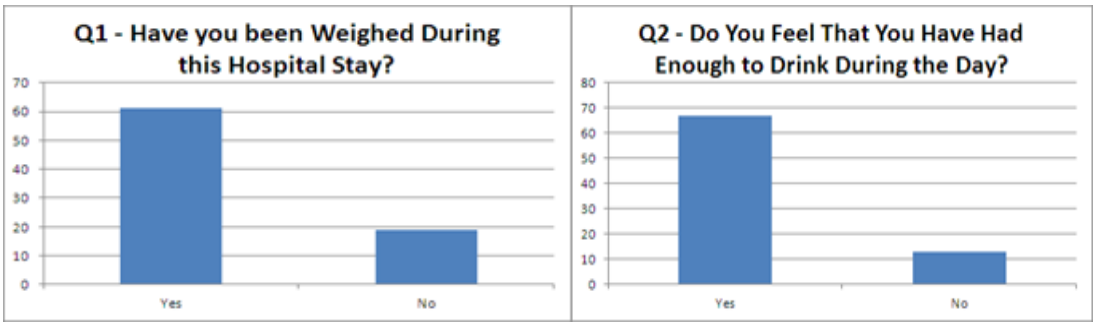
As can be seen by the above figures the training levels remain relatively static; which is unsurprising given the cycle of three yearly renewal on safeguarding training.
Further work is being undertaken to drill into the training data to identify areas for targeted work over the next 6 months to improve on compliance levels.

9.2 Dementia Care – CQUIN Compliance
At the time of the last report, the Trust had achieved 66% of the CQUIN compliance; two of the three months of the final quarter. We are pleased to be able to confirm that the full CQUIN requirement was subsequently met and achieved for 2013/14.

The requirements for the national dementia CQUIN for 2014/15 remain the same in terms of the measures, however for this year; the Trust must achieve the 90% compliance across the three domains on an ongoing monthly basis. At the current position [mid-point month three] we do not have validated first quarter data, however the first two months of the year were successfully achieved.

10. Patient Safety Academy
Safety Champions are the 'eyes & ears' of patient safety within their work area. There are currently 255 safety champions in the Trust.
Safety Champions are asked to complete a safety climate questionnaire bi-monthly. The subject of the questionnaires is chosen to be relevant to any ongoing campaign or pertinent safety issue. The results of the most recent questionnaires will be to support and inform projects to be undertaken by this year's Aspiring to Excellence students and will help inform a future Safety Campaign which will focus on fluids.

10.1 Safety Climate Questionnaire – April 2014
The questionnaire for April was sent to ward based champions asking for five patients in their care to be asked four questions with the following results:



Already with the inception of Weigh day Wednesday the results from Question 1 are greatly improved. The results indicate that most patients feel they had been receiving sufficient fluids. Equally there is clear indication from the results and comments received from the patients questioned that not all are aware of the need for fluid input and output monitoring.

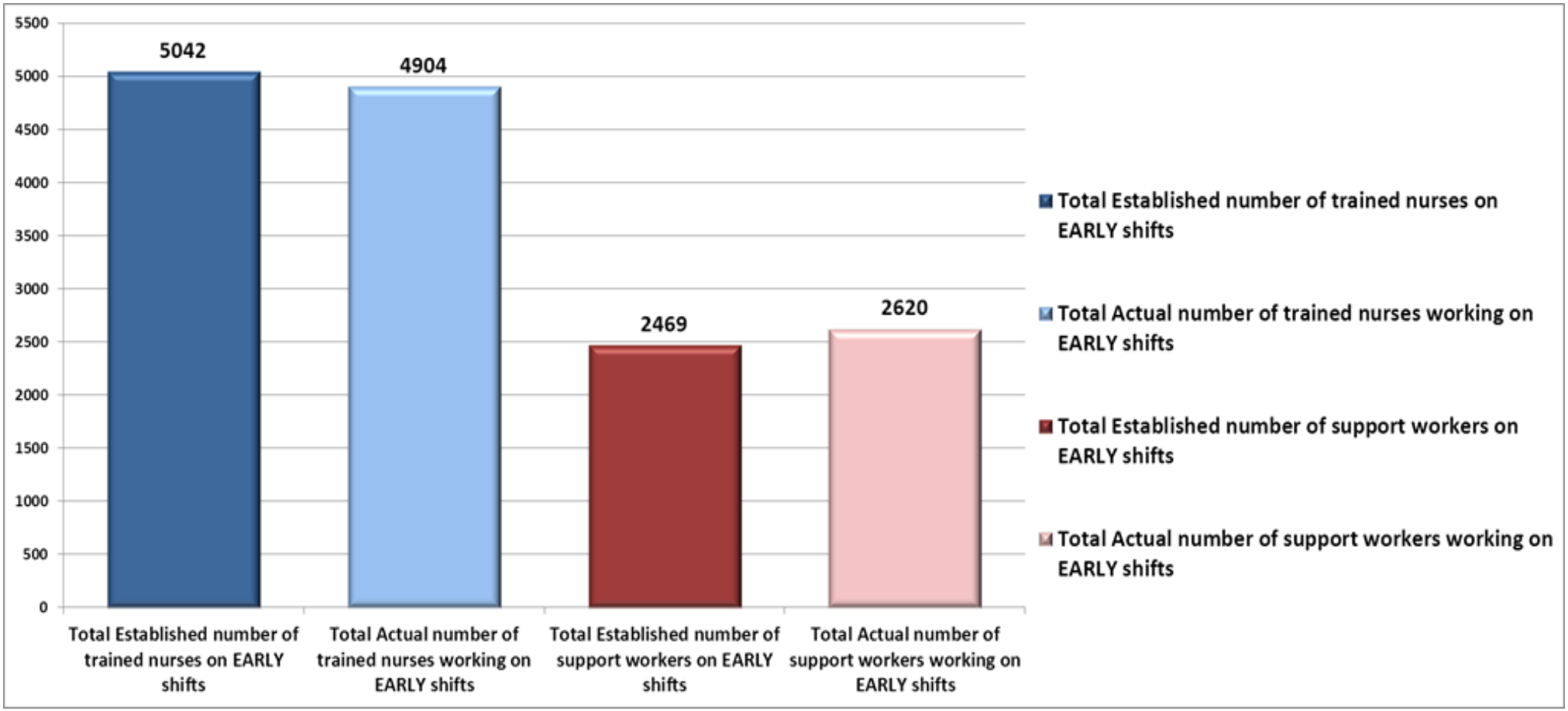
11. Recommendations

The 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.

Appendix 1

WARD STAFFING LEVELS ON EARLY SHIFTS – all inpatient ward areas

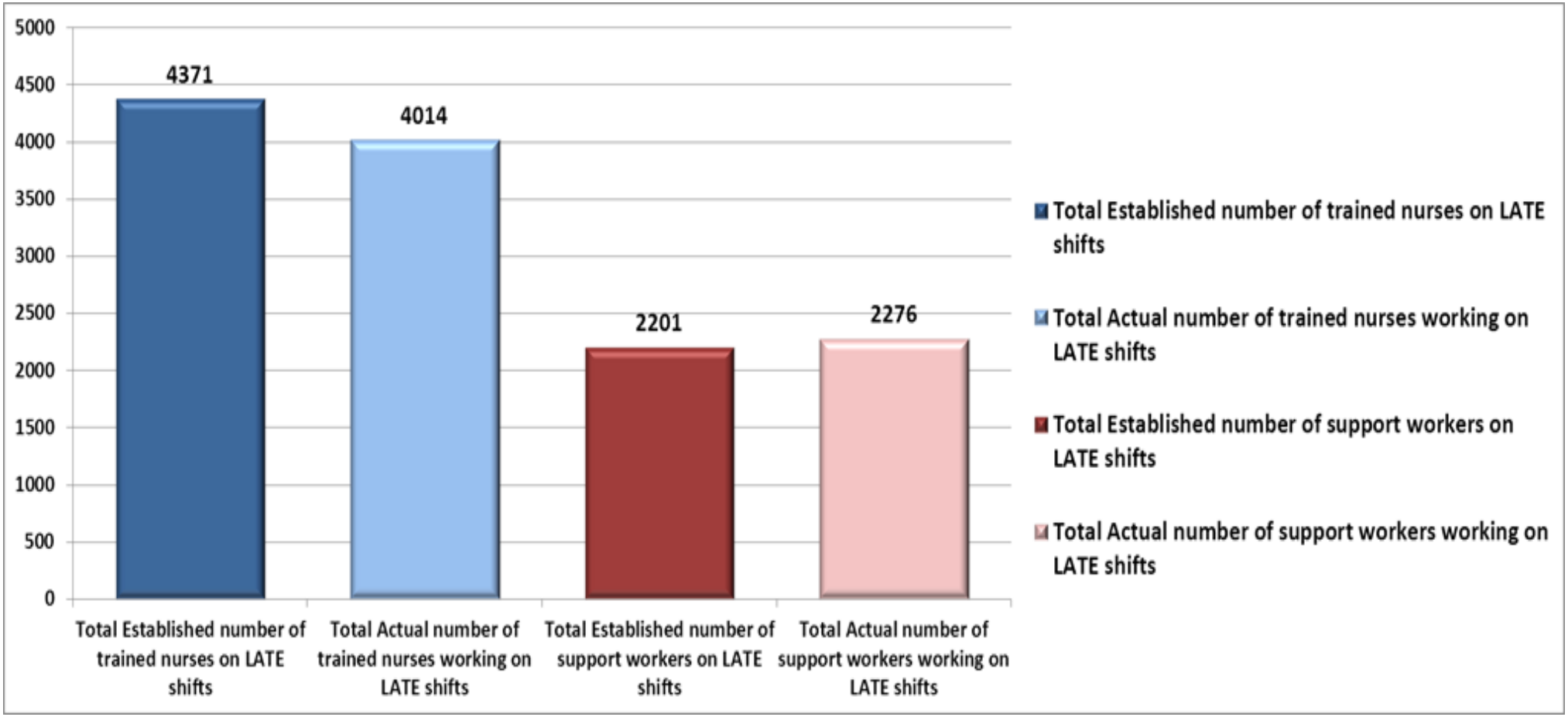
Period 01-31 May 2014



Appendix 1

WARD STAFFING LEVELS ON LATE SHIFTS – all inpatient ward areas

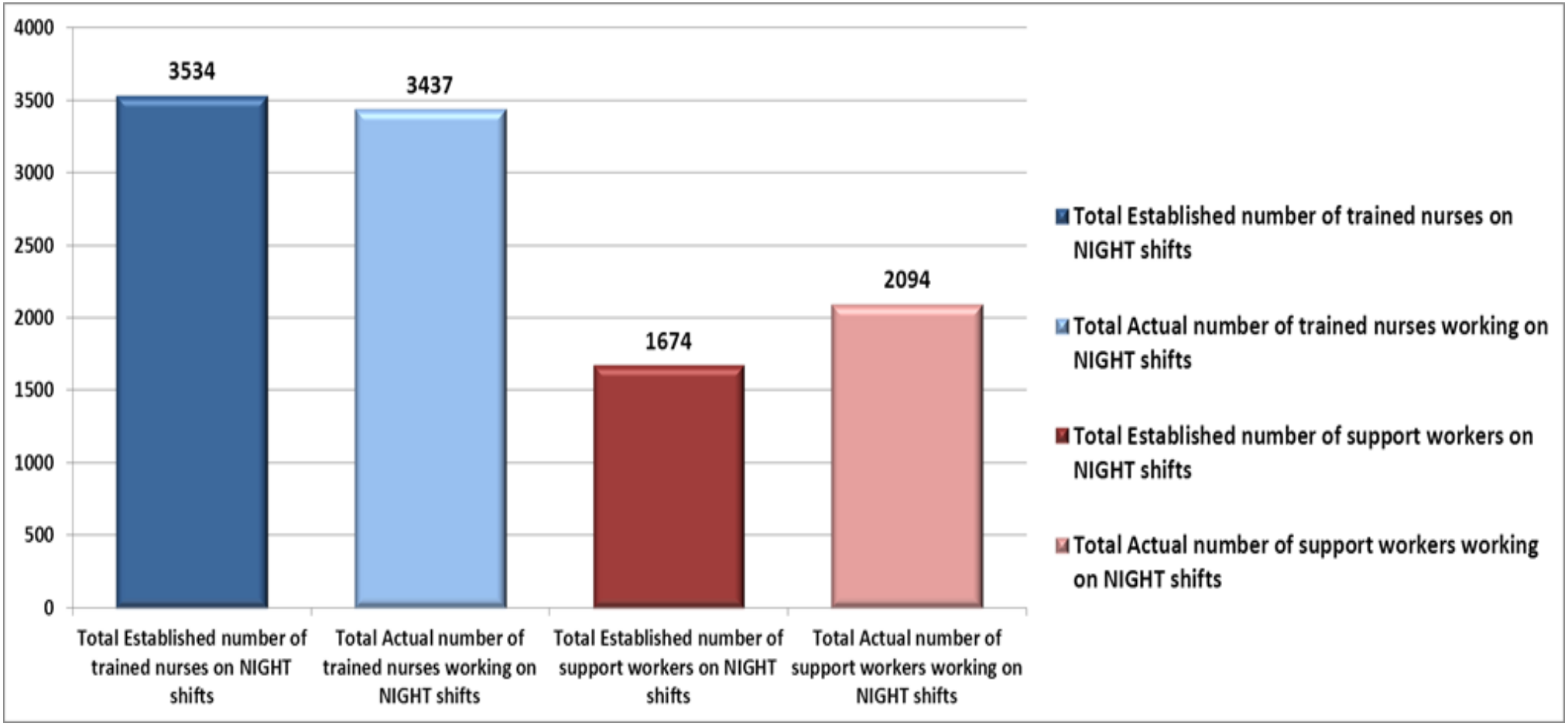
Period 01-31 May 2014



Appendix 1

WARD STAFFING LEVELS ON NIGHT SHIFTS – all inpatient ward areas

Period 01-31 May 2014



Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Hard Truths Commitments regarding the publishing of staffing data
Agenda item	10
Sponsoring Director	Mrs Jane Bradley, Director of Nursing, Midwifery & Patient Services (Interim)
Author(s) of Report	Mrs Jane Bradley, Director of Nursing, Midwifery & Patient Services (Interim) Mrs Kate Terrell Gray, Project Lead, Hard Truths
Purpose	To update Board on the Trust's ward staffing levels in relation to established numbers, as required by the National Quality Board's Hard Truths Commitments initiative

Executive summary

The Trust completed its inaugural May 2014 ward staffing levels return for the Hard Truths commitment, which progresses on the expectations outlined in the National Quality Boards latest guidance on safe staffing levels for patients.

The impact of the right staff being in the right place with the right skills is clear. However assurance from real time data collection on a shift by shift by basis requires refinement.

This paper provides a detailed breakdown of staffing levels on a shift by shift basis (Appendix 1 planned staffing numbers versus actual staffing numbers) for 26 inpatient wards.

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 specialling, escalation area resourcing and patient acuity and dependency.

Further work is required to standardise the completion and validation of staff hours worked in "real time" and develop a process that can simplify the collection and validation of staffing data.

Accurate recording of the rationale for shortfall and overfill of shifts also requires time to develop and embed.

An electronic solution to enhance the current Healthroster system is being explored; however, the success of an electronic solution would be reliant upon ward manager engagement and change management at system implementation.

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	Does the content of the report present any risks to the Trust or consequently provide assurances on risks – **YES – reputational risk**
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? **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 Board is asked to:

- Note that the first monthly NGH ward staffing return was submitted to the National Quality Board on Friday 6 June, ahead of the 10 June deadline for this region
- Review the month of May's staffing levels in wards across the Trust and note that actual established staff numbers were reactive to reflect patient acuity, patient numbers, established staffing pressures and staff skill mix per ward
- Consider if future staffing reports to the Board should be presented via exception i.e. wards below 80% staffing levels and/or wards above 120% staffing levels
- Approve the requirement to further explore and identify electronic solutions to collect, record and report staffing data in real time, acknowledging an IT solution would enable the Trust to continue to submit the NQB returns more efficiently and accurately

Public Trust Board
26 June 2014

Hard Truths Commitments Regarding the Publishing of Staffing Data

1. Introduction

The first phase of the NHS England Hard Truths initiative was completed by the Trust ahead of schedule. This focused on reporting inpatient area staffing levels on a daily, shift by shift basis for the month of May 2014. This will be further supported by the pending publication of the initial Open and Honest report on the Trust website.

The optimum level and skill mix required to deliver care is a perennial question. Currently there are no nationally defined minimum safe staffing levels; however there are recommendations on skill mix and the number of registered nurse to patient ratio.

Staffing data for all Trusts will be published by NHS England (NHSE) and will also be available on the Trust's website and on NHS Choices.

This paper identifies the current staffing levels on 26 inpatient wards and will 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.

2. Body of Report

The completed safe staffing report confirms 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 are not included in these calculations. Wards in the maternity and paediatric areas were consolidated into two groups as resources are merged to be reactive and reflect demand in their specialist ward areas (Appendix 1).

May 2014 ward staffing trends: 26 inpatient wards were calculated, including the consolidated maternity and paediatric areas. Results show that 15 ward areas were staffed by RGNs at ≥95% of establishment across day shifts (23 wards were staffed at ≥90% establishment), with 22 wards at ≥95% of establishment at night.

18 out of 26 wards recruited additional HCAs, reflecting an increased patient demand/acuity and the requirement to increase capacity, 22 wards deployed additional support at night.

A ward may be below its established staffing level on shift, however if trained and support staff are experienced, matrons and ward sisters may confirm the ward remains safe. Alternatively, a ward may be working at establishment, and patient acuity may rise. Staffing capacity and capability will be reviewed at the twice daily safety huddles and matrons ward rounds, this may result in the ward being identified as requiring extra support i.e. a transfer of an experienced nurse from another ward or HCA.

Data collection – challenges: Despite successfully completing the NHS England's May 2014 return, the collection and re-calculation of accurate ward staffing data on a shift by shift/day by day basis proved more challenging and labour intensive than predicted.

While NGH uses Allocate Software's Healthroster to manage ward staffing, the system's reports are limited and do not reflect the NHSE requirement. Staffing data is not always validated in a timely manner, nor can the system always reveal the 'live' daily staffing picture.

During the data collection it became apparent that Healthroster records when Bank and agency staff are transferred or re-assigned from their original booked ward, whereas permanent staff transfers are not currently recorded on the system.

Short term: The ongoing challenge is to obtain a more accurate picture of actual changes in staffing levels, with reasons for those changes. To do this, several data sources have to be interrogated and data re-keyed and re-calculated. Short term, this is a resource-intensive task which required data entry support from administrative and clerical staff and a Senior Project lead.

Long term: IT solutions are available as a bolt-on to Healthroster electronic staffing solutions. These applications, will provide the staffing data required for the NHSE monthly returns, and enable wards to manage safe staffing levels in relation to the number of patients on the ward, their acuity levels and the available staff skill-mix on each shift. Safe Care staffing electronic solutions are being explored for functionality, compatibility and ease of use.

3. Assessment of Risk

The process to accurately capture staffing levels on a shift by shift basis and present it in a format that is meaningful for patients requires further refinement.

Reporting the reason for shortfall/overfill of staff requires contextualisation for patients and the public as they can be misleading.

There is a risk associated with implementing an additional resourcing management system to Healthroster. Currently, user engagement issues and allocated time hinder accurate data recording on a live basis in some areas.

Safe Care electronic solution will only be successful if ward managers are actively engaged and motivated to use the system consistently throughout each shift as part of their standard management brief, this is currently not standard practice.

Failure to update staffing data on a live basis will result in manual workarounds to capture staff data and the limited information to inform nurse management rostering decisions.

In the absence of an electronic Safe Care Staffing tool, Hard Truths staffing data will be manually re-keyed, re-calculated and re-entered on NHS England's template monthly. The staffing data will be published on the Trust website and NHS Choices site to allow members of the public to access more detailed information regarding staffing.

Safe staffing data will form part of the wider data set available to patients and the public regarding the quality and safety of care and will be available via NHS Choices.

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4. Recommendations/Resolutions Required

It is proposed that the Safe Care solution is presented to nursing management in July, with the intention of running a pilot on one or two wards to confirm the solution is effective and accurate, this will enhance and support ward manager engagement. In the interim, the current manual process will continue and will be refined to maximise its efficiency.

5. Next Steps

1. Prepare ward staffing data for NHSE July return and refine the reporting tool and data presentation.
2. Engage staff and encourage accurate, timely data entry in Healthroster.
3. Organise a demonstration of Safe Care staffing Tool and develop a pilot project.
4. Commence ward manager leadership programme in July 2014
5. Review workforce plans and broaden the current recruitment programmes in place.
6. Review the extra support required for overseas nurses recently recruited to NGH to support socialisation to healthcare in England

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	5	4	3	4	4	3
02 May 2014	6	3	3	4	4	3
03 May 2014	4	4	3	4	4	4
04 May 2014	4	3	3	4	4	4
05 May 2014	5	4	3	4	4	3
06 May 2014	5	4	3	5	4	3
07 May 2014	5	4	3	4	4	3
08 May 2014	5	4	3	4	4	3
09 May 2014	4	4	3	5	4	4
10 May 2014	4	4	3	4	4	3
11 May 2014	4	4	3	5	3	4
12 May 2014	5	4	3	4	4	3
13 May 2014	5	3	3	4	3	2
14 May 2014	5	4	3	4	3	2
15 May 2014	5	4	2	4	3	4
16 May 2014	5	4	3	4	4	2
17 May 2014	5	4	3	4	3	4
18 May 2014	4	4	3	5	3	4
19 May 2014	5	4	3	4	4	3
20 May 2014	5	3	2	4	4	3
21 May 2014	5	4	3	4	4	5
22 May 2014	5	4	3	5	4	3
23 May 2014	4	4	3	6	4	5
24 May 2014	5	4	3	4	4	4
25 May 2014	4	4	2	6	5	4
26 May 2014	5	3	3	4	4	3
27 May 2014	4	3	3	5	5	4
28 May 2014	5	4	3	4	4	3
29 May 2014	5	3	4	4	4	4
30 May 2014	4	4	3	4	4	4
31 May 2014	5	4	2	4	4	5

ALLEBONE WARD: Acute Medicine

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	5	2	3	2	3	2
02 May 2014	5	4	3	3	3	3
03 May 2014	5	4	3	3	3	2
04 May 2014	5	4	4	3	3	3
05 May 2014	6	4	4	4	4	2
06 May 2014	5	6	3	3	4	4
07 May 2014	5	5	3	3	4	4
08 May 2014	5	4	3	3	4	3
09 May 2014	5	4	3	4	3	3
10 May 2014	3	4	3	4	4	4
11 May 2014	5	4	3	3	4	3
12 May 2014	5	4	3	2	3	3
13 May 2014	6	4	3	2	3	3
14 May 2014	5	4	3	3	4	4
15 May 2014	5	3	3	3	3	3
16 May 2014	5	4	2	4	4	4
17 May 2014	5	4	3	5	5	4
18 May 2014	5	4	3	4	3	2
19 May 2014	4	4	4	3	3	3
20 May 2014	4	4	3	3	3	3
21 May 2014	5	4	4	3	4	4
22 May 2014	3	4	3	3	4	4
23 May 2014	5	4	4	5	3	4
24 May 2014	4	4	4	5	5	5
25 May 2014	4	4	3	5	4	4
26 May 2014	5	4	3	5	5	4
27 May 2014	4	4	2	5	2	4
28 May 2014	4	3	3	3	3	2
29 May 2014	5	3	4	3	3	3
30 May 2014	5	4	4	3	4	3
31 May 2014	5	4	3	3	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	4	2	1
Support W'end	2	1	1

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	4	2	2	3	2	2
02 May 2014	3	2	2	2	2	1
03 May 2014	2	2	2	2	1	2
04 May 2014	2	2	2	1	1	2
05 May 2014	2	2	1	3	1	1
06 May 2014	3	2	3	2	0	2
07 May 2014	4	2	4	2	2	2
08 May 2014	3	2	2	2	2	2
09 May 2014	3	3	3	1	2	3
10 May 2014	3	3	3	2	2	2
11 May 2014	3	3	3	2	2	2
12 May 2014	2	2	3	1	2	1
13 May 2014	3	2	2	2	2	2
14 May 2014	4	2	2	2	3	1
15 May 2014	4	2	3	2	2	2
16 May 2014	3	2	3	2	2	1
17 May 2014	2	2	2	2	1	2
18 May 2014	2	3	3	1	1	1
19 May 2014	4	4	3	2	3	3
20 May 2014	3	3	2	2	2	0
21 May 2014	5	2	2	1	4	3
22 May 2014	3	3	2	3	3	2
23 May 2014	3	4	2	3	3	1
24 May 2014	3	2	3	2	1	2
25 May 2014	2	2	3	2	1	1
26 May 2014	4	2	3	2	2	3
27 May 2014	4	2	3	2	3	2
28 May 2014	4	2	2	3	2	1
29 May 2014	4	2	2	2	2	2
30 May 2014	3	2	3	2	2	2
31 May 2014	4	4	2	3	2	2

BECKET WARD: Respiratory

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	6	5	4	5	3	2
02 May 2014	6	5	4	2	2	2
03 May 2014	5	5	4	3	3	2
04 May 2014	4	5	4	4	4	2
05 May 2014	6	4	4	3	3	2
06 May 2014	6	5	4	4	2	2
07 May 2014	6	5	4	3	3	2
08 May 2014	6	5	4	4	3	3
09 May 2014	6	4	4	4	3	2
10 May 2014	5	5	4	4	3	2
11 May 2014	5	5	4	5	3	2
12 May 2014	6	5	4	4	4	2
13 May 2014	6	5	4	3	2	2
14 May 2014	6	5	4	4	4	2
15 May 2014	6	5	4	4	5	2
16 May 2014	6	5	4	3	4	2
17 May 2014	4	3	4	3	1	2
18 May 2014	5	4	4	4	4	1
19 May 2014	4	4	4	4	3	2
20 May 2014	6	5	4	4	4	2
21 May 2014	5	5	4	3	2	2
22 May 2014	5	4	4	4	3	2
23 May 2014	6	4	4	3	3	2
24 May 2014	4	4	4	4	4	2
25 May 2014	5	4	4	4	4	2
26 May 2014	6	5	4	4	4	2
27 May 2014	6	5	4	3	4	3
28 May 2014	5	4	4	3	3	2
29 May 2014	5	5	4	4	3	2
30 May 2014	6	5	4	3	4	3
31 May 2014	5	5	4	5	4	3

BENHAM WARD: Male Assessment Unit

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT Workers on shift E	TOTAL SUPPORT Workers on shift L	TOTAL SUPPORT Workers on shift N
01 May 2014	5	5	4	1	2	2
02 May 2014	5	4	4	2	2	3
03 May 2014	5	5	4	2	3	3
04 May 2014	5	5	5	2	2	2
05 May 2014	5	5	5	2	2	2
06 May 2014	5	4	4	3	2	2
07 May 2014	5	5	5	4	2	3
08 May 2014	5	5	4	3	2	2
09 May 2014	5	5	3	2	2	3
10 May 2014	5	5	4	2	2	2
11 May 2014	5	5	4	2	2	2
12 May 2014	5	5	4	2	2	3
13 May 2014	5	5	4	3	2	4
14 May 2014	5	5	4	3	3	3
15 May 2014	5	5	4	4	2	3
16 May 2014	4	3	5	4	2	3
17 May 2014	5	5	4	3	2	3
18 May 2014	5	4	4	3	2	3
19 May 2014	5	5	4	2	2	2
20 May 2014	5	4	4	2	2	2
21 May 2014	4	3	4	2	2	2
22 May 2014	5	5	4	2	2	2
23 May 2014	5	5	4	2	2	2
24 May 2014	5	5	4	3	2	3
25 May 2014	5	5	4	2	2	3
26 May 2014	5	4	3	2	2	2
27 May 2014	5	4	4	2	2	3
28 May 2014	5	5	4	3	2	2
29 May 2014	5	4	4	2	3	3
30 May 2014	5	5	4	3	2	3
31 May 2014	5	5	4	3	1	2

BRAMPTON WARD: Elderly Short Stay

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	6	3	2	3	3	2
02 May 2014	6	3	2	3	3	2
03 May 2014	3	3	2	4	2	2
04 May 2014	3	3	3	4	4	2
05 May 2014	4	3	2	5	4	2
06 May 2014	4	3	2	3	2	3
07 May 2014	4	3	2	5	4	3
08 May 2014	4	3	2	5	4	3
09 May 2014	4	4	2	3	3	2
10 May 2014	3	3	2	3	3	3
11 May 2014	4	3	2	3	3	2
12 May 2014	4	3	2	4	2	2
13 May 2014	4	3	2	4	2	2
14 May 2014	5	3	2	3	3	2
15 May 2014	4	3	2	4	3	2
16 May 2014	4	3	2	4	3	3
17 May 2014	3	3	2	4	3	3
18 May 2014	3	3	2	6	3	3
19 May 2014	4	3	2	2	3	3
20 May 2014	3	2	2	4	3	3
21 May 2014	4	3	2	5	4	3
22 May 2014	4	3	2	3	2	3
23 May 2014	4	2	2	4	3	3
24 May 2014	3	3	2	4	3	3
25 May 2014	3	3	2	4	4	3
26 May 2014	4	3	2	5	4	3
27 May 2014	4	3	2	6	4	3
28 May 2014	3	3	2	5	3	3
29 May 2014	4	3	2	4	5	3
30 May 2014	4	3	2	3	3	4
31 May 2014	3	3	2	5	3	3

CEDAR WARD: Trauma & Orthopaedics - Trauma

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	4	4	3	4	3	5
02 May 2014	5	3	3	4	4	3
03 May 2014	4	3	3	5	4	3
04 May 2014	4	3	3	5	4	3
05 May 2014	4	3	3	5	4	2
06 May 2014	5	4	3	5	4	3
07 May 2014	5	4	3	4	3	4
08 May 2014	5	4	3	5	2	3
09 May 2014	5	3	3	5	4	3
10 May 2014	4	3	3	5	3	3
11 May 2014	4	3	3	5	3	3
12 May 2014	5	4	3	5	4	3
13 May 2014	5	4	3	4	3	3
14 May 2014	5	4	3	4	4	3
15 May 2014	5	4	3	4	3	3
16 May 2014	5	4	3	5	4	4
17 May 2014	4	3	3	4	4	4
18 May 2014	4	3	3	5	4	3
19 May 2014	5	3	3	4	4	3
20 May 2014	5	4	3	5	4	3
21 May 2014	5	4	3	5	3	3
22 May 2014	6	4	3	5	4	4
23 May 2014	5	3	3	5	5	4
24 May 2014	4	3	3	5	4	3
25 May 2014	4	3	3	5	4	3
26 May 2014	4	4	3	6	4	3
27 May 2014	5	4	3	4	4	3
28 May 2014	5	4	3	5	3	3
29 May 2014	4	3	3	4	3	3
30 May 2014	5	4	3	5	4	3
31 May 2014	4	3	3	5	4	3

CHILD HEALTH SPECIALTY: DISNEY WARD - Oncology

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	5	4	2	2	1	1
02 May 2014	7	5	2	2	2	1
03 May 2014	2	2	2	1	1	0
04 May 2014	2	2	2	1	1	0
05 May 2014	3	3	2	1	1	0
06 May 2014	5	4	3	1	1	1
07 May 2014	5	3	2	2	2	1
08 May 2014	6	5	2	1	1	1
09 May 2014	5	5	2	2	2	0
10 May 2014	3	3	2	1	1	0
11 May 2014	3	3	2	1	1	0
12 May 2014	5	4	2	1	1	0
13 May 2014	5	6	2	1	1	1
14 May 2014	5	4	3	2	2	0
15 May 2014	4	3	2	2	2	1
16 May 2014	6	5	2	1	1	0
17 May 2014	3	3	2	1	1	0
18 May 2014	2	2	2	1	1	0
19 May 2014	5	3	2	2	2	0
20 May 2014	7	5	2	1	1	1
21 May 2014	7	4	2	0	0	0
22 May 2014	6	3	2	2	2	1
23 May 2014	6	6	2	1	1	0
24 May 2014	3	3	2	0	0	0
25 May 2014	2	2	2	1	1	0
26 May 2014	3	3	2	1	1	1
27 May 2014	8	5	2	1	1	1
28 May 2014	5	4	3	0	0	0
29 May 2014	6	4	2	1	1	0
30 May 2014	6	5	2	0	0	0
31 May 2014	4	3	2	0	0	0

CHILD HEALTH SPECIALTY: GOSSET WARD - SCBU

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	8	7	6
Support Planned Staff	1	1	1

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	13	7	7	1	2	0
02 May 2014	10	8	5	1	1	1
03 May 2014	6	6	5	1	1	1
04 May 2014	6	6	5	1	1	1
05 May 2014	7	7	4	1	1	1
06 May 2014	12	8	5	1	1	1
07 May 2014	10	7	5	0	0	1
08 May 2014	11	7	5	2	2	1
09 May 2014	12	7	5	0	0	1
10 May 2014	8	8	5	0	0	1
11 May 2014	8	7	5	1	1	1
12 May 2014	9	8	6	1	1	1
13 May 2014	13	8	5	1	1	0
14 May 2014	10	7	5	0	1	0
15 May 2014	8	5	5	1	1	1
16 May 2014	12	7	5	1	1	1
17 May 2014	5	5	4	1	1	1
18 May 2014	7	5	5	1	1	1
19 May 2014	9	7	4	1	1	1
20 May 2014	12	8	5	1	1	1
21 May 2014	11	8	5	0	0	0
22 May 2014	10	6	5	1	1	0
23 May 2014	10	5	5	1	2	0
24 May 2014	6	5	5	0	0	1
25 May 2014	5	5	6	1	1	0
26 May 2014	8	8	6	1	1	0
27 May 2014	9	7	6	1	1	0
28 May 2014	7	4	6	1	1	0
29 May 2014	9	6	5	1	1	1
30 May 2014	8	6	5	1	1	1
31 May 2014	5	5	4	2	2	1

CHILD HEALTH SPECIALTY: PADDINGTON WARD - General Paediatrics

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

Date	TOTAL RGNs on shift E	TOTAL RGNs on shift L	TOTAL RGNs on shift N	TOTAL SUPPORT on shift E	TOTAL SUPPORT on shift L	TOTAL SUPPORT on shift N
01 May 2014	8	5	4	2	2	1
02 May 2014	6	5	5	1	1	1
03 May 2014	5	5	5	1	1	1
04 May 2014	6	6	5	2	2	1
05 May 2014	6	6	5	1	1	0
06 May 2014	6	6	5	1	1	1
07 May 2014	8	6	5	1	1	2
08 May 2014	7	6	5	1	1	1
09 May 2014	8	7	5	1	1	1
10 May 2014	7	7	6	1	1	1
11 May 2014	7	8	6	1	1	1
12 May 2014	7	6	5	1	1	1
13 May 2014	6	3	5	1	1	1
14 May 2014	7	6	5	0	0	1
15 May 2014	8	7	4	1	1	1
16 May 2014	8	6	5	1	1	1
17 May 2014	6	5	5	1	1	0
18 May 2014	6	6	5	1	1	0
19 May 2014	6	5	5	1	1	0
20 May 2014	7	6	5	1	1	1
21 May 2014	7	5	5	0	0	1
22 May 2014	8	6	5	0	0	1
23 May 2014	7	6	5	1	1	2
24 May 2014	6	6	5	1	1	1
25 May 2014	6	6	4	0	0	2
26 May 2014	6	5	4	1	1	0
27 May 2014	7	6	4	1	1	0
28 May 2014	5	7	5	1	1	1
29 May 2014	8	7	5	0	0	1
30 May 2014	9	5	5	0	1	1
31 May 2014	7	6	5	1	1	1

COMPTON WARD: Medical Rehabilitation

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

Date	SHIFT	TOTAL RGNs on shift	TOTAL SUPPORT on shift
01 May 2014	E	3	3
01 May 2014	L	2	3
01 May 2014	N	2	2
02 May 2014	E	4	3
02 May 2014	L	2	2
02 May 2014	N	2	2
03 May 2014	E	3	3
03 May 2014	L	2	2
03 May 2014	N	1	2
04 May 2014	E	3	3
04 May 2014	L	2	3
04 May 2014	N	2	2
05 May 2014	E	3	3
05 May 2014	L	2	3
05 May 2014	N	2	2
06 May 2014	E	3	2
06 May 2014	L	2	2
06 May 2014	N	2	1
07 May 2014	E	3	2
07 May 2014	L	2	2
07 May 2014	N	2	1
08 May 2014	E	3	2
08 May 2014	L	2	2
08 May 2014	N	2	2
09 May 2014	E	3	3
09 May 2014	L	2	2
09 May 2014	N	2	2
10 May 2014	E	3	3
10 May 2014	L	2	2
10 May 2014	N	2	2
11 May 2014	E	3	2
11 May 2014	L	2	3
11 May 2014	N	2	2
12 May 2014	E	2	3
12 May 2014	L	2	3
12 May 2014	N	2	2
13 May 2014	E	3	3
13 May 2014	L	1	3
13 May 2014	N	2	2
14 May 2014	E	3	2
14 May 2014	L	2	3
14 May 2014	N	2	2
15 May 2014	E	3	2
15 May 2014	L	2	2
15 May 2014	N	2	2
16 May 2014	E	3	2
16 May 2014	L	2	2
16 May 2014	N	2	1
17 May 2014	E	3	1
17 May 2014	L	2	2
17 May 2014	N	2	2
18 May 2014	E	3	2
18 May 2014	L	2	1
18 May 2014	N	2	1
19 May 2014	E	3	2
19 May 2014	L	2	2
19 May 2014	N	2	1
20 May 2014	E	3	2
20 May 2014	L	2	2
20 May 2014	N	2	1
21 May 2014	E	4	1
21 May 2014	L	2	2
21 May 2014	N	2	1
22 May 2014	E	3	2
22 May 2014	L	2	1
22 May 2014	N	2	1
23 May 2014	E	3	1
23 May 2014	L	2	1
23 May 2014	N	2	1
24 May 2014	E	3	2
24 May 2014	L	2	2
24 May 2014	N	2	1
25 May 2014	E	3	3
25 May 2014	L	2	2
25 May 2014	N	2	1
26 May 2014	E	2	2
26 May 2014	L	2	2
26 May 2014	N	2	1
27 May 2014	E	3	2
27 May 2014	L	2	2
27 May 2014	N	2	1
28 May 2014	E	3	2
28 May 2014	L	1	2
28 May 2014	N	2	1
29 May 2014	E	2	2
29 May 2014	L	2	1
29 May 2014	N	2	1
30 May 2014	E	3	1
30 May 2014	L	2	1
30 May 2014	N	2	1
31 May 2014	E	3	1
31 May 2014	L	2	2
31 May 2014	N	2	1

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

Date	SHIFT	TOTAL RGNs on shift	TOTAL SUPPORT on shift
01 May 2014	E	7	4
01 May 2014	L	4	6
01 May 2014	N	4	5
02 May 2014	E	8	4
02 May 2014	L	4	5
02 May 2014	N	4	5
03 May 2014	E	5	7
03 May 2014	L	6	6
03 May 2014	N	4	5
04 May 2014	E	5	7
04 May 2014	L	5	6
04 May 2014	N	5	5
05 May 2014	E	6	7
05 May 2014	L	5	6
05 May 2014	N	4	5
06 May 2014	E	6	4
06 May 2014	L	4	5
06 May 2014	N	4	4
07 May 2014	E	8	5
07 May 2014	L	5	4
07 May 2014	N	4	4
08 May 2014	E	7	5
08 May 2014	L	4	4
08 May 2014	N	4	4
09 May 2014	E	7	6
09 May 2014	L	5	3
09 May 2014	N	5	4
10 May 2014	E	6	4
10 May 2014	L	5	4
10 May 2014	N	5	4
11 May 2014	E	7	6
11 May 2014	L	6	5
11 May 2014	N	5	4
12 May 2014	E	7	5
12 May 2014	L	5	5
12 May 2014	N	5	4
13 May 2014	E	9	5
13 May 2014	L	4	4
13 May 2014	N	4	4
14 May 2014	E	8	5
14 May 2014	L	6	5
14 May 2014	N	4	4
15 May 2014	E	9	6
15 May 2014	L	6	5
15 May 2014	N	4	4
16 May 2014	E	6	5
16 May 2014	L	6	4
16 May 2014	N	4	5
17 May 2014	E	5	6
17 May 2014	L	5	5
17 May 2014	N	4	4
18 May 2014	E	4	5
18 May 2014	L	4	6
18 May 2014	N	4	4
19 May 2014	E	6	5
19 May 2014	L	4	4
19 May 2014	N	4	3
20 May 2014	E	7	5
20 May 2014	L	4	5
20 May 2014	N	4	4
21 May 2014	E	8	5
21 May 2014	L	4	4
21 May 2014	N	4	4
22 May 2014	E	7	6
22 May 2014	L	5	5
22 May 2014	N	4	4
23 May 2014	E	8	6
23 May 2014	L	5	5
23 May 2014	N	4	4
24 May 2014	E	5	5
24 May 2014	L	5	3
24 May 2014	N	4	3
25 May 2014	E	6	4
25 May 2014	L	5	4
25 May 2014	N	4	3
26 May 2014	E	8	4
26 May 2014	L	7	4
26 May 2014	N	4	4
27 May 2014	E	7	5
27 May 2014	L	5	5
27 May 2014	N	4	4
28 May 2014	E	7	3
28 May 2014	L	5	3
28 May 2014	N	4	3
29 May 2014	E	6	4
29 May 2014	L	5	4
29 May 2014	N	4	3
30 May 2014	E	7	4
30 May 2014	L	6	3
30 May 2014	N	4	3
31 May 2014	E	6	5
31 May 2014	L	5	3
31 May 2014	N	4	3

CREATON WARD: Acute Medicine

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

Date	SHIFT	TOTAL RGNs on shift	TOTAL SUPPORT on shift
01 May 2014	E	5	4
01 May 2014	L	4	4
01 May 2014	N	3	4
02 May 2014	E	5	3
02 May 2014	L	4	3
02 May 2014	N	3	4
03 May 2014	E	4	5
03 May 2014	L	4	5
03 May 2014	N	3	5
04 May 2014	E	4	4
04 May 2014	L	4	4
04 May 2014	N	3	3
05 May 2014	E	5	3
05 May 2014	L	4	3
05 May 2014	N	3	3
06 May 2014	E	5	4
06 May 2014	L	4	4
06 May 2014	N	3	3
07 May 2014	E	5	4
07 May 2014	L	4	4
07 May 2014	N	3	3
08 May 2014	E	5	3
08 May 2014	L	3	4
08 May 2014	N	3	3
09 May 2014	E	5	4
09 May 2014	L	4	4
09 May 2014	N	3	3
10 May 2014	E	4	4
10 May 2014	L	4	4
10 May 2014	N	3	2
11 May 2014	E	4	4
11 May 2014	L	4	4
11 May 2014	N	3	3
12 May 2014	E	5	4
12 May 2014	L	3	4
12 May 2014	N	3	3
13 May 2014	E	5	4
13 May 2014	L	4	3
13 May 2014	N	3	3
14 May 2014	E	5	4
14 May 2014	L	4	4
14 May 2014	N	3	2
15 May 2014	E	5	4
15 May 2014	L	3	4
15 May 2014	N	3	3
16 May 2014	E	5	3
16 May 2014	L	4	3
16 May 2014	N	4	3
17 May 2014	E	4	4
17 May 2014	L	4	3
17 May 2014	N	3	3
18 May 2014	E	4	4
18 May 2014	L	4	4
18 May 2014	N	3	3
19 May 2014	E	5	4
19 May 2014	L	4	4
19 May 2014	N	3	4
20 May 2014	E	5	3
20 May 2014	L	4	4
20 May 2014	N	3	4
21 May 2014	E	5	4
21 May 2014	L	3	4
21 May 2014	N	3	3
22 May 2014	E	5	3
22 May 2014	L	3	4
22 May 2014	N	3	3
23 May 2014	E	5	3
23 May 2014	L	4	4
23 May 2014	N	3	3
24 May 2014	E	4	5
24 May 2014	L	3	4
24 May 2014	N	3	3
25 May 2014	E	4	4
25 May 2014	L	4	4
25 May 2014	N	3	3
26 May 2014	E	5	4
26 May 2014	L	4	4
26 May 2014	N	4	4
27 May 2014	E	5	3
27 May 2014	L	4	4
27 May 2014	N	3	3
28 May 2014	E	5	4
28 May 2014	L	3	4
28 May 2014	N	3	3
29 May 2014	E	5	4
29 May 2014	L	4	3
29 May 2014	N	3	4
30 May 2014	E	5	4
30 May 2014	L	4	4
30 May 2014	N	3	5
31 May 2014	E	4	3
31 May 2014	L	5	3
31 May 2014	N	3	3

DRYDEN WARD: Cardiac + Heart Centre (Escalation Area)

	EARLY SHIFT	LATE SHIFT	NIGHT SHIFT
RGN Planned Staff	5	5	4
Support Planned Staff	2	1	1

Date	SHIFT	TOTAL RGNs on shift	TOTAL SUPPORT on shift
01 May 2014	E	6	2
01 May 2014	L	4	2
01 May 2014	N	5	2
02 May 2014	E	5	3
02 May 2014	L	5	3
02 May 2014	N	4	1
03 May 2014	E	5	2
03 May 2014	L	3	1
03 May 2014	N	4	1
04 May 2014	E	6	2
04 May 2014	L	5	2
04 May 2014	N	5	2
05 May 2014	E	5	3
05 May 2014	L	5	3
05 May 2014	N	6	2
06 May 2014	E	5	2
06 May 2014	L	6	1
06 May 2014	N	7	1
07 May 2014	E	5	3
07 May 2014	L	5	1
07 May 2014	N	6	1
08 May 2014	E	5	2
08 May 2014	L	5	1
08 May 2014	N	5	1
09 May 2014	E	6	3
09 May 2014	L	5	2
09 May 2014	N	4	2
10 May 2014	E	5	3
10 May 2014	L	4	2
10 May 2014	N	3	2
11 May 2014	E	5	3
11 May 2014	L	5	2
11 May 2014	N	5	2
12 May 2014	E	5	2
12 May 2014	L	5	1
12 May 2014	N	6	1
13 May 2014	E	4	2
13 May 2014	L	3	1
13 May 2014	N	5	2
14 May 2014	E	5	1
14 May 2014	L	6	2
14 May 2014	N	6	3
15 May 2014	E	5	3
15 May 2014	L	4	3
15 May 2014	N	5	3
16 May 2014	E	5	4
16 May 2014	L	4	4
16 May 2014	N	5	2
17 May 2014	E	5	4
17 May 2014	L	5	2
17 May 2014	N	4	4
18 May 2014	E	5	4
18 May 2014	L	5	0
18 May 2014	N	5	3
19 May 2014	E	6	3
19 May 2014	L	5	1
19 May 2014	N	4	3
20 May 2014	E	5	3
20 May 2014	L	5	3
20 May 2014	N	6	3
21 May 2014	E	5	3
21 May 2014	L	3	3
21 May 2014	N	5	3
22 May 2014	E	5	4
22 May 2014	L	5	1
22 May 2014	N	4	3
23 May 2014	E	5	4
23 May 2014	L	4	3
23 May 2014	N	4	3
24 May 2014	E	5	4
24 May 2014	L	5	2
24 May 2014	N	5	2
25 May 2014	E	5	3
25 May 2014	L	4	4
25 May 2014	N	4	3
26 May 2014	E	6	3
26 May 2014	L	7	4
26 May 2014	N	6	2
27 May 2014	E	5	3
27 May 2014	L	4	2
27 May 2014	N	6	2
28 May 2014	E	5	2
28 May 2014	L	5	2
28 May 2014	N	6	2
29 May 2014	E	5	2
29 May 2014	L	3	1
29 May 2014	N	6	2
30 May 2014	E	5	2
30 May 2014	L	4	1
30 May 2014	N	4	2
31 May 2014	E	5	3
31 May 2014	L	6	1
31 May 2014	N	4	2

EAU WARD: Female Assessment Unit

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

Date	SHIFT	TOTAL RGNs on shift	TOTAL SUPPORT on shift
01 May 2014	E	6	5
01 May 2014	L	6	7
01 May 2014	N	5	6
02 May 2014	E	6	6
02 May 2014	L	6	3
02 May 2014	N	5	4
03 May 2014	E	6	5
03 May 2014	L	6	5
03 May 2014	N	5	5
04 May 2014	E	6	5
04 May 2014	L	6	4
04 May 2014	N	6	3
05 May 2014	E	6	4
05 May 2014	L	6	4
05 May 2014	N	5	4
06 May 2014	E	5	2
06 May 2014	L	5	4
06 May 2014	N	5	5
07 May 2014	E	6	4
07 May 2014	L	6	3
07 May 2014	N	5	4
08 May 2014	E	6	3
08 May 2014	L	6	4
08 May 2014	N	4	3
09 May 2014	E	6	3
09 May 2014	L	6	2
09 May 2014	N	5	4
10 May 2014	E	6	4
10 May 2014	L	6	3
10 May 2014	N	5	3
11 May 2014	E	6	6
11 May 2014	L	6	5
11 May 2014	N	5	5
12 May 2014	E	6	4
12 May 2014	L	6	4
12 May 2014	N	5	6
13 May 2014	E	6	7
13 May 2014	L	6	3
13 May 2014	N	5	5
14 May 2014	E	6	6
14 May 2014	L	6	5
14 May 2014	N	4	6
15 May 2014	E	6	6
15 May 2014	L	6	5
15 May 2014	N	5	5
16 May 2014	E	6	4
16 May 2014	L	6	2
16 May 2014	N	5	4
17 May 2014	E	5	4
17 May 2014	L	6	3
17 May 2014	N	7	3
18 May 2014	E	6	5
18 May 2014	L	5	3
18 May 2014	N	4	4
19 May 2014	E	6	3
19 May 2014	L	6	3
19 May 2014	N	5	3
20 May 2014	E	6	3
20 May 2014	L	6	4
20 May 2014	N	5	8
21 May 2014	E	6	3
21 May 2014	L	6	3
21 May 2014	N	5	4
22 May 2014	E	6	5
22 May 2014	L	6	3
22 May 2014	N	6	3
23 May 2014	E	6	3
23 May 2014	L	6	3
23 May 2014	N	8	5
24 May 2014	E	6	4
24 May 2014	L	6	3
24 May 2014	N	6	4
25 May 2014	E	5	4
25 May 2014	L	6	3
25 May 2014	N	5	4
26 May 2014	E	6	3
26 May 2014	L	6	4
26 May 2014	N	5	2
27 May 2014	E	6	4
27 May 2014	L	6	3
27 May 2014	N	5	3
28 May 2014	E	6	2
28 May 2014	L	6	2
28 May 2014	N	5	4
29 May 2014	E	6	4
29 May 2014	L	6	3
29 May 2014	N	6	4
30 May 2014	E	6	2
30 May 2014	L	6	1
30 May 2014	N	6	6
31 May 2014	E	6	5
31 May 2014	L	6	4
31 May 2014	N	5	3

ELEANOR WARD: Hyper Acute Stroke Unit

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

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

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
Support W'end	3	3	3

HDU + ITU WARD: Critical Care

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

HEAD & NECK WARD: Head + Neck / Treatment Room

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

Date	SHIFT	ELEANOR TOTAL RGNs on shift	ELEANOR TOTAL SUPPORT on shift	FINEDON TOTAL RGNs on shift	FINEDON TOTAL SUPPORT on shift	HAWTHORN TOTAL RGNs on shift	HAWTHORN TOTAL SUPPORT on shift	HDU + ITU TOTAL RGNs on shift	HDU + ITU TOTAL SUPPORT on shift	HEAD & NECK TOTAL RGNs on shift	HEAD & NECK TOTAL SUPPORT on shift
01 May 2014	E	3	2	6	1	6	3	17	2	5	2
01 May 2014	L	2	1	5	1	5	4	12	1	3	2
01 May 2014	N	2	1	3	1	3	4	12	2	3	1
02 May 2014	E	2	2	6	3	6	4	16	1	5	2
02 May 2014	L	2	1	5	2	4	3	11	1	3	2
02 May 2014	N	2	2	3	1	3	5	13	2	2	1
03 May 2014	E	3	3	4	2	5	6	14	2	3	1
03 May 2014	L	2	2	5	1	4	4	13	2	3	1
03 May 2014	N	2	2	3	1	3	3	10	3	2	1
04 May 2014	E	3	3	4	1	5	4	13	2	3	2
04 May 2014	L	2	2	4	1	4	4	12	2	2	1
04 May 2014	N	2	2	3	1	3	3	12	2	2	1
05 May 2014	E	3	3	7	2	7	4	13	2	4	2
05 May 2014	L	2	3	6	1	5	4	12	2	2	1
05 May 2014	N	2	2	3	1	3	3	14	2	2	1
06 May 2014	E	3	3	5	3	6	4	13	1	4	2
06 May 2014	L	3	1	5	2	4	2	13	1	2	3
06 May 2014	N	2	2	3	1	3	3	12	2	2	2
07 May 2014	E	3	3	6	3	6	3	14	2	4	2
07 May 2014	L	3	1	6	2	4	3	12	1	3	2
07 May 2014	N	2	2	3	1	3	3	13	2	2	1
08 May 2014	E	2	3	6	2	5	3	13	1	5	2
08 May 2014	L	3	2	6	1	5	3	12	1	3	2
08 May 2014	N	2	2	3	1	3	3	12	2	3	0
09 May 2014	E	3	3	7	2	6	3	12	2	4	2
09 May 2014	L	3	1	4	1	4	2	11	1	3	2
09 May 2014	N	2	2	3	1	3	3	12	3	2	1
10 May 2014	E	3	3	4	1	5	2	13	1	3	1
10 May 2014	L	2	2	3	1	4	3	11	1	2	1
10 May 2014	N	2	2	3	1	3	3	12	3	2	1
11 May 2014	E	3	3	4	1	4	2	13	2	3	2
11 May 2014	L	2	1	4	1	4	5	13	2	3	1
11 May 2014	N	2	2	3	1	3	3	13	1	2	1
12 May 2014	E	3	3	6	2	5	3	10	2	4	2
12 May 2014	L	2	2	6	1	5	2	10	2	2	2
12 May 2014	N	2	2	3	1	3	3	12	2	2	1
13 May 2014	E	3	2	6	3	5	3	13	1	4	2
13 May 2014	L	2	1	6	2	3	3	13	1	2	2
13 May 2014	N	2	1	3	1	3	2	12	2	2	1
14 May 2014	E	3	2	6	3	5	3	15	2	4	2
14 May 2014	L	3	1	5	2	5	3	13	1	3	2
14 May 2014	N	2	2	3	1	3	3	11	2	2	1
15 May 2014	E	3	2	6	2	5	3	13	1	5	2
15 May 2014	L	2	2	5	1	4	2	12	0	3	2
15 May 2014	N	2	2	3	1	3	2	11	2	2	1
16 May 2014	E	2	2	6	2	5	2	12	1	4	2
16 May 2014	L	3	1	4	1	6	2	12	1	3	2
16 May 2014	N	2	1	3	1	3	3	11	2	2	1
17 May 2014	E	3	2	3	1	5	3	12	1	3	2
17 May 2014	L	2	1	3	1	4	3	13	1	3	1
17 May 2014	N	2	2	3	1	3	3	11	2	2	1
18 May 2014	E	3	2	4	1	5	3	11	0	3	2
18 May 2014	L	2	1	3	0	4	2	11	0	2	0
18 May 2014	N	2	1	3	1	3	2	10	1	2	1
19 May 2014	E	3	2	6	2	7	2	11	1	4	1
19 May 2014	L	2	1	6	1	4	3	13	2	2	1
19 May 2014	N	2	1	3	1	3	3	12	2	2	1
20 May 2014	E	3	2	6	2	6	2	12	2	4	2
20 May 2014	L	2	1	6	1	6	3	12	1	2	2
20 May 2014	N	2	1	3	1	3	3	12	2	2	2
21 May 2014	E	3	2	6	2	6	4	12	2	4	3
21 May 2014	L	2	1	6	2	5	3	12	1	3	1
21 May 2014	N	2	2	3	1	3	3	12	1	3	2
22 May 2014	E	3	2	6	3	6	2	15	2	5	3
22 May 2014	L	2	2	6	2	4	2	9	2	3	2
22 May 2014	N	2	0	3	1	3	4	13	2	2	2
23 May 2014	E	3	3	5	2	6	2	13	3	5	3
23 May 2014	L	2	1	5	1	5	2	12	1	3	1
23 May 2014	N	2	1	3	1	3	3	12	1	3	3
24 May 2014	E	3	2	5	1	6	3	13	1	3	3
24 May 2014	L	2	1	4	1	4	3	11	1	3	1
24 May 2014	N	2	2	3	1	3	3	12	2	2	2
25 May 2014	E	3	3	4	2	5	3	13	1	3	2
25 May 2014	L	2	1	4	2	5	4	12	1	3	1
25 May 2014	N	2	2	3	1	3	3	11	2	2	2
26 May 2014	E	3	3	6	2	5	4	13	2	4	3
26 May 2014	L	3	2	5	1	5	4	12	2	2	3
26 May 2014	N	2	2	3	1	3	3	10	1	2	1
27 May 2014	E	3	3	5	2	7	2	13	2	4	2
27 May 2014	L	2	1	4	1	5	1	12	0	2	1
27 May 2014	N	2	2	3	1	3	4	10	1	2	1
28 May 2014	E	3	3	5	3	6	3	16	1	3	2
28 May 2014	L	2	2	6	2	5	4	10	0	3	2
28 May 2014	N	2	2	3	1	3	4	12	2	3	1
29 May 2014	E	3	3	6	3	6	3	13	1	5	2
29 May 2014	L	3	2	6	2	5	3	10	0	3	1
29 May 2014	N	2	2	3	1	3	4	14	3	2	1
30 May 2014	E	3	2	5	2	6	3	11	2	5	2
30 May 2014	L	3	1	5	1	6	3	9	1	3	2
30 May 2014	N	2	1	3	1	3	3	13	2	3	1
31 May 2014	E	3	2	5	1	5	2	12	2	3	2
31 May 2014	L	2	1	4	1	4	2	11	2	2	1
31 May 2014	N	2	1	3	1	3	2	13	2	2	1

HOLCOT WARD: Stroke Rehabilitation

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

Date	E: TOTAL RGNs on shift	E: TOTAL SUPPORT on shift	L: TOTAL RGNs on shift	L: TOTAL SUPPORT on shift	N: TOTAL RGNs on shift	N: TOTAL SUPPORT on shift
01 May 2014	5	4	3	3	3	6
02 May 2014	3	3	3	1	3	4
03 May 2014	5	3	3	3	2	4
04 May 2014	4	4	3	5	3	4
05 May 2014	4	4	3	3	3	4
06 May 2014	5	3	3	3	3	4
07 May 2014	5	4	3	3	3	4
08 May 2014	4	3	3	3	3	4
09 May 2014	5	3	3	3	3	3
10 May 2014	4	3	3	4	3	3
11 May 2014	4	4	3	4	3	4
12 May 2014	6	4	3	4	3	4
13 May 2014	5	3	3	4	3	5
14 May 2014	5	3	3	3	3	3
15 May 2014	4	3	3	3	3	3
16 May 2014	5	3	3	4	3	4
17 May 2014	4	3	3	4	3	4
18 May 2014	4	3	3	4	3	3
19 May 2014	5	3	3	0	3	3
20 May 2014	4	3	3	3	3	5
21 May 2014	5	4	3	3	4	4
22 May 2014	5	3	3	3	3	2
23 May 2014	5	3	3	3	3	4
24 May 2014	3	2	3	4	3	3
25 May 2014	4	2	3	4	4	3
26 May 2014	5	4	3	5	3	4
27 May 2014	5	5	3	5	3	4
28 May 2014	4	4	3	3	3	4
29 May 2014	3	2	3	3	3	4
30 May 2014	5	3	3	1	3	3
31 May 2014	2	3	3	3	3	4

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

Date	E: TOTAL RGNs on shift	E: TOTAL SUPPORT on shift	L: TOTAL RGNs on shift	L: TOTAL SUPPORT on shift	N: TOTAL RGNs on shift	N: TOTAL SUPPORT on shift
01 May 2014	5	4	4	1	4	3
02 May 2014	6	3	4	2	4	3
03 May 2014	6	4	4	3	3	4
04 May 2014	6	4	4	2	4	3
05 May 2014	5	4	4	3	4	2
06 May 2014	6	3	4	3	4	2
07 May 2014	7	4	6	3	4	3
08 May 2014	6	3	5	3	4	3
09 May 2014	7	3	4	3	4	3
10 May 2014	5	4	4	2	4	2
11 May 2014	5	3	4	0	3	2
12 May 2014	6	4	5	3	4	2
13 May 2014	7	4	5	2	4	3
14 May 2014	7	3	4	3	4	2
15 May 2014	6	3	4	2	4	3
16 May 2014	7	3	4	2	4	3
17 May 2014	4	4	4	3	4	2
18 May 2014	5	4	4	2	5	2
19 May 2014	6	4	5	3	4	3
20 May 2014	5	2	5	3	4	3
21 May 2014	6	4	4	3	4	3
22 May 2014	6	3	4	2	5	3
23 May 2014	6	4	4	3	5	3
24 May 2014	6	3	4	3	2	4
25 May 2014	4	5	3	3	4	3
26 May 2014	7	4	4	3	3	2
27 May 2014	6	3	4	2	5	3
28 May 2014	7	4	4	3	4	3
29 May 2014	5	4	3	3	4	3
30 May 2014	6	3	4	3	4	3
31 May 2014	5	3	4	3	4	3

SPENCER WARD: Gynaecology

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

Date	E: TOTAL RGNs on shift	E: TOTAL SUPPORT on shift	L: TOTAL RGNs on shift	L: TOTAL SUPPORT on shift	N: TOTAL RGNs on shift	N: TOTAL SUPPORT on shift
01 May 2014	3	1	2	2	2	1
02 May 2014	3	1	2	1	2	1
03 May 2014	3	2	2	1	2	1
04 May 2014	3	1	2	1	2	1
05 May 2014	3	1	2	2	2	1
06 May 2014	3	1	2	1	2	1
07 May 2014	3	2	2	1	3	2
08 May 2014	3	1	2	1	3	2
09 May 2014	3	1	3	1	3	2
10 May 2014	3	2	2	2	2	1
11 May 2014	2	1	2	1	2	1
12 May 2014	3	1	2	1	3	2
13 May 2014	3	1	2	0	3	2
14 May 2014	3	1	2	1	3	2
15 May 2014	3	2	2	1	3	2
16 May 2014	2	2	2	1	2	1
17 May 2014	2	1	2	1	2	1
18 May 2014	2	1	2	1	2	1
19 May 2014	3	1	2	1	3	2
20 May 2014	3	2	2	1	3	2
21 May 2014	3	2	2	1	3	2
22 May 2014	3	2	2	1	3	2
23 May 2014	3	3	3	2	3	2
24 May 2014	3	2	3	2	3	2
25 May 2014	3	3	3	2	3	2
26 May 2014	3	2	3	1	3	2
27 May 2014	3	2	2	1	3	1
28 May 2014	3	2	2	1	2	1
29 May 2014	3	2	2	2	3	1
30 May 2014	3	1	2	2	2	1
31 May 2014	3	1	2	0	2	1

TALBOT BUTLER WARD: Haematology & Oncology

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

Date	E: TOTAL RGNs on shift	E: TOTAL SUPPORT on shift	L: TOTAL RGNs on shift	L: TOTAL SUPPORT on shift	N: TOTAL RGNs on shift	N: TOTAL SUPPORT on shift
01 May 2014	6	4	5	3	3	3
02 May 2014	8	4	5	3	2	3
03 May 2014	6	4	6	3	3	3
04 May 2014	6	4	4	4	3	3
05 May 2014	6	3	5	3	2	3
06 May 2014	7	4	5	3	3	3
07 May 2014	8	4	6	4	3	3
08 May 2014	7	4	5	3	2	3
09 May 2014	8	3	5	3	3	3
10 May 2014	6	4	5	3	3	3
11 May 2014	6	3	5	4	3	3
12 May 2014	7	3	6	2	3	3
13 May 2014	7	3	5	2	2	3
14 May 2014	7	4	5	3	3	3
15 May 2014	7	4	6	3	2	3
16 May 2014	8	4	5	3	3	3
17 May 2014	6	3	5	3	3	3
18 May 2014	7	3	5	3	3	3
19 May 2014	6	4	5	2	3	3
20 May 2014	6	2	5	2	2	3
21 May 2014	8	4	5	2	3	3
22 May 2014	8	4	5	3	3	4
23 May 2014	8	3	4	3	3	3
24 May 2014	6	3	5	2	2	3
25 May 2014	6	3	5	2	3	2
26 May 2014	8	3	4	3	3	3
27 May 2014	8	4	5	2	2	3
28 May 2014	8	3	5	2	2	3
29 May 2014	7	3	5	3	3	3
30 May 2014	8	4	5	2	3	3
31 May 2014	6	3	5	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

Date	E: TOTAL RGNs on shift	E: TOTAL SUPPORT on shift	L: TOTAL RGNs on shift	L: TOTAL SUPPORT on shift	N: TOTAL RGNs on shift	N: TOTAL SUPPORT on shift
01 May 2014	4	4	3	4	2	2
02 May 2014	4	4	3	4	2	2
03 May 2014	3	3	3	3	2	1
04 May 2014	3	3	3	3	2	1
05 May 2014	5	3	3	3	2	1
06 May 2014	4	3	3	3	2	2
07 May 2014	4	3	3	3	2	1
08 May 2014	4	3	3	3	3	1
09 May 2014	4	3	3	3	2	1
10 May 2014	3	3	3	3	2	1
11 May 2014	3	3	3	3	2	1
12 May 2014	4	3	3	3	2	1
13 May 2014	5	3	3	3	2	1
14 May 2014	4	3	3	3	2	1
15 May 2014	4	3	3	3	2	1
16 May 2014	4	3	3	3	2	1
17 May 2014	3	3	3	3	2	1
18 May 2014	3	3	3	3	2	1
19 May 2014	5	3	3	3	2	1
20 May 2014	4	4	3	3	2	1
21 May 2014	4	3	3	3	2	1
22 May 2014	4	3	3	3	2	1
23 May 2014	4	3	3	3	2	1
24 May 2014	3	3	3	3	2	1
25 May 2014	3	3	3	3	2	1
26 May 2014	5	3	4	3	2	1
27 May 2014	4	3	3	3	2	1
28 May 2014	4	3	3	3	2	1
29 May 2014	4	3	3	3	2	1
30 May 2014	4	3	3	3	2	4
31 May 2014	3	5	3	5	2	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

Date	01 May 2014	01 May 2014	01 May 2014	02 May 2014	02 May 2014	02 May 2014	03 May 2014	03 May 2014	03 May 2014	04 May 2014	04 May 2014	04 May 2014	05 May 2014	05 May 2014	05 May 2014	06 May 2014	06 May 2014	06 May 2014	07 May 2014	07 May 2014	07 May 2014	08 May 2014	08 May 2014	08 May 2014
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
TOTAL RGNs on shift	9	6	5	7	6	5	6	5	5	6	5	5	8	6	5	9	6	5	7	6	5	8	6	5
TOTAL SUPPORT Workers on shift	4	3	2	3	2	3	4	3	3	3	4	3	4	3	1	4	3	2	4	3	2	4	3	2

Date	09 May 2014	09 May 2014	09 May 2014	10 May 2014	10 May 2014	10 May 2014	11 May 2014	11 May 2014	11 May 2014	12 May 2014	12 May 2014	12 May 2014	13 May 2014	13 May 2014	13 May 2014	14 May 2014	14 May 2014	14 May 2014	15 May 2014	15 May 2014	15 May 2014	16 May 2014	16 May 2014	16 May 2014
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
TOTAL RGNs on shift	7	5	5	6	5	5	6	5	5	12	6	5	8	6	5	8	6	5	8	6	5	8	5	5
TOTAL SUPPORT Workers on shift	4	3	2	3	3	2	3	3	2	3	3	2	3	3	2	3	3	3	3	1	1	2	2	1

Date	17 May 2014	17 May 2014	17 May 2014	18 May 2014	18 May 2014	18 May 2014	19 May 2014	19 May 2014	19 May 2014	20 May 2014	20 May 2014	20 May 2014	21 May 2014	21 May 2014	21 May 2014	22 May 2014	22 May 2014	22 May 2014	23 May 2014	23 May 2014	23 May 2014	24 May 2014	24 May 2014	24 May 2014
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
TOTAL RGNs on shift	6	5	5	6	5	5	7	6	5	7	6	5	7	6	5	7	6	5	7	5	5	6	5	5
TOTAL SUPPORT Workers on shift	2	2	1	2	2	1	3	2	2	3	2	1	3	2	3	3	2	2	3	2	1	2	2	2

Date	25 May 2014	25 May 2014	25 May 2014	26 May 2014	26 May 2014	26 May 2014	27 May 2014	27 May 2014	27 May 2014	28 May 2014	28 May 2014	28 May 2014	29 May 2014	29 May 2014	29 May 2014	30 May 2014	30 May 2014	30 May 2014	31 May 2014	31 May 2014	31 May 2014
SHIFT	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
TOTAL RGNs on shift	6	5	5	8	6	4	6	5	5	7	6	5	6	6	5	6	5	5	7	5	5
TOTAL SUPPORT Workers on shift	2	2	1	3	2	1	2	2	2	3	2	2	3	2	2	3	2	3	3	2	1

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Personalised Care Plan for the Dying (PCPFD)
Agenda item	11
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Dolly Barron, Team Leader Specialist Palliative Care Team Wendy Smith, End of Life Care Facilitator.
Purpose	To provide an update to the Board on the care plan that has been designed to replace the Liverpool Care Pathway (LCP) and to seek approval for their implementation following the pilot phase.

Executive summary

The LCP was recommended as a model of good care by the Department of Health's End of Life Care Strategy in 2008, by the General Medical Council in 2010, and the National Institute for Health and Care Excellence in 2011. It was designed to be used as a means to manage a patient's pain and distress when clinicians considered that they were in their last hours or days of life, and there was no appropriate reversible treatment for their condition. The LCP was intended to transfer best practice from hospice care into other settings, and ensure uniformly good care would be given to those thought to be in the last hours or days of life.

Care of the dying is, and will remain 'core business' for the trust. No national tool is going to be developed to replace the LCP, but improved quality of care for the dying remains a priority. This paper presents the NGH 'Personalised Care for the Dying Person and their Family' and asks the board to approve its use to support compassionate care and clinical decision-making for those dying at NGH.

Related strategic aim and corporate objective	Focus on Quality and Safety
Risk and assurance	CQC report and associated risks
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)

Enclosure H

	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N) The PCPFD promotes equality of care by describing the minimum standards which we expect to be provided for our patients at NGH
Legal implications / regulatory requirements	No

Actions required by the Trust Board

The Trust Board is asked to:

- Approve the Personalised Care Plan for the Dying at NGH

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26 June 2014

Personalised Care Plan for the Dying

1. Introduction

The Liverpool Care Pathway (LCP) was recommended as a model of good care by the Department of Health's End of Life Care Strategy in 2008, by the General Medical Council in 2010, and the National Institute for Health and Care Excellence in 2011. It was designed to be used as a means to manage a patient's pain and distress when clinicians considered that they were in their last hours or days of life, and there was no appropriate reversible treatment for their condition. The LCP was intended to transfer best practice from hospice care into other settings, and ensure uniformly good care would be given to those thought to be in the last hours or days of life.

After widespread criticism by bereaved relatives and in the media nationally however, Norman Lamb (Minister of State) asked Baroness Julia Neuberger to chair an independent review of the end of life care in England, including the use of the LCP. In July 2013 the Neuberger report '*More Care, Less Pathway*' was published. It recognised that when used properly the LCP supported many to die peaceful and dignified deaths. However, in a significant number of cases the LCP had been wrongly applied. Nationally therefore the LCP has become associated with poor communication and care, and is now seen as too generic and impersonal. Consequently use of the LCP must be phased out before July 14th 2014.

Providing good end of life care in the acute setting has particular challenges. Without a clear End of Life Care Plan clinicians by default, often treat dying patients as though they are curable. This can mean that dying people are subjected to unnecessary and unpleasant invasive investigations and treatments. It can also mean that both patients and families are left unaware that death is a possibility. This can lead to lost opportunities to say good-bye or heal differences. It also limits patients choice in terms of where they might want to live (and die) all of which are recognised as important aspects of quality at the end of life.

We know that Northampton General Hospital is one of the main providers of care for dying people locally. Care of the dying is, and will remain 'core business' for the trust. No national tool is going to be developed to replace the LCP, but improved quality of care for the dying remains a priority. This paper presents the NGH 'Personalised Care for the Dying Person and their Family' and asks the board to approve its use to support compassionate care and clinical decision-making for dying people here at NGH.

2. Body of Report

When used properly structured approaches like the LCP improve the timeliness and quality of clinical decisions. Evidence suggests that when used well, families were more likely to be involved and informed, and patients more likely to experience a peaceful and dignified death. However, the national review identified evidence of poor practice. At a National level it became clear that however well intentioned, the LCP was not being applied properly. Many of the problems in the care of the dying were not necessarily due to the LCP itself, but to poor understanding among clinicians of best practice and an unwillingness to discuss with patients, and relatives when death is a possibility. The LCP has never-the-less become associated with poor communication and care, and is now seen as too generic and impersonal. Consequently use of the LCP must be phased out by July 14th 2014.

Enclosure H

The Leadership Alliance for Care of the Dying Person (Alliance) was convened in response to the Neuberger report. The Alliance is independent of government and Chaired by Dr Bee Wee, National Clinical Director for End of Life Care at NHS England. Membership comprises statutory and voluntary organisations and includes: Professional bodies (medical and nursing), Care Quality Commission (CQC) and the NHS Trust Development Authority (NTDA). Alliance work has also included detailed consultation with bereaved relatives, the general public and front-line clinical staff.

The Alliance has identified five aspects necessary to provide high-quality care for dying people:

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the person who is dying, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Full details of the Alliance work has not yet been published, but it has been made explicit that no national guidelines or care plans will be provided. There is an expectation that health communities will work together locally and develop systems and care-plans which pay attention to these five broad areas of care.

3. Developing a Personalised Care Plan for the Dying

With the agreement of the NGH End of Life Strategy Group, we are running two strands of urgent work to address the transition away from the LCP. Firstly, the End of Life Care Facilitator (Wendy Smith) and Specialist Palliative Care Team Leader (Dolly Barron) are working in collaboration with the Northamptonshire End of Life Care 'task and finish' group to develop county-wide guidance for end of life care. This is a multi-professional and multi-agency group. Whilst it is anticipated that the county-wide document will reflect the broad national recommendations, it will not provide detailed clinical guidance sufficient to capture individualised care given to people in the last hours of life.

A more detailed individual care plan is therefore needed to support the care of people in the last hours or days of life. Wendy Smith and the Specialist Palliative Care Team (SPCT) have been leading on the development of the personalised end of life care plan for use in NGH (Appendix 1). A multi-disciplinary steering group was convened comprising: ward based nurses (surgery, medical, oncology, emergency assessment and critical care wards), a member of the hospital chaplaincy, PALS and the SPCT. We have been careful to ensure that nurses and doctors who provide direct care for dying people have been consulted and their feedback used in the care-plan development.

Timely and sensitive communication with patients (and those important to them) underpins the care plan. It also addresses the five broad elements of good care identified by the national Alliance, and additional necessary requirements such as identifying the named consultant and nurse responsible for providing care. Written information to support the care plan and provide sensitive explanation for relatives has also been developed (Appendix 2).

At the request of nurses and doctors, guidelines for safe symptom control prescribing at the end of life are incorporated in the plan. The up-dated guidelines reflect Palliative Adult Network Guidelines (PAN Guidelines 2011) and will include illness-specific recommendations such as when prescribing in renal failure. These will all be made available on the intranet. A brief has been submitted for ratification of the revised guidelines to the Medicines Optimisation Committee in preparation for piloting the use of the new plan (Appendix 3).

Unlike the LCP, the plan is not devised as a separate folder, but will be part of the existing clinical notes, so that there is a clear and single record of care given. The focus of care, clinical assessment and monitoring within the care plan also reflects the indicators of the quality which are assessed within the National Care of the Dying Audit. The Trust participated in the national programme last year, and will be conducting a local re-audit in the autumn.

4. Assessment of Risk

In modern society, death can often be seen as a failure, rather than as the natural consequence of advanced and progressive illness. National evidence suggests that poor standards are largely based around failure to recognise and acknowledge the end of life, and subsequently failing to communicate with patients and their families that death is a possibility. At NGH we want to generate a culture of care trust-wide so that where death cannot be prevented, we do what can be done to promote a peaceful and dignified death. We know that for individual patients there is only one chance to get it right.

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

5. Next Steps

The End of Life Steering Group has agreed to pilot the care plan on two wards which has been supported by the Chief Executive and Medical Director. These wards are the Emergency Assessment Unit EAU, and Talbot Butler. The pilot will commence on 23rd June 2014. This work will enable 'real-time' testing and evaluation of the care-plan, under close monitoring and support of the End of Life Care Facilitator and the SPCT.

An action plan for implementing the transition to the new care plans will be agreed at the next End of Life Care Strategy Group in July. Revisions to the care plan resulting from the pilot will be agreed at this meeting.

There are 'drop-in' awareness sessions, and the Palliative/End of Life Care link nurses in each ward will also receive 'Train the Trainer' education on June 27th 2014. This will increase local expertise – the Link Nurses can help their own ward areas and influence sustainability.

The trust has a new system for raising awareness of the needs of our dying patients. This started in May 2014, and uses the daily 'Patient Safety Huddle' to create the 'End of Life Care Register' which is held by the SPCT. This enables the whole organisation to better recognise and focus upon the needs of the dying and focus additional staffing and specialist support where it is needed in 'real-time'. The Huddle and the End of Life Register will enable the SPCT and the End of Life Facilitator support and monitor the transition to the Personalised Care Plan across the trust from Monday 14th July 2014.

The trust participated in the National Care of the Dying Audit Round 4 (NCDA). , The audit was based on the recommendations of the Neuberger report (2013) and local results have helped establish our existing standards for care of the dying. There will be a re-audit in the autumn following the NCDA outline to help evaluate the effectiveness of individualised care

plans. Audit of care for dying patients is now part of the NGH Trust annual audit programme.

Implementation will also include a 'real time' audit of the notes and care provided to patients who die in the trust. This data will be analysed on a monthly basis for at least the first six months, with reporting and subsequent action presented to the End of Life Care Strategy Group (Monthly until Dec 2014 and quarterly from Jan 2015). We will monitor both when 'Personalised Plans' are used, and when not used. Learning from the LCP and moving forward we need to ensure that if a clinician recognises a dying patient and uses the Individualised plan that they have the necessary confidence and knowledge to do so correctly.

We also need to understand at ward level where dying patients' needs are not being recognised and care plans not being used. This highlights the need for all staff to be to maintain competencies related to End of Life Care. The trust is developing its first End of Life Care Training and Education Strategy (and the prospectus to support this). Implementation (and sustainability) of the Personalised Care Plan and good end of life care which it supports, is not viable without well trained staff able to recognise and value care for the dying, and support patients (and families) with sensitivity and compassion.

6. Recommendations/Resolutions Required

The Trust Board is asked to endorse the document and approve the process of development, piloting, evaluating and continual monitoring of the care plan.

NGV0000
06/14

Northampton General Hospital NHS
NHS Trust

Personalised Care for the Dying Person and their Family

Initial Assessment

ADDRESSOGRAPH LABEL

The principles of the 2005 Mental Capacity Act should be applied throughout the care process. Discussion and information should reflect the individual's preferences

RECOGNITION OF THE DYING PHASE

- The possibility that a person may die with the next few days or hours is recognised and communicated clearly with the individual person and family/significant others.
- The named consultant is responsible for ensuring that all decision making and subsequent actions are in accordance with the individual person's wishes. An individual plan of care is established; regularly reviewed, decisions revised accordingly and actions are clearly documented.
- It is the responsibility of the team members to deliver the individualised plan of care with compassion, provide ongoing assessment of physical, psychological, spiritual and social needs of both the dying person and their family/significant others

N.B. The named consultant must sign the box below prior to the commencement of the personalised care document. All team members involved in care must sign the signatory sheet on page 12

File behind ******** – ***** divider

Date: ..... Time:	Named Consultant: ..... Signature: .....

Team members included in assessment and review of individual person plan of care (minimum Doctor & senior nurse)

Name: ..... Position: ..... Signature: .....
Name: ..... Position: ..... Signature: .....
Name: ..... Position: ..... Signature: .....
Name: ..... Position: ..... Signature: .....

Reason for Admission:
Diagnosis:
Co-morbidities:
Summary of investigations, treatment and response:

SENSITIVE COMMUNICATION WITH THE FAMILY

- The recognition that a person is dying should be in collaboration with the individual person if appropriate and always with the family/significant others. This should include:
- What is happening and why you think the person is dying.
- Discussion of the individual person preferences, wishes and priorities of care, likely prognosis and clinical uncertainties.
- Individualised plan of care.
- Ascertain any concerns the individual person and/or family may have.
- Provide information on local facilities, parking, open visiting etc.
- End of life care at Northampton General Hospital leaflet given Yes ☐ No ☐

Communication with the individual person and family/significant others

Date: ..... Time: .....

Person present:

Patient: Conscious ☐
Semi-conscious ☐
Unconscious ☐

Summary of discussion:

Family/significant other contact detail	
Next of Kin/First Contact:	Next of Kin/First Contact:
Relationship to patient: Contact any time? Yes ☐ No ☐ Comments	Relationship to patient: Contact any time? Yes ☐ No ☐ Comments
Tel No:	Tel No:
Mobile:	Mobile:

PREFERENCES AND/OR WISHES AT THE END OF LIFE

It is important to understand any physical, psychological, social or spiritual needs a individual person and family/significant others may have. What is important to them right now? This may be personal, religious or cultural (Please detail below).

Does the individual person have an:	Yes	No
Advance Care Plan?		
Advance Decision to refuse Treatment?		
Registered Organ Donor?		
Lasting Power of Attorney for Health Welfare appointed? Name:		
Lasting Power of Attorney for Property and Financial affairs appointed? Name:		

Priorities and preferences of individual person

Chaplaincy support offered Yes ☐ No ☐
Religion: ..... Practising: Yes ☐ No ☐
Patient consent to Chaplaincy: Yes ☐ No ☐
Family/significant others consent to Chaplaincy Yes ☐ No ☐

Priorities/preferences of family/significant others for the individual person

Priorities/preferences after death

Clinical Decisions made after discussion with individual person and family/significant others **Date:** ..... **Time:** ..... **Dr:** ..... **Sign:**	Yes	No	N/A
Treatment Escalation Plan updated			
Allow a natural death, Do Not Attempt Cardiopulmonary Resuscitation discussed and in place.			
Investigations/observations: Routine observations			
Blood Glucose			
Blood Tests			
Oxygen			
Antibiotics			
Discontinuation of non-essential medicines			
Pre-emptive prescribing as per local guidelines (Pain, Breathlessness, Agitation, Delirium, Nausea/Vomiting & Respiratory Tract Secretions).			
Has the patient got an Implantable Cardiac Defibrillator?			
Has the patient's ability to take oral fluids been assessed?			
Are they able to take oral fluids?			
Are they able to take food orally?			
Have risks and benefits of artificial hydration been reviewed?			
Intravenous fluids appropriate?			
Subcutaneous fluilds appropriate?			
Have risks and benefits of artificial feeding been reviewed?			
Enteral feeding appropriate?			
Parental feeding appropriate?			
Other:			

Common symptoms at the end of life	
A)	**Pain or Discomfort** ● Assess pain using verbal and non-verbal communication, ● "Continuous" "On movement" ● Record on pain chart and variance sheet. ● Consider reversible causes; position, constipation, retention etc. ● Have pre-emptive opioids been prescribed?
B)	**Agitation** ● Consider reversible causes; constipation, urinary retention, anxiety/fear. ● Has pre-emptive Midazolam been prescribed?
C)	**Delirium** ● Is there altered consciousness? Is the patient seeing or hearing things or "picking at the air? ● Has pre-emptive Haloperidol been prescribed?
D)	**Nausea and/or vomiting** ● Have reversible causes been considered? ● If this is an existing symptom ensure a regular anti-emetic is prescribed and administered parentally. ● Is a NG tube required to minimise distress of vomiting? ● Tissues and bowls to hand. ● Have pre-emptive anti-emetics been prescribed?
E)	**Breathlessness** ● Calm, reassure and comfort. ● Provide flow of air i.e. window, fan therapy, Oxygen if prescribed. ● Treat rapid breathing with opioids. ● Cheyne-Stokes breathing - explain and offer reassurance to family/significant others. ● Have pre-emptive opioids been prescribed?
F)	**Respiratory tract secretions** ● Respiratory tract secretions occur in dying patients who are no longer conscious. They are not believed to be distressing to unconscious patients, but difficult for family and significant others to listen too. ● Moist breathing/bubbling can occur as a consequence of heart failure, respiratory tract infections. Does not usually respond to Glycopyrronium. ● Change position. ● Gentle suction only if secretions have pooled inside the mouth. ● Has Glycopyrronium been prescribed?
G)	**Mouth Care** ● Frequent sips if able (beaker/syringe). ● Moisten mouth regularly with foam sticks. ● Artificial saliva (Biotain Gel). ● Vaseline to lips (KY Jelly if using oxygen).
H)	**Nutrition** ● Oral diet as desired and tolerated by patient. ● Have discussions taken place regarding artificial nutritional support?

Common symptoms at the end of life continued	
I)	**Dehydration** ● Ice chips to suck if appropriate ● 2 hourly mouth care ● Have discussions taken place regarding hydration? ● Explain to family if necessary that IV fluids do not increase comfort.
J)	**Thirst** ● IV fluids ● SC fluids 50-100ml\hour (i.e. 1.2-2.4L\day). The thighs are the best site.
K)	**Urinary Problems** ● Is the patient in retention? ● Protect skin if incontinent. ● Is the patient catheterised?
L)	**Bowel problems** ● Constipation – is bowel care appropriate? ● Diarrhoea - ? Faecal catheter. ● Protect skin if incontinent.
N)	**Vulnerable Skin integrity** ● Continue the use of the SSKIN Bundle
M)	**Recognised emotion, psychological or spiritual distress?** ● What are the present needs of the individual person? ● What are the present needs of the family/significant others? ● Can these be addressed at ward base level or require specialist input? ● Refer to Specialist Palliative Care Team if help/advice is needed.

If symptoms persist for more than 24 hours or for further advice, contact the Specialist Palliative Care Team on extension 4484, bleep 4451. Or out of hours, contact Cynthia Spencer Hospice 01604 678031.

Management of Breathlessness

Does the patient complain of breathlessness?

No

Prescribe in anticipation of the symptom developing:

- Morphine Sulphate 2.5-5mg by subcutaneous injection, PRN maximum 30 minute intervals, and Midazolam 2.5mg by subcutaneous injection, PRN maximum 30 minute intervals.

If breathlessness develops, follow guidelines as for a patient who is breathless.

Yes

First Considerations:

- Reposition the patient, e.g. sit up in bed
- Calm and reassure patient and carers by touch, talking and explanation.
- Keep air moving across the face e.g. open the window, use a fan or try oxygen

Is the patient taking regular Morphine Sulphate?

No

- Give Morphine Sulphate 2.5-5mg by subcutaneous injection.
- If not sufficiently effective give 2.5mg Midazolam by subcutaneous injection.
- Doses can be repeated every 30 minutes as required.
- Specialist advice should be sought if symptoms persist (e.g. after 3 PRN doses in quick succession).
- After 24 hours, review medication
- If two or more PRN doses required, consider a T34 McKinley continuous syringe pump

Patients who have not taken opioids before should be prescribed Haloperidol 0.5mg PRN subcutaneous as an anti-emetic.

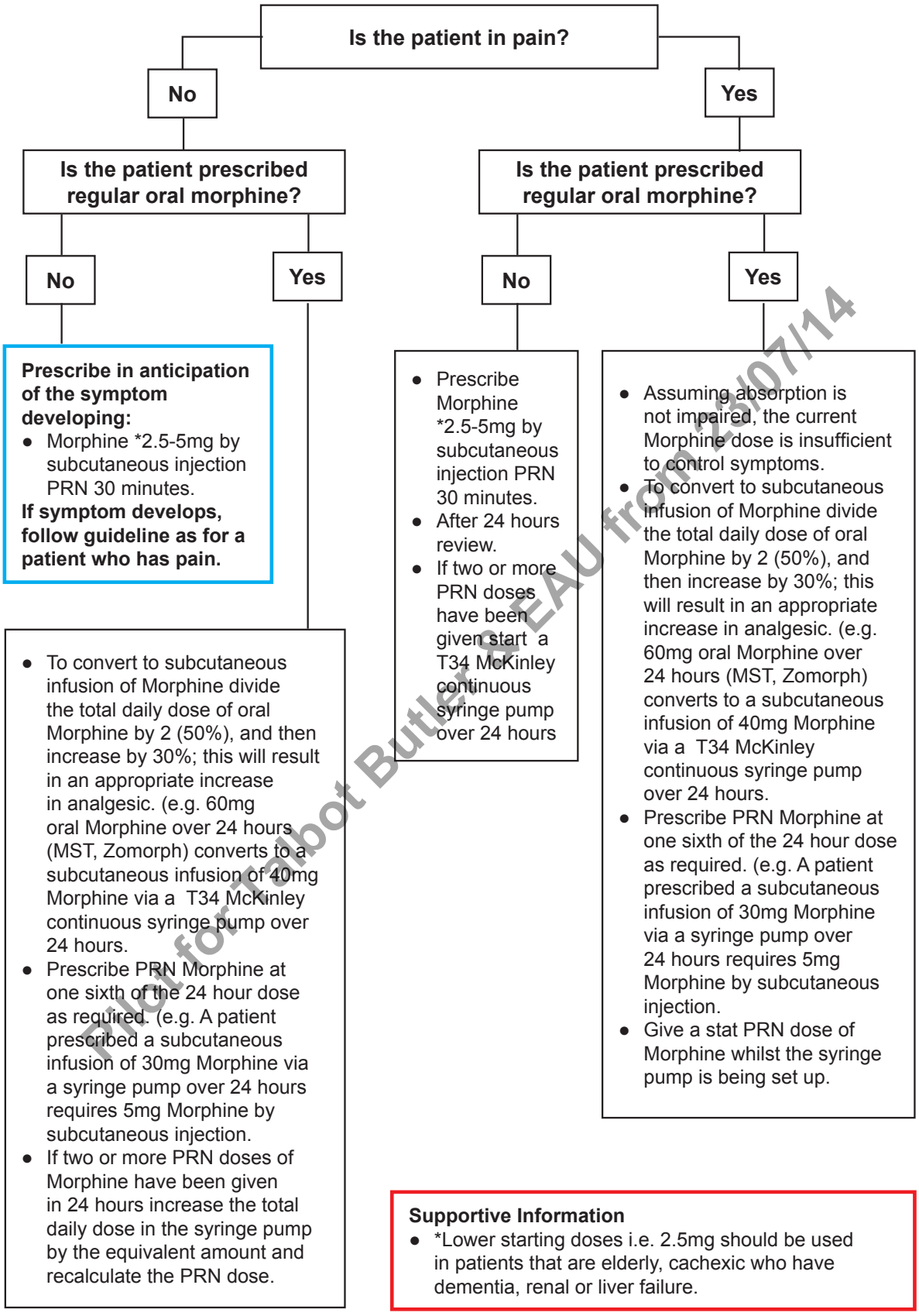
Yes

- Assuming absorption is not impaired, the current Morphine Sulphate dose is insufficient to control symptoms.
- To convert a patient from oral Morphine Sulphate to a subcutaneous infusion of Morphine Sulphate divide the total daily dose of oral morphine by 2 (50%), and then increase the dose by 30%; this will result in an appropriate increase in the amount of opioid being given.
- Give PRN Morphine Sulphate at one sixth of the 24 hour dose (see Management of Pain).
- If not sufficiently effective give 2.5mg Midazolam by subcutaneous injection.
- Review after 24 hours. If two or more doses of Midazolam have been given, consider starting a subcutaneous infusion of 5-10mg Midazolam over 24 hours via a T34 McKinley continuous syringe pump.

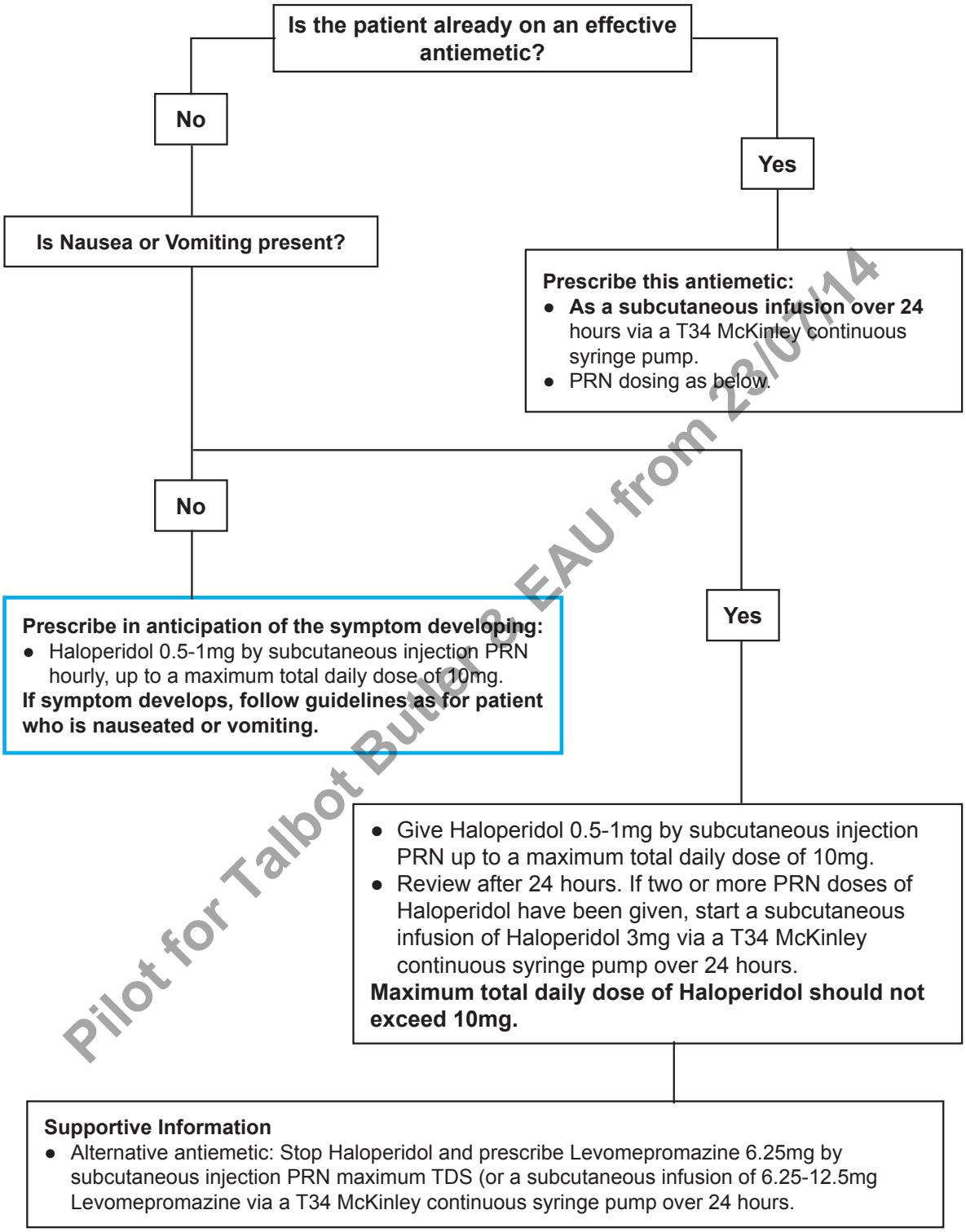
Supportive Information

- Morphine Sulphate is used for the relief of the sensation of breathlessness; Midazolam is used for the relief of anxiety associated with breathlessness.
- To convert oral Morphine Sulphate to subcutaneous Diamorphine, divide the oral dose by 3.

Management of Pain with Morphine



Management of Nausea & Vomiting



Management of Respiratory Tract Secretions

- Noisy respiratory tract secretions can be a normal part of dying
- Consider whether they are troublesome or need treating at all
- Changing the patient's position is the first step of management.

Does the patient have troublesome respiratory tract secretions?

No

Prescribe in anticipation of symptom developing:

- Glycopyrronium 200 micrograms by subcutaneous injection PRN, up to every four hours

If symptoms develop, follow guidelines as for a patient who has respiratory tract secretions.

Yes

Consider:

- Patient positioning
- Stopping intravenous or subcutaneous fluids or PEG feed.

- Give Glycopyrroniun 400 micrograms by subcutaneous injection as soon as symptom arises and 200 micrograms PRN up to every four hours.
- If two or more doses of Glycopyrronium have been given and are effective, start a subcutaneous infusion of 800 micrograms Glycopyrronium via T34 McKinley continuous syringe pump over 24 hours.

If symptoms persist, increase the total daily dose to a maximum of 1.2mg Glycopyrronium over 24 hours.

Supportive Information

- In a VERY SMALL number of patients, suction may be helpful.
- This is a difficult symptom to treat and drugs may not be effective. Remember to reassure family/significant others.
- Hyoscine Hydrobromide is an alternative but is sedative and frequently causes confusion (400micrograms stat and up to 2.4mg over 24 hours).

Management of Restlessness & Agitation

Is the patient restless or agitated?

No

Prescribe in anticipation of the symptom developing:
- Midazolam 2.5-5mg by subcutaneous injection PRN 30 minutes.

If symptom develops, follow guidelines for a patient who is restless or agitated.

Yes

Consider underlying causes:
- Uncontrolled pain
- Full bladder
- Full rectum
- Breathlessness
- Anxiety/fear resolve where possible

If the patient's distress cannot otherwise be relieved

Where anguish and anxiety are predominant:
- Give Midazolam 2.5-5mg stat and PRN by subcutaneous injection (this may need to be repeated after 30 minutes).
- If two or more doses have been given in 24 hours, start a subcutaneous infusion of 10mg Midazolam over 24 hours via a T34 McKinley continuous syringe pump.
- The subcutaneous infusion dose may need to be increased gradually to Midazolam 30mg via a T34 McKinley syringe pump over 24 hours.

Where delirium and psychotic features are predominant (e.g. hallucinations, confusion):
- Give Haloperidol 1.5mg stat and 0.5-1mg Haloperidol PRN by subcutaneous injection up to a maximum total daily dose of 10mg.
- Start a subcutaneous infusion of Haloperidol 3mg and Midazolam 10mg via a T34 McKinley continuous syringe pump over 24hours.
- As second line, if two or more PRN doses required (i.e. Haloperidol ineffective) give Levomepromazine12.5-25mg by subcutaneous injection PRN 2 hourly. If two or more doses required in 24 hours start 50mgs Levomepromazine subcutaneous infusion via a T34 McKinley continuous syringe pump over 24 hours and call Specialist Palliative Care Team (Bleep 4451).

Signatory sheet

Name (print)	Full signature	Initials	Professional title/contact	Date

NGV0000
06/14

Northampton General Hospital NHS
NHS Trust

Personalised Care for the Dying Person and their Family

DAILY CLINICAL REVIEW

ADDRESSOGRAPH LABEL

Day ..... Date .....

As a ward team please consider the following:	Yes	No
Is the patient at risk of dying in the next few days/hours?		
Have the holistic needs of the patient changed?		
Have the needs of the family/significant others been assessed?		
Have you reviewed and updated the patient if appropriate and/or family/ significant others?		
NAME OF ASSESSOR:	**SIGNATURE OF ASSESSOR:**	

If there are clinical actions required following the above assessment please document these in the plan below or free text on communication sheet

Need/Preference	Action	Outcome
Physical	TIME: ..... SIGN:	TIME: ..... SIGN: .....
Nutrition/Hydration	TIME: ..... SIGN:	TIME: ..... SIGN: .....
Communication	TIME: ..... SIGN:	TIME: ..... SIGN: .....

File behind ******** – ***** divider

Enclosure H

-1-

Personalised Plan of Care for the Dying Patient and their Family
Multidisciplinary Communication Sheet

Date	Time	(Each entry must record a signature and name in block capitals, date, time and bleep number)

Day ..... Date .....

Daily Assessment Record **Please initial each symptom A-N following assessment and document actions required below** (Each symptom must be assessed at 4hrly intervals and signatory sheet must be completed).							
Assessment		**Time**	**Time**	**Time**	**Time**	**Time**	**Time**
A)	**Pain or Discomfort**						
B)	**Agitation**						
C)	**Delirium**						
D)	**Nausea and/or Vomiting**						
E)	**Breathlessness**						
F)	**Respiratory Tract Secretions**						
G)	**Mouth Care**						
H)	**Nutrition**						
I)	**Dehydration**						
J)	**Thirst**						
K)	**Urinary Problems**						
L)	**Bowel Problems**						
M)	**Vulnerable Skin Integrity**						
N)	**Emotional/Psychological/Spiritual**						
Name of responsible nurse							
Signature							

If symptoms are uncontrolled you must identify the action required and measure the outcome.		
Symptom/Problem/ Need	**Action Required**	**Outcome**
TIME: ..... SIGN:	TIME: ..... SIGN:	TIME: ..... SIGN: .....
TIME: ..... SIGN:	TIME: ..... SIGN:	TIME: ..... SIGN: .....

Symptom/Problem/ Need	Action Required	Outcome
TIME: ..... SIGN:	TIME: ..... SIGN:	TIME: ..... SIGN: .....
TIME: ..... SIGN:	TIME: ..... SIGN:	TIME: ..... SIGN: .....
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ONCOLOGY DEPARTMENT

PATIENT INFORMATION

Enclosure H

End of life care at Northampton General Hospital

Information for relatives and friends

Northampton General Hospital NHS Trust

Introduction

The doctors and nurses will have explained there has been a change in your relative or friends condition that indicates they are dying. This booklet provides information about care at Northampton General Hospital when a person is believed to be in the last hours or days of life.

The dying process is unique to each person but in most cases, there are common characteristics or changes which help to indicate a person is dying. A plan of care will be put in place to support the patient in receiving the best quality care at the end of life. Patients, if able and relatives or friends are invited to be involved in discussion regarding the plan of care, with the aim that everyone fully understands the reason why decisions are being made. If a person's condition improves, then the plan of care will be reviewed and changed if needed. All decisions will be reviewed daily.

It is difficult to predict exactly what will happen or how quickly changes will occur. However, dying people usually become very weak with decreasing energy to carry out day to day activities, eventually becoming too weak to talk or respond to family and friends. Dying people spend increasing periods sleeping and are often drowsy when awake. Eventually dying people usually lapse into unconsciousness, sometimes this is just for a short period before death, sometimes people can remain in this state for a surprising amount of days.

Communication

The ward team will ask for your contact details, as keeping you up to date is our priority. You will be asked if you wish to be contacted urgently if we notice any further deterioration in your

relative or friends condition and we will do our utmost to inform you of changes as they occur. The ward team will try to give you some privacy whist visiting, but please let them know if you have any questions or concerns.

Sometimes it is hard to know what to do when visiting a dying person in hospital. Even if the person is too unwell to respond, they may still be able to hear and know you are there. Talking and sharing memories and news of family and friends or simply spending time together can be comforting to both the dying person and yourself.

When a dying person is drifting in and out of consciousness, they may not seem to recognise you or other people around them which is sometimes upsetting. If they appear to become panicky or agitated, please let the ward staff know and we can help them feel more settled

Comfort

When a person is dying and the focus changes from routine monitoring to individualised comfort care, it may be appropriate to stop tests such as blood taking, blood pressure and temperature monitoring. The ward team will make regular assessments around comfort, please feel free to discuss this if you wish.

Medication

Medicine that is no longer helpful will be stopped. It may not be possible for a dying person to take medication by mouth, so medication may be given by injection or sometimes if needed, by a continuous infusion by a small pump. All medicines are tailored to an individual person's needs and medicines for symptom control will only be given when needed, and no more than is needed to

help the symptom. Although many people do not experience any new symptoms when dying, the team will arrange medication for common symptoms such as pain, restlessness and nausea to be available so that if they occur, they can be managed quickly.

Reduced need for food and drink

Loss of interest in, and a reduced need for food and drink is part of the normal dying process. This can be upsetting to see as it is a physical sign that a person will not get better. Dying people can be supported to eat and drink for as long as they wish to. If people cannot take fluids by mouth, fluids by drip will be considered. However, fluids are only given by drip if they would be helpful, not harmful. The decision whether to start a drip or not will be explained to the patient if possible, and to you, and will be reviewed daily.

It is always important to offer dying people 'mouth care'. Dry mouths can be refreshed regardless of whether a person is able to drink. Moistening the mouth with a damp sponge and applying lip salve aids comfort. If you would like to help with mouth care, the nurses will be happy to show you how.

When death is imminent

There are no certain stages of dying and exact timescales can be difficult to predict, but there are some familiar features that people may experience.

Occasionally, in the last hours of life there can be a noisy rattle to the breathing. This is due to a build-up of mucous that a person is no longer able to cough up. Medication and changes in position may help, but these measures have limited success. While noisy

breathing is upsetting to loved ones it rarely appears to distress dying people.

When death is very close (within minutes or hours), breathing patterns may change. Sometimes there are very long pauses between breaths, or breathing becomes very shallow and fast. People might switch between these two types of breathing.

The skin can become pale, moist and cool prior to death. Most people do not rouse from sleep, but die peacefully. If you feel they are not as settled as you would wish, please call a member of staff who will review the situation with you and might suggest specific care or medication to help comfort.

For most people, the final moments of life are very peaceful. Sometimes it is difficult to pinpoint the exact moment of death. If you are present at the time of death, you may wish to call a nurse for reassurance, but you do not have to if you prefer not to. You are welcome to stay with your relative or friend for a while after they have died. There are other opportunities to see them again, you will be given written information about what happens after someone has died before you leave.

Sometimes it is not possible to be with a person as they die even if you wish to be, as changes can be very subtle and give little or no time to inform you. This is likely associated with the dying person being very settled and therefore not causing concern. If you struggle with the idea of not being present when your loved one dies, please speak to a member of the ward team about your concerns.

Religion/spiritual needs

It is important we understand a person's wishes when they are dying and those of their friends/relatives. If possible, a person who is dying will be asked if they have any religious or spiritual needs. You might be asked on their behalf if they would want support from a chaplain or other spiritual advisor regarding special needs now, at the time of death or after death.

If someone has no formal religion but other values, beliefs, wishes or desires at the end of life, please let the ward team know and we will do our best to support any needs of this nature.

Facilities for relatives and friends

Refreshments and Catering

Café Royale serves drinks, snacks, sandwiches and pastries at Cliftonville main reception, (Area D).

Opening Hours
08:00 – 19:00 Monday to Friday.

The Cliftonville restaurant is situated centrally on Hospital Street and offers a wide range of hot and cold meals.

Opening Hours
07:15 – 19:00, Monday to Friday
07:15 – 18:00, Saturday and Sunday

Shops

The Royal Voluntary Service runs shops at the hospital, which both sell confectionery, soft drinks, crisps, fruit, toiletries, stationery, stamps, cards, toys, small gifts, newspapers and magazines. You will also find cash machines located near the shops.

The shops are situated:
Close to South entrance, (Area B, near the main car park)

Opening Hours
Monday to Friday - 07:00 – 20:00
Saturday, Sunday and Bank Holidays - 10:00 – 16:00

At the Billing Road entrance, (Area T)

Opening Hours
Monday to Friday - 09:00 – 16:00

Cash points

There are cashpoints situated near both shops, close to South entrance, (Area B, near the main car park), and at the Billing Road entrance.

Visiting times

Our standard visiting times for most inpatient areas are:
14:00 – 16:00
18:00 – 20:00

However various visiting arrangements may apply to certain wards It is likely a more flexible approach will be offered when a person is dying and often ‘open visiting’ can be arranged. To ensure your special circumstances are taken into account, please talk to member of staff on the ward.

Parking

There are various car parks around the Hospital. Unfortunately parking in the hospital can be a significant problem between 09:00 – 16:00. If you cannot park at the hospital, there are public car parks in the town centre, which is a short walk away.
Pay on Foot ticket machine operate in car park 1 and gives you change. Pay and Display operates in car parks 2 (available to the public 15:00 – 07:30), 3 and 4, they do not give you change. Some subsidised parking is available and might be preferable for people who visit frequently or for long periods, please speak to ward staff for further details.

Caring well for your relative of friend as they approach the end of their life is important to us. Please speak to the doctors or nurses if there are any questions that occur to you, no matter how small you think they may be or how busy staff may seem. This may all be very unfamiliar to you and we are here to explain, support and care.

Useful local and national contacts

Cruse (bereavement care). For people bereaved in any way, whatever their age, nationality or beliefs. This service is only offered from six months following bereavement, you can make contact around two months after a bereavement

National telephone: 08444779400
Northampton telephone: 07772 428532
Web: www.crusebereavementcare.org.uk
e-mail: helpline@cruse.org.uk

The Way foundation. (support and social network for young widows/widowers)

National telephone: 0300 012 4929
Web: www.wayfoundation.org.uk
e-mail: info@wayfoundation.org.uk

Lowdown. (Youth information and counselling service)

Northampton telephone: (01604) 622223
Web: www.thelowdown.info

Northampton children's and adolescents bereavement group

Northampton telephone: (01604) 545131

Winston's wish. (Support for bereaved families and children)

National telephone: 08452 030405
Web: www.winstonswish.org.uk

The Samaritans.

National telephone: 08457 90 90 90
Northampton telephone: (01604) 637637

Notes

Useful websites

www.nhs.uk

www.northamptongeneral.nhs.uk

Other information

Northampton General Hospital operates a smoke-free policy. This means that smoking is not allowed anywhere on the Trust site, this includes all buildings, grounds and car parks.

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Northampton General Hospital NHS Trust, Cliftonville, Northampton NN1 5BD.
www.northamptongeneral.nhs.uk
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ONCOLOGY DEPARTMENT

PATIENT INFORMATION

Strong Opioids (Painkillers)

Information for patients

Enclosure H

Northampton General Hospital NHS Trust

Introduction

This leaflet explains what opioids are and what we think you might want to know about them. It does not replace conversations with your doctor, nurse or pharmacist. Reading this leaflet may help you decide what questions to ask when you next speak to someone from your healthcare team.

Usually, the first step to deal with pain is to try a simple pain killer, like paracetamol, on a regular basis. Sometimes this may be combined with a further medicine, like ibuprofen, an anti-inflammatory pain killer. If this is not effective the next step is generally a stronger pain relief medicine like codeine. If your pain is still not well controlled then your doctor or nurse specialist will usually prescribe a strong opioid.

What are opioids?

Opioids are a group of medicines that have been used for many years to treat pain. They provide pain relief by imitating the body's natural pain relievers. Morphine is the most commonly used example.

Examples of ***weak*** opioids include **codeine** and **dihydrocodeine**. Sometimes they are combined with paracetamol to make them work better. Codeine is available in low doses over-the-counter in the UK in combination with paracetamol (co-codamol). **Morphine** is a ***stronger*** opioid. Other examples of strong opioids include **diamorphine**, **oxycodone**, **hydromorphone** and **fentanyl**. Opioids medicines come in a variety of ways including tablets, capsules, liquids, skin patches and injections.

When are strong opioids used?

Most people who are prescribed a strong opioid have a lot of pain. This pain can be present for various reasons such as cancer, heart, kidney or lung disease or following an accident or operation. If simple pain killing medicines are not enough to control the pain, this is when opioids can be a better option. The first opioid treatment offered is usually morphine. It should be offered in a form that you can take by mouth, such as tablets, capsules, liquid or powder. Your dose will be adjusted to your pain to find the maximum benefit for you.

What are the benefits of taking strong opioids?

Strong opioids are good at relieving many types of pain, and you will have been prescribed them because your healthcare professional believes they will help. If they help reduce your pain or distress it may improve your ability to function both physically and socially. This may also allow you to eat and sleep better. Sometimes pain can be a reason for people not wanting to move, for example after a bone fracture. By reducing this pain, morphine can help you achieve goals like walking, rehabilitation and being more independent.

Common worries or concerns about strong opioids

Some people worry that they will become addicted to strong opioids or that there will be unpleasant side effects. Your healthcare professional should reassure you that addiction to opioids is very unlikely when used appropriately for pain and that you will be

monitored carefully for side effects. They should also reassure you that being offered strong opioids can happen at different stages in the course of an illness, and it does not necessarily mean you are close to the end of your life. Some people find that a short course of strong opioids is required to get over an event like an accident, operation or illness and pain can then be managed with simple pain killers after this. If you are finding it difficult to manage without your painkillers or feel you need a bigger dose, please discuss with you doctor.

Background pain and breakthrough pain

Your pain will be different to other people's pain, even if you have the same type of illness. When you feel pain and how much pain you feel will vary from day to day and hour to hour. Often how 'bad' a pain is will depend on a range of factors; for example how tired you are, how active you have been the day before or whether you are bored or enjoying what you are doing. This can mean that the same dose of medicine each day may not fully 'match' your pain. A pain which is present nearly all the time, at a predictable level, is usually referred to as **background** pain and can be treated with a regular **long-acting** strong opioid at a set dose.

For those occasions when, for whatever reason, your pain levels increase for a while (known as **breakthrough** pain), you will be prescribed a **fast acting immediate release** opioid which will add to your background dose for a few hours, to cover the extra pain you have experienced.

What are the usual doses of opioids and how should I take them?

It is important to find the most effective dose to relieve your pain. The amount needed to control pain varies from person to person. There is no standard dose of an opioid as pain is a very personal experience. You will usually start with a low dose and gradually build it up until you find the dose that suits you. Your doctor, nurse or pharmacist will explain how to take your medication. A typically prescribed opioid, like morphine, is usually used in a combination of two forms: a **long-acting** (sustained-release) form and a **fast-acting** (immediate-release) form:

Fast-acting morphine is often prescribed as a liquid (Oramorph) or a tablet (Sevredol). It starts working quickly, after about 15 to 30 minutes, and can wear off after about three to four hours. If you get additional pain you can take **rescue** or **breakthrough** doses of the same medicine at the same dose.

Long-acting preparations of morphine are used to control **background** pain which is constant and continuous. Doses are taken at regular times each day to prevent the pain recurring. These preparations will take a few hours to start reducing pain and are likely to last for up to twelve hours. If the pain is not controlled by this long-acting preparation alone, you can take additional rescue doses of the fast-acting version for any breakthrough pain.

Can I take opioids with other medicines?

Yes, morphine does not usually cause problems with your other regular medicines. In fact, it is often prescribed in addition to other pain medicines, such as regular paracetamol or ibuprofen, as they work in different ways to help reduce your pain.

What about side-effects?

There are several common side effects with opioids. Some get better after a short time, but others last longer. Your doctor, pharmacist or nurse will be able to advise you how to manage these side effects:

Constipation

Most people taking opioids will have constipation. Your doctor or nurse specialist will prescribe a laxative right from the start of opioid treatment to overcome this. It is much easier to prevent constipation than to sort it out once it has taken hold.

Sickness or nausea and vomiting

Some people may feel sick when they first start taking an opioid medicine; in most cases it should wear off after a few days. However if you do feel sick your doctor or nurse specialist can offer you a medicine to stop this.

Drowsiness

You may find you cannot concentrate or that you feel more sleepy than normal when you first start taking an opioid medicine or when the dose is increased. This should wear off after a few days.

Dry mouth

Frequent sips of cool drinks may help if your mouth is dry. Sucking boiled sweets, ice cubes, frozen segments of pineapple and melon or chewing gum may also help.

Medicines are also available to treat a dry mouth by replacing saliva in the form of oral gel and mouth sprays.

Occasionally opioid medicine can cause other side effects such as prolonged sleepiness, muddled thoughts, bad dreams, hallucinations or muscle twitching. If these occur, contact your doctor or nurse specialist for advice; it may be necessary to reduce your dose or change your opioid medicine to a different one.

What if I can't take morphine?

Most people find that morphine suits them well. If you find it doesn't suit you, other strong pain medicines may be tried. It is difficult to predict from the outset who will get side-effects from morphine. There are a number of other medicines similar to morphine which are available. Your doctor may suggest stopping the morphine and trying other oral opioid medicines like oxycodone or hydromorphone. Buprenorphine and fentanyl are opioids available as patches which release medication through the skin. They are useful for people who cannot swallow normally. Pain relief of this kind can last from 3 to 7 days depending on the type of skin patch. There are also short-acting preparations of these opioids for treatment of breakthrough pain.

Can I drink alcohol?

Taking alcohol and opioids together will cause sleepiness and reduce your ability to concentrate. When you first start taking opioids, or when your dose is increased, you should be more careful. When you are on a steady dose of opioid, you should be able to drink a modest amount of alcohol (1-2 units per day) without experiencing any extra unusual effects. When you are taking opioids you should NOT drink alcohol if you are going to drive or operate machinery.

Can I continue to drive?

UK law allows you to drive if you are taking opioid medicines. However you are responsible for making sure you are fit to drive. Because opioid medicines can make you feel sleepy, you should not drive or operate machinery until you see how it affects you as your reactions and alertness may be affected. You should only consider driving regularly if you are confident that your concentration is not impaired. You should NOT drive if your dose has changed or you feel unsafe. You do not need to inform the DVLA that you are starting an opioid medicine; however there may be other information about your illness that the DVLA needs to know. You can check this at
https://www.uk/driving-medical-conditions

How do I store opioids?

You should store opioids safely, in a cool, dark place. Make sure it is well out of reach of children, vulnerable adults and pets. It is important that only YOU take the opioids prescribed for your pain. Opioid medicines should be kept in their original containers and clearly labelled.

What should I do with unused opioid medicines?

Do NOT flush them down a toilet or throw in the rubbish bin. Return them to a pharmacist for safe disposal.

How do I get further supplies of my medicines?

You will have been given a suitable supply of pain medicine that you are taking regularly. Any medicines which you are taking for breakthrough pain may run out sooner. You can get further supplies of these medicines from your GP. Your GP and local pharmacist may also be able to provide help and advice about your medicines.

This leaflet contains important information about using strong opioid medication. We can provide this leaflet in large print, braille, on audio tape, disc and other languages or formats on request. Please contact the Patient Advice and Liaison Service on 0800 917 8504 or email pals@nhft.nhs.uk

Notes

Enclosure H

Useful websites

www.nhs.uk

www.northamptongeneral.nhs.uk

Other information

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Northampton General Hospital NHS Trust, Cliftonville, Northampton NN1 5BD.
www.northamptongeneral.nhs.uk
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NGV0000 June 2014

Medicines Optimisation Committee [MOC] Brief

Committee Meeting:	Medicines Optimisation Committee ()			
Topic:	Pre-emptive prescribing at the end of life for those patients with a "personalised care plan for the dying person and family"			
Background:	In response to national priorities from the leadership alliance for end of life care the Liverpool care pathway is being removed from practice as of 14th July 2014. We have produced an initial assessment form to be completed by the name consultant and ward team. The personalised care plan for the dying person and family includes advice on how to manage common symptoms and includes the pre-emptive prescribing flow charts. That have been reviewed and updated in line with the Palliative Adult Network Guidelines (PANG) (2011) and approved by Dr Riley consultant in palliative medicine. To note the PANG doses are lower than those recommended by the LCP v12. This pre-emptive guidance will be piloted on EAU and TB from the 23rd June and is intended to be used across the trust by 14th July.			
Consultation Process *(Directorate related to and contacts involved)*	**Directorate related to:** Please complete this section		**Directorate contact:**	**Pharmacist:**
	Anaesthetics	Yes/No		
	Child Health	Yes/No		
	Head & Neck	Yes/No		
	Medical	Yes/No		Gill Williams/Karin Start
	O&G	Yes/No		
	Oncology & Diagnostics	Yes/No		Simon Stapley
	Surgery	Yes/No		
	T&O	Yes/No		
	Trustwide	Yes/No		Nicola Bryan
Committee Action:	For ratification / re-ratification / approval			
Author:	Kerry Messam, Macmillan Specialist Palliative Care CNS			
Date:	13th June 2014			

Enclosure H

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Organisational Effectiveness Strategy
Agenda item	12
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Janine Brennan, Director of Workforce & Transformation
Purpose	For Approval
Executive summary The attached report is the Organisational Effectiveness strategy for the trust which addresses a number of key strategic challenges faced by the trust.	
Related strategic aim and corporate objective	Focus on Quality and Safety Exceed Patient Expectations Strengthen our local services Enabling excellence through our people Ensure a sustainable future
Risk and assurance	The report provides assurances that we are addressing a number of our key risks and challenges, for example the staff survey results and Cost Improvement Challenge
Related Board Assurance Framework entries	BAF 1, 12, 14, 16 and 19.
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	No

Enclosure I

Actions required by the Trust Board

The Trust Board is asked to:

- Approve the strategy

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26 June 2014

Organisational Effectiveness Strategy

1. Introduction
The attached document sets out the Organisational Effectiveness strategy for the trust which addresses a number of key strategic challenges faced by the trust.

The approach outlined in the strategy has been discussed and debated by the board on a number of occasions.

2. Body of Report
The strategy sets out our approach called '*Connecting for Quality, Committed to Excellence*' which is underpinned by 7 strategic work streams.

3. Assessment of Risk
The strategy is designed to address a number of challenges and risks faced by the trust, including, but not restricted to, the results of the annual staff survey which has been poor for a number of years.

4. Recommendations/Resolutions Required
The Board is asked to approve the strategy.

5. Next Steps
The strategy will be implemented in accordance with the timeline contained in the strategy

Enclosure I

Northampton General Hospital

Organisational Effectiveness Strategy

Our Journey to Excellence

Enclosure I

Connecting for Quality, Committed to Excellence

Our Journey to Excellence.

Our vision

This document sets out our organisational effectiveness strategy to move us from where we are now to where we want to be, which is an organisation that delivers the best possible care to our patients – this is our journey towards excellence.

But to start – what do we mean by Best Possible Care and how will we know when we have got there? We will know this because we will be able to tell the story of how we:

- Went from 24 out of 28 key indicators being in the lowest 20% of the country in the annual staff survey to having at least 75% of our key indicators being in the top 20% and staff tell us it's a great place to work
- Improved our patient safety performance seeing year on year reductions in patient harm events
- Improved our patient experience scores from 'within expected' to better than expected
- Moved from 'just getting by financially with help', to being self-sufficient, and delivering a surplus so that we can invest in our services in a measured and prudent way
- Consistently achieve our targets including moving from being a trust that had achieved its urgent care target for 3 months out of 24 to consistently and indeed exceeding that target, effortlessly.

But above all else we will be able to say that we are well on our way to achieving our vision of delivering best possible care and we know this because at least 95% of our patients would recommend us.

This is the story of our search for excellence.

Introduction

This strategy sets out an approach to enable our Trust to become a more integrated, aligned organisation focussed on achieving our vision of providing best possible care to our patients and maintaining clinical, financial and operational viability as a stand-alone DGH. To do this we must work in a joined up way, avoiding unnecessary duplication and disconnections, minimising wasted activity that don't add value and most importantly engaging all our staff and nurturing their commitment to continuously improving care. This is the primary focus of our ***Organisational Effectiveness strategy.***

The aim of this strategy is to identify, design and build the organisational capabilities that will enable the trust to achieve this and ensure lasting organisational health and viability for today and tomorrow.

Organisational Effectiveness Strategy

Gap analysis and Overview

An initial assessment of our current state was undertaken, based primarily on qualitative feedback from staff and data from for example staff surveys. This analysis highlighted the following key strengths within NGH:

- Examples of innovation – e.g. ward round project (urgent care programme)
- The trust constantly strives to develop services rather stand still e.g. maternity capital developments
- A clear, coherent Patient Safety strategy that focusses on the key issues
- A Board that focusses on quality despite financial pressures
- The Board's genuine commitment to staff engagement
- There are some exceptionally talented and committed people who work in the trust
- Staff turnover is low because staff like the 'family' culture.

However equally the trust has faced challenges that it has to date been unable to address including:

- Year on year staff survey results that indicate a lack of engagement and commitment
- Operational performance targets are not consistently achieved e.g. Urgent care, cancer

- Achievement of our statutory break-even financial duty, but often through obtaining additional funding from PCTs/CCG's in the past.
- Patient experience consistently rates as 'within expected' range
- There are from time to time unacceptable patient safety failures such as at an individual patient level e.g. avoidable pressure ulcers and at a team level e.g. recent whistle blowing events.

To address these we want to:

- Develop a clear line of sight/direction for people to rally around
- Provide consistent, supportive leadership.
- Improve the way we lead change – providing a consistent approach and supporting our staff that are affected by change
- Develop an 'NGH way' that guides our behaviour's.
- Find new ways to engage and involve our staff in things that really matter – quality of care and making NGH a great place to work
- Develop and support managers to be the best they can and manage effectively the competing demands placed upon them.
- Help our staff to find different ways of working, removing unnecessary bureaurocracy and working efficiently
- Get better at systematically improving our performance and dealing with it when we don't - a performance focussed culture, which focuses on the right things in the right way.

Bu ultimately it is about greater alignment- the people and systems in the organisation must 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.

Connecting for Quality, Committed to Excellence

Our journey to excellence requires a relentless focus on quality improvement, innovation (doing things differently) and efficiency to ensure we get it right for each and every patient we provide care for. By organising around the principle of quality and efficiency this will increase the likelihood that any service change and improvement make sense for patients and clinical teams. Working together in this way we will be able to provide a quality patient experience, improve clinical outcomes, deliver value for money and make it a better place to work, train and learn.

Connecting for quality will form our staff engagement strategy which engages all staff around the common goal of quality improvement. Staff engagement will therefore shift from a series of isolated engagement 'events' to a new way of creating a systematic process to increase connections between staff in order to facilitate the potential for diversity and thus creativity.

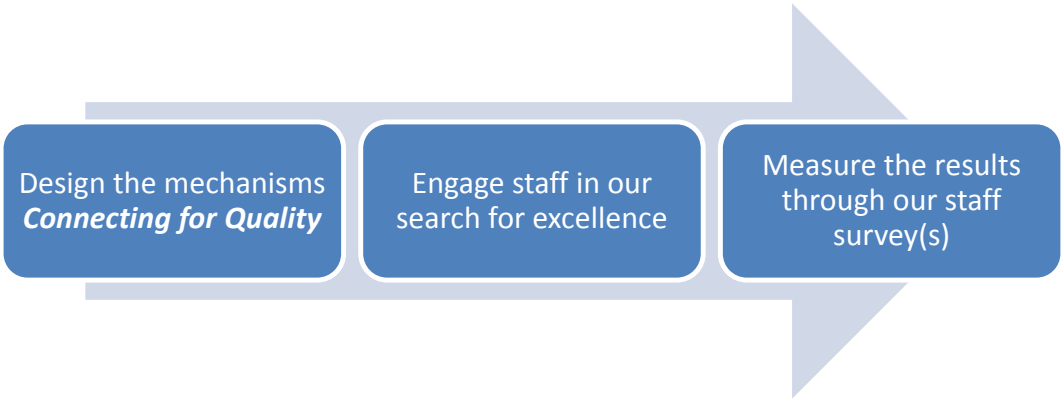
Being *Committed to Excellence* means aligning everyone around a common purpose of quality and aspiring to excellence, and to do this we need to define excellence at every level and embed it into our way of thinking/and working.

Connecting for Quality– our staff engagement strategy

It is acknowledged that since 2003 when the staff survey was first implemented, the results for NGH have been consistently poor. There is evidence of action plans designed to address this but to date they have had little or no impact, indicating that the issues are deep rooted and probably cultural. This suggests that actions targeted at individual findings within the survey will be unsuccessful and therefore a different approach is warranted. This needs to be systematic and integrated with a long term approach to affecting a real change in staff engagement and levels of staff satisfaction.

In 2012/13 we implemented Listening into Action (LiA). This had differing degrees of success and what we learnt most from this is that it is essential to integrate the principles of LiA locally and sustainably, so that it is embedded in day to day practice and isn't seen as just another initiative. On this basis we took the first step towards this in 2013 by training our line managers in the principles and tools of LiA so that they could continue the drive to improve staff engagement locally.

The *Connecting for Quality*, staff engagement strategy builds on these principles by embedding staff engagement locally, supported by opportunities for staff to get involved corporately in our search for excellence. The strategy will therefore include



Designing the mechanisms

This is about engaging staff individually and collectively around our *search for excellence* putting staff in teams in the driving seat of improving ***their*** service and managing ***their*** change programmes, through the Annual IQE programme (see *'Managing for Quality'* section below). This means that all staff will be actively involved in identifying areas for improvements for their services, and across the trust. All service areas will identify annual quality and efficiency improvement programmes. The teams will identify the opportunities, defining what improvement looks like and be supported to make those changes happen within their service area.

This requires us to create a new language and dialogue around inspiring everyone to deliver excellence as standard –which will mean that we need all staff to think about and talk about how they can help us on our journey to excellence. To do this we will brand our staff engagement, including events: ***In Search of Excellence at NGH.*** This will involve staff in conversations around how they can:

- challenge things and people that get in the way of great patient care e.g. lack of collaboration
- produce value – namely achieving good outcomes as efficiently as possible; tackle variation, find ways to increase productivity, develop new ways of working, strip out waste, stamp out bureaucracy without a purpose
- organise themselves within their teams to deliver the best performance and remove barriers that get in the way
- access training and development to help them get the best results
- Make NGH a great place to work where people can realise their potential and have the highest levels of job and work satisfaction.

The evidence shows us that from this will flow improvements in:

- **Staff satisfaction** through being connected in our search for excellence to enable us to deliver the best possible care and being supported to really make a difference to improve care and work at optimal levels with colleagues in meaningful way. And through that...
- Improvements in **Patient care** in terms of safety, healthcare outcomes and experience.

These results will be measured through our staff surveys, our staff friends and family test results and patient experience feedback.

Strategic Themes

Our ***Committed to Excellence, Connecting for Quality*** strategy will be underpinned by a number of work streams and programmes designed to help us on our journey to excellence, these include:

Committed to Excellence

Connecting for Quality

- **Making Quality Count** moving from traditional approaches to cost improvement to using quality and efficiency improvements to improve patient experience and care and deliver greater efficiencies
- **Leading for Excellence** developing leaders who engage staff in such a way that staff want to improve everything they do rather than feel they have to
- **Managing for Quality** developing and supporting managers so they have the skills, confidence and competence to manage the multiple demands placed upon them
- Developing a **Culture of Excellence** helping staff to understand where to focus their energies so they can all contribute towards our common goal of delivering excellence
- **Enabling Quality** organising and structuring ourselves so that we are best able to achieve excellence in all we do.
- **Changing for the Better** providing a consistent framework for managing change
- **Rewarding Excellence** recognising and rewarding those individuals and teams that strive for excellence in their day to day practice.

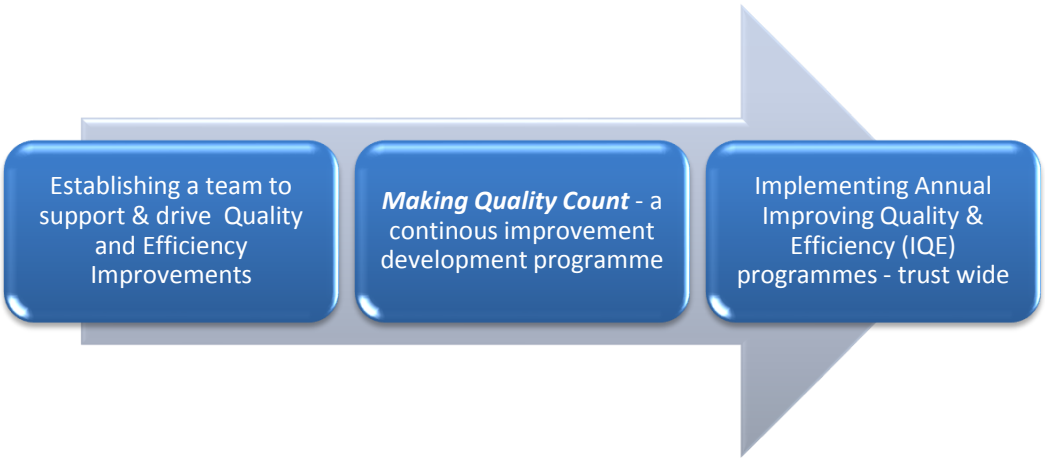
Making Quality Count

Patients and the general public have the right to expect that healthcare services provide good value for money and high quality care. To do this requires the trust to adopt a systematic approach to continually reviewing and renewing services, driving out inefficiencies and maximising the ability of staff to do what they do best

Our **strategy** is to deliver highest quality and highest value care by integrating quality, patient safety, and cost improvement and engaging all our staff around delivering this thereby enabling us to achieve viable and sustainable cost reductions. It's about improving quality *and* being more efficient but most importantly quality must drive efficiency not the other way round.

Staff are the experts in their area and know what gets in the way and how it could be improved. This will require a shift from 'Transformation' – centrally driven, top down to Improving Quality and Efficiency (bottom up and across).

The key work streams in *Making Quality Count* are



Establishing an IQE team

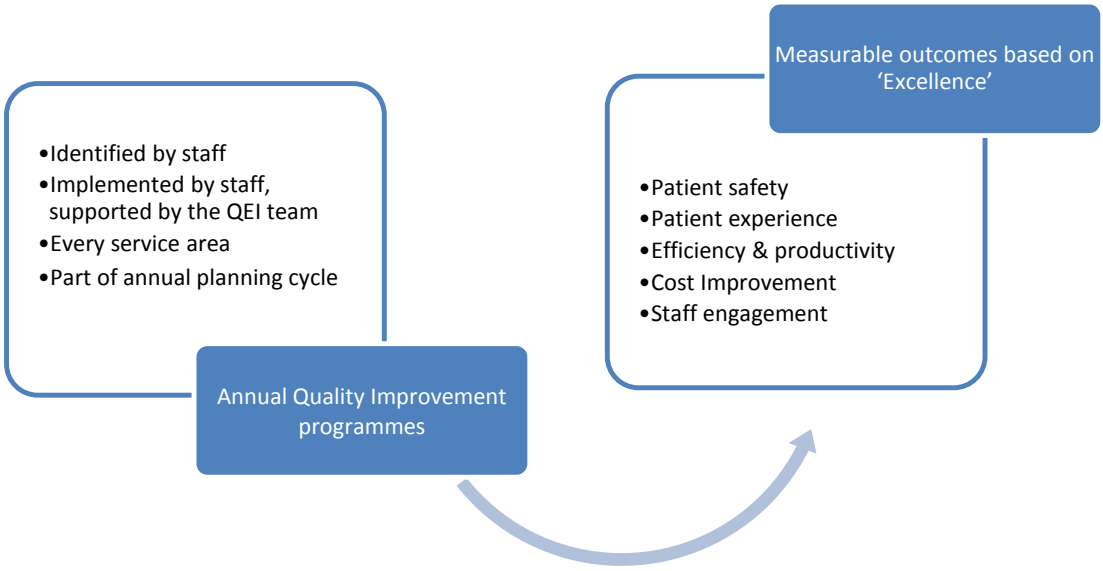
The IQE team that is now in place will be responsible for supporting teams to drive quality and efficiency improvements in their areas and developing the capability of staff to identify and deliver their annual IQE programmes.

***Making Quality Count* – a continuous improvement development programme**

We are implementing a training programme in quality, safety and efficiency improvement, starting with line managers and leaders and then extending that to other staff groups. This programme will be built around the NGH Improvement methodology and use a learning through doing approach that will include some learning and refection, away from the workplace (off line), together with periods of time working through their identified programs of improvement (on line) – see Appendix 1.

Implementing Annual Quality & Efficiency improvement programmes:

The greatest change will be in introducing local quality and efficiency improvement programmes. An annual programme will be developed based on diagnostics undertaken in service areas and staff/team ideas. It will look like this:



This approach will see a focus and energy on implementing quality and safety improvements and clearly identifying the benefits that will flow from this including:

- Quality improvements and improvements in patient experience
- Cost reductions
- Efficiency improvements e.g. throughput and flow leading to reduced length of stay
- Improved productivity, leading to the ability to deliver more with fewer resources
- Reduction in costly patient safety incidents
- Redesigned pathways that improve patient experience and efficiency
- Reduction in unnecessary waste and duplication
- Rationalisation/elimination of unnecessary, non-value added activities that improve cost effectiveness.

Leading For Excellence

Evidence shows that leadership behaviours significantly influence organisational culture, are a key determinant of staff engagement and motivation and have an impact on the ability to successfully implement change management programmes. Our leaders and their behaviour are therefore critical to ensuring the organisation successfully achieves its vision, goals and values.

Leadership is concerned with:

- Establishing vision
- Aligning people
- Motivating and inspiring

And its focus is therefore on **leading change.**

Our **strategy** is to recruit, develop and support leaders through the creation of a framework that encourages leaders to display effective leadership behaviours and motivate and inspire staff to work towards the trust goals and objectives.

The key work streams in Leading for Excellence are:

Creating an NGH Leadership model

A Leadership model has been developed that is based around our leaders being:

- *Leaders who are trusted*
- *Leaders who are committed to excellence*
- *Leaders who motivate staff*

An outline of the Leadership model is set out at Appendix 2.

Recruiting & developing our leaders

A Leadership development programme will be implemented to enable leaders to develop and implement the skills and behaviours required. We will also develop a mechanism to include an assessment against the leadership behaviours when we recruit to leadership roles.

Embedding leadership

We will do this by:

- developing a 360 degree leadership feedback tool
- Incorporating the leadership framework with the appraisal process for managers and leaders
- Measuring our leaders performance through staff surveys and other feedback mechanism

By taking a baseline of our leadership effectiveness in 2014 (using questions based on the new leadership framework), through the staff survey, we will monitor and improve our staff ratings on the effectiveness of our leaders.

Additionally, in the annual staff survey we aim to improve our results on the key finding: 'Support from immediate Manager' from 3.37 in 2013 to 3.55 by 2016.

Managing For Quality

Managers and leaders, particularly those coming from clinical roles have a right to be clear about the expectations of their role, their responsibilities, and the resources they will have to support them, together with the development they can expect to enable them to do this effectively. Equally the trust has the right to expect managers to discharge their duties and

responsibilities effectively, focus their efforts on achieving best patient outcomes, best patient experience and delivering lowest unit costs. We also expect managers to think and act beyond the boundaries of their service and work positively to contribute to organisational success.

Management is concerned with:

- Planning
- Budgeting
- Governance
- Organising
- Staffing
- Controlling
- Problem solving

And its focus therefore is on quality, governance and stability.

Our **Strategy:** to design and roll out a Management development programme designed to improve manager's effectiveness and enable them to drive their service performance around quality and efficiency.

The key aspects of the strategy involve:

Conduct a Training Needs Analysis

We will identify the appropriate type and level of development that individuals need. We anticipate, based on current evidence that the focus will primarily be on people and resource management.

Developing and Implementing a *Managing for Quality* programme

Based on the results of the training needs analysis a development programme will be implemented. All managers from team leaders to clinical managers and senior management will be required to engage with the programme. It is expected that there will be different

levels of programmes such as: back to basics management, intermediate level and potentially advanced level management.

To support our staff engagement programme, *Connecting for Quality*, Managers will be asked to have a regular dialogue with staff, around how we improve services using the following framework:

Overall effectiveness – how does what we're doing align to our vision of best patient care?

Clinical effectiveness – how can we achieve best patient outcomes?

Patient effectiveness – how will do we improve the quality of our service and the experience that patients receive?

People effectiveness – how should we develop and deploy staff to maximum effect?

Financial effectiveness – how can we make best use of our resources to provide value for money.

This will form part of a Responsibility framework (see *'Enabling Quality'* section below).

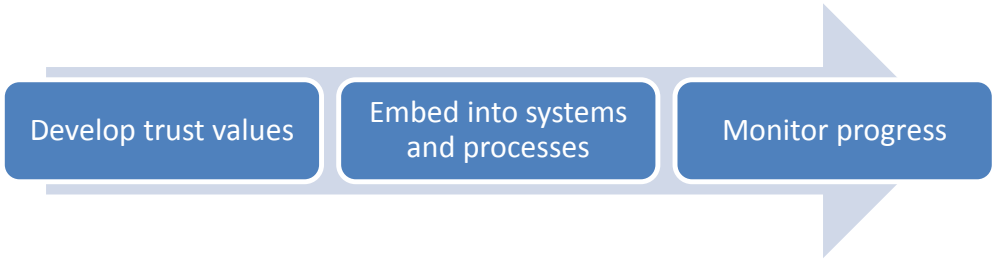
Ultimately we would aim to have in place an aspiring manager's programme. This will also set the context for a future succession planning strategy.

Results: will be measured through:

- participants feedback,
- rating of managers effectiveness through the performance appraisal process and
- service KPI's based on people, financial contribution and achievement of service targets.

Culture of Excellence

Our **strategy** is to shape our culture by developing a set of values which guides our day to day practice and behaviour, with an emphasis on patient safety, learning and improvement and supporting each other on our journey to excellence.



These values will help staff understand what is expected of them in terms of what they do and how they practice and create an 'NGH way'.

Develop the Trust values

The values were developed during 2013 through a number of working groups and surveys. These are:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each other.

Work is already in progress to communicate these new values, however to embed them in day to day practice we need to do more than this.

Embed the values

A) How our staff will live and experience the values :

We will do this by embedding values in the whole of our employment processes throughout the employment cycle. This will include:

- Redesigning our employment processes from recruitment (whereby we will incorporate the values into job descriptions and recruit people who share our values and can demonstrate the skills and aptitude to role model them daily) through induction and staff training programmes.

- Employment policies, as they come up for renewal will be reviewed against the values to see if they are compatible or need changing.

- Creating a new form of dialogue amongst staff. We will do this by introducing and rolling out a simple psychometric tool that enables staff to understand theirs and others preferences in terms of personal style and communication. This will encourage and enable staff to think about how they can best interact with their colleagues, thus demonstrating respect and support through understanding and thereby enabling conversations to take place that diffuse possible conflict by creating a common language around behaviours and understanding This may also help in

relation to the evidence we have regarding bullying and harassment claims, whereby such issues can arise as a result of a conflicting styles.

A set of behaviours that guide staff on how they live the values is attached at Appendix 3.

B) How our patients will experience those values

We will embed the values throughout the patient journey. From the first contact point patients have we will expect our staff to share with them the values and what it means for them. For example 'We put patient safety above all else', patients should be informed of this of at the earliest possible point of contact and mechanisms should be in place where patients can raise issues if their experience does not match that expectation.

The need for us to reflect, learn and improve will also be key to improving patient care so we can start to think about what feedback we ask from patients e.g. If you raised a concern did we improve the situation to your satisfaction? Did we deliver excellence at all times – if not why not?

In order to do this a task and finish group will be established, in conjunction with the patient experience lead and the patient safety team, to identify the contact points through the patient journey where the values are critical and introduce changes that reinforce the values. This will include an exercise to "walk a mile in patients footsteps," which will include involving patients, to identify those aspects that matter most to patients at various contact points in their pathway.

C) In the way we run our hospital

We will consider where there are opportunities to create reflection and consideration of our values through for example:

- Meetings/committees – encouraging reflection and learning and the degree to which conversations included consideration of our values
- Changing report templates to include a reference to alignment with trust values

We will undertake regular reviews of our performance against the values which shall include reflections on:

- Patient safety key performance trends e.g. Incidents, complaints, PALS, SI and Patient experience surveys.
- Examples of excellence will be recognised through our 'Best Possible Care Awards'

- Whether we 'Reflect, Learn, Improve' by, for example reviewing the frequency/recurrence of adverse incidents, evidence of learning and knowledge transfer and innovation spread
- Staff survey feedback – we will take a baseline of our performance against the values from the 2014 staff survey and we will then measure this year on year to assess progress.
- Exit interviews will include questions about our values.

Enabling Quality

Our **strategy** is to create a structure and performance framework that is an enabler of excellence.

Review and Strengthen the current structure

A recent review of our governance arrangements has resulted in a recommendation that we review our current management structure. This has been agreed based on the following:

- We see the future structure as being increasingly clinically led, to provide further impetus and create sustainable change around improving quality.
- Becoming a more 'localised' organisation by devolving appropriate decision making to staff as the experts in the delivery and development of care, initially through the Making Quality Count programme by engaging and involving more directly all clinical and other staff, in service improvement, in order to maximise our ability to drive opportunities for innovation in the way in which services are provided – this will be aligned to our management development programme and performance management framework.

Creating a Responsibility Framework

The responsibility framework will contain a simple set of expectations, particularly for leaders and managers based around getting the basics right.

There will be a number of actions needed to underpin this including:

- Successfully implementing '*Making Quality Count'*
- Better development and understanding of key performance indicators at the service/patient level to facilitate improvement and provide assurance as to performance.
- Roll out of Service Line Reporting, and importantly Service Line Management which undoubtedly presents us with an opportunity to more effectively measure, monitor and manage our business at a local level.
- Performance review and performance monitoring mechanisms need to be enhanced and leadership capability of the directorates strengthened
- Successfully implementing the *'Managing for Quality'* development programme.

Fundamentally this must be underpinned by having the right leadership style that builds staff commitment to improving patients' experience and delivering continuous performance improvements.

Creating a Performance Management culture

Firstly we will design a new approach that will be our 'Committed to Excellence' framework and its goals will be:

- To enable our people to do their best work
- To improve organisational performance
- To deepen a culture of ownership and participation – it's all our responsibility
- To identify and deal with people who are not committed to excellence or are unable to perform at the level required.

We will do this by:

I. Setting clear expectations (using the Responsibility Framework)
II. Agreeing SMART objectives as part of the appraisal process
III. Providing development for staff e.g. mandatory training and personal development
IV. Provide development for managers to enable them to hold structured quality performance contribution conversations with staff
V. Monitoring performance effectively – at the right level, to the right detail and at the right time
VI. Introducing new monitoring mechanisms such as the mandatory training performance wave
VII. Supporting individuals and teams to deliver in accordance with the required standards and expectations and holding them to account where this does not happen

VIII. For band 8c and above linking this to the non-consolidated pay element at the top of the band, potentially using a performance distribution curve to ensure that only those who deliver excellence, as evidenced within their appraisal.

IX. Taking decisions to exit individuals that are not committed to excellence, are unable to perform at the level required and/or choose to ignore organisational standards/expectations.

This work will be aligned with the outputs from the Governance review currently underway.

Results will be identified through feedback from managers, individual service improvements being successfully delivered, service areas demonstrating effective management control and delivering and exceeding against all operational targets and standards.

Changing for the Better

To lead change effectively we must adopt a systematic approach to managing change that covers people and process, and we will therefore adopt a change management process that reflects the need to help people through change.

Develop an NGH change management model.

This will be shaped through the adoption of an NGH change model that will provide a systematic approach to change management, that includes managing the emotional aspects of change with an emphasis on principles that include:

- Recognising that we're all different and we need to hear the narrative in different ways, based on what motivates us as individuals
- Understanding that people support the change they help to create

- Engaging people's energies and working on strengths not just weaknesses makes change easier
- Creating psychological safety nets for people to help them cope with change

Develop Managers and leaders to help them apply the model

Managers and leaders will receive training and development in the change model as part of both the *'Leading for Excellence'* development programme and '*Managing for Quality'* development programme.

We will measure the results of this through:

- participant feedback on training programmes
- In line with our value of 'we reflect, we learn, we improve', we will carry out post change de-briefs with staff involved where we will reflect and learn from change programmes. We aim that this will demonstrate that the majority of our change programmes were successful (compared to the typical 1/3rd success rate) and sustainability measures of programme's success.

Rewarding Excellence

We currently have some recognition systems in place, for example the Best Possible Care Awards, however we need a more systematic and integrated approach to reward and recognition that is consistent with and acts as a lever for this strategy and its underpinning strategic themes.

Strategy:

Develop recognition mechanisms.

The recognition and reward strategy will be developed in conjunction with staff through the ***Connecting for Quality*** staff engagement mechanism and will build on existing recognition processes.

We will also review and consider adopting the NHS Employers total reward system.

Implement a revised system,

It is likely that implementation will be phased using a pilot approach to ensure there are not any unintended consequences or that perverse incentives are not built in to the system either by design or default.

We will see the result of this through:

- Increased staff motivation scores, as measured through the staff survey
- Improvements in the staff friends and family test scores
- Increase in the number of improvement programmes that are successful and sustainable

Timeframes and Next Steps

Attached at appendix 4 sets out the timeline for the strategic themes and their phasing.

This will be shared with staff, using simplified narratives – an example is given at Appendix 5 that sets an out a pictorial story for sharing with staff as part of the programme of work to make this a reality.

Janine Brennan

Director of Workforce & Transformation

June 2014.

Appendix 1

Making Quality Count Programme

Audience

The programme requires the following involvement and engagement:

- Executives: attending a development programme and sponsoring change projects
- Managers: (Matrons, Clinical Directors, service managers, General Managers and Care Group Directors and Chairs – the programme works best if the teams come together for their off line learning and work together on their local improvement programmes) – attend programmes, develop and lead projects for their area(s) and engage teams in those projects
- Staff: Attend briefing session run by managers, engage in implementation and support the projects and be part of the digest phase and identification of future improvement projects.

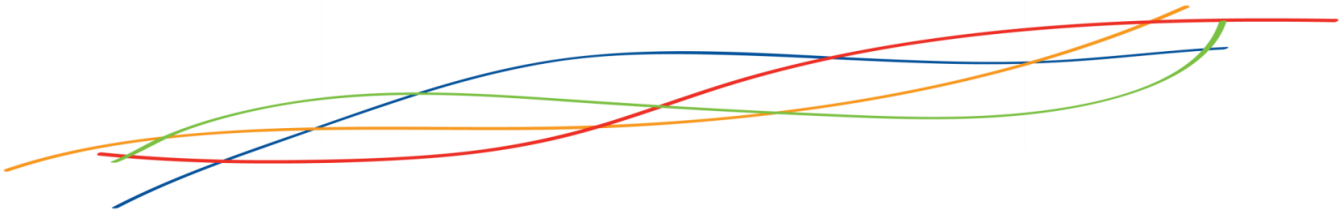
As momentum builds the development programme will evolve toward developing individual teams that wish to focus on a particular change project e.g. ward based teams.

Programme Outline

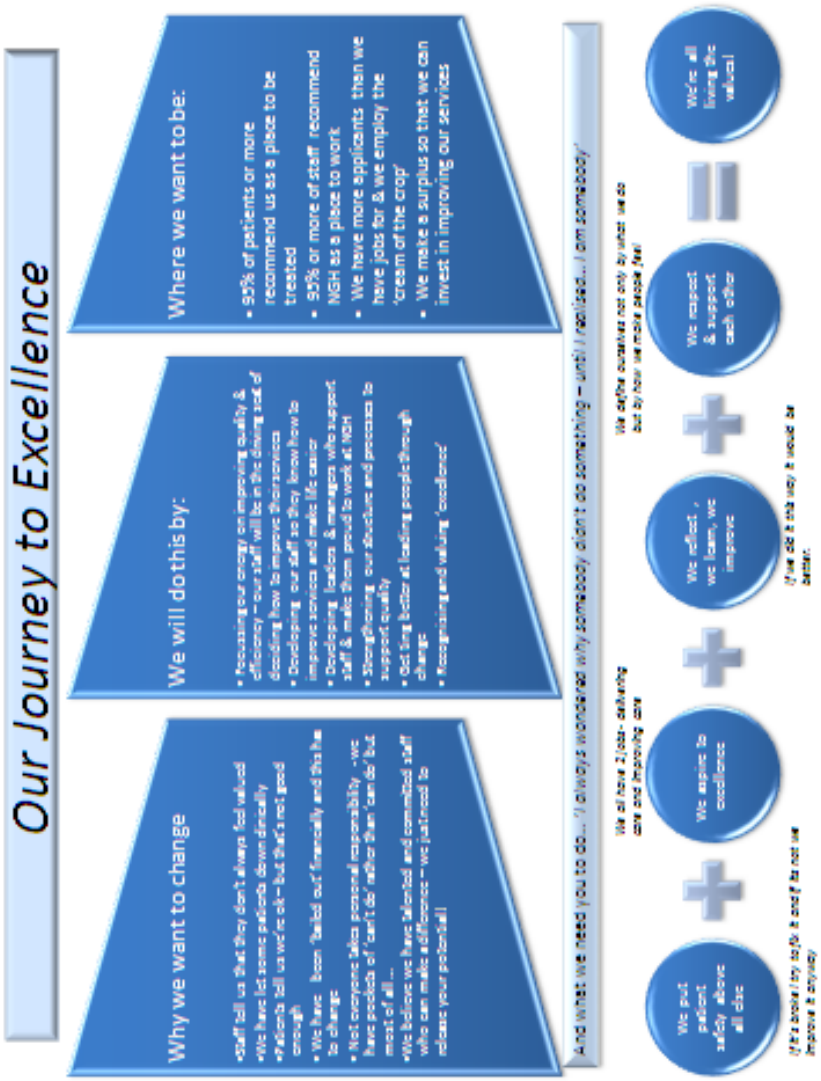
Phase	Aim	Principle actions	We will have been successful at this stage if....
Define	Define the need for the change in the context of what the service needs to deliver	Identify and capture the basic question/issue to be resolved and the vision for the project, captured through a Project delivery sheet	The Team is formed and stakeholders agree the need for the change
Describe	Establish what currently happens and what the issues are.	Understand current process, baseline performance and root causes and set targets	The team understands the process and the issues
Design	Generate, assess and prioritise solutions	Defining objective assessment criteria, generating and optimising potential solutions, developing a final solution with benefits targeted.	The team and stakeholders are committed to the chosen solution
Deliver	Do it!	Agree the implementation plan and act on it, define how to track the effect of the changes, document and communicate the changes.	The team is focussed and they know what to do, the team implements the plan and communicates the change.
Digest	Celebrate the project and reflect on its learning's	Identify realised benefits, learn lessons for the future, roll out successful improvement and celebrate, share the success	The team reflects on improvements and identifies future opportunities.

Our leaders will be…	Because….	And they will know….
Leaders who are trusted	Staff will only follow leaders if they trust them to do the right thing and support them when they take steps to improve things.	They are trusted by their staff and colleagues to do the right thing, and they know this because of feedback and the results of the staff pulse survey.
Leaders who are committed to excellence	Leaders need to have the vision and commitment to follow the path to excellence so that staff follow them on this path.	All of their direct reports have identified what excellence looks like in their role and have an agreed pathway to excellence. Their results show teams progress on the journey to excellence.
Leaders who motivate	Genuine leaders understand that they have a direct impact on the motivation and engagement of their staff.	As a leader their job is to release the talent and potential of their team As a result their staff are motivated and enjoy being at work. They know this because of feedback and the results of the staff pulse survey.

We put patient safety above all else	We reflect, we learn, we improve	We respect and support each other	We aspire to excellence
I take personal responsibility for patient safety in my working environment, I look for risks and am prepared to speak up '*This isn't right and we mustn't put up with it*'.	I take personal responsibility for my own learning	I treat others with respect and I avoid hurtful gossiping	I understand what excellence looks like for my team/service and I work to achieve that
I role model high patient safety standards so that people can feel confident in my practice	I admit to my mistakes and use them to improve my practice	I treat others as they want to be treated.	I strive for excellence in everything that I do at work
I follow all hygiene and infection control standards	I take responsibility for resolving problems that I encounter in my work	I understand that people are different. I pay attention to their different needs so that everyone is treated fairly	I share ideas for excellence with others
I make sure I am fit and able to provide the right level of care & service.	I seek to understand and get involved with changes that are happening in my area or team	I listen to other people's opinions and put my own views forward in a constructive way	I constantly look for ways to improve things and discuss my ideas with others.
If it's broke I try and fix it and if it's not we improve it anyway	I regularly review what I do and how I do it to improve my personal performance: *My Appraisal, My responsibility.*	I offer help to others when they need support	***We all have two jobs – delivering care and improving care***
	'***You know what, if we did it this way it would be better.***'	***We define ourselves not only by what we do but by how we make people feel***	




2013/14
2014/15
2015/16
Q4
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Design & organise development programme
Run Tranche 1 Medicine MQC
Run Tranche 2 Surgery MQC
Run Tranche 3 Medicine MQC
Run Tranche 4 Surgery MQC
Annual IQE programme operational
Run Tranche 5 corporate MQC
Run on-going MQC
Develop L4E
Design L4E development programme
Run L4E tier 1 programmes
Run L4E tier 2programmes
Run L4E tier 3 programmes
Design L4Q staff survey Questions
Baseline L4Q S/S results
Track results against Baseline
Design 360 degree tool
Launch 360 degree tool
Amend Appraisal
Appraisal results
Conduct TNA
Design programmme
Run Intermediate level management
Run advanced level management
Develop Aspiring Managers programme
Aspiring Managers
Develop values
Identify systems to embed
Redesign systems & processes
Communicate values
Amend appraisial process
Golden thread embedded through appraisal
Design values staff survey Questions
Baseline S/S results
Track results against Baseline results
Design FFT
Implement FFT
Develop Staff Engagment strategy
Implement staff enagagement around quality
Design Short term
Implement Short term pulse suvery
Design long term staff pulse surveys
Implement pulse surveys
Staff engage in MQC programme & Annual IQE
Develop NGH change management model
Staff development through L4E & M4Q
Review managerial structure
Create a Responsibility framework
Implement a performance management culture
Develop Reward strategy


Our Journey to Excellence
Why we want to change
We will do this by:
Where we want to be:
We put patient safety above all else
We aspire to excellence
We reflect, we learn, we improve
We respect & support each other
We're all living the values!

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Integrated Performance Report and Quality Scorecard
Agenda item	13
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. There are 22 areas that are Red rated, 3 Amber rated and 31 rated as Green.

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

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
26 June 2014

Integrated Performance Report and Quality Scorecard

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.

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.

The scorecard is accompanied by individual exception reports.

Northampton General Hospital NHS Trust Quality Scorecard 2014-15

Caring

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Complaints rate per bed days	None	⇔	0.22%	0.23%	0.24%
Complaints responded to within agreed timescales	90%	⇩	93%	76%	73%
Friends & Family Test: Inpatient score	70	⇩	74	71	57
Friends & Family Test: A&E score	60	⇔	63	57	67
Friends & Family Test: Maternity score	70	⇩	76	80	68
Mixed Sex Accommodation	0	⇔	0	0	0
Patients in last days of life with a care plan in place	None		Available from May - 14		25.0%
Transfers: All patients moved / transferred out of hours	None	⇔	N/Avail	30	31
Transfers: Patients moved with a risk assessment completed	None	⇧	N/Avail	15	23

Effective

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Emergency re-admissions within 30 days (adult elective)	None	⇧	4.9%	4.2%	4.1%
Emergency re-admissions within 30 days (adult non - elective)	None	⇩	7.9%	8.3%	9.2%
Length of stay - All	None	⇧		4.84	4.35
Length of stay - Elective	None	⇩		2.78	3.06
Length of stay - Non Elective	None	⇧		5.18	4.58
Maternity: C Section Rates - Total	<25%	⇩	29.2%	27.3%	27.9%
Maternity: C Section Rates - Emergency	<14%	⇧	16.8%	16.4%	14.2%
Maternity: C Section Rates - Elective	<10%	⇩	12.4%	10.9%	13.7%
Mortality: SHMI*	Within expected range	⇔		109.8	No Update on Dr Foster - SUS data withheld
Mortality: HSMR**		⇔	89	88	
Mortality: HSMR - Weekend**		⇔		88	
Mortality: HSMR - Week day**		⇔		89	
Mortality: Low risk conditions**		⇔		86	
Mortality: Maternal Deaths	0	⇔	0	0	0
NICE compliance	80%	⇧	81.1%	96.5%	96.6%
Number of patients cared for in an escalation area	None	⇩	115	148	187
# NoF - Fit patients operated on within 36 hours	100%	⇩	85.7%	92%	70.6%
Percentage of patients cared for outside of specialty (General Medicine)	None	⇔	11.6%	12.2%	11.0%
Stroke patients spending at least 90% of their time on the stroke unit	80%	⇧	63.0%	88.4%	83%
Suspected stroke patients given a CT within 1 hour of arrival	50%	⇧	49%	62%	58%

Safe

Indicator	Target	Trend	Mar-14	Apr-14	May-14
C-Diff	Max 2.9 p/mth	⇔	2	1	5
Dementia: Case finding	90%	⇔	90.7%	90.7%	91.0%
Dementia: Initial diagnostic assessment	90%	⇔	95.5%	100.0%	98.8%
Dementia: Referral for specialist diagnosis/Follow-up	90%	⇔	95.0%	95.2%	91.7%
Falls per 1,000 occupied bed days	5.8	⇔	5.00	5.37	4.42
Harm Free Care (Safety Thermometer)	93%	⇧	91.6%	90.4%	93.1%
Medical Notes: Availability for clinics***	99%		N/A	N/A	N/A
Medical notes: Documentation - Doctors	95%	⇧	N/A	73.2%	75.7%
Medical notes: Documentation - Nurses	95%	⇧	N/A	65.8%	66.4%
Medical notes: Documentation - Allied Health	95%	⇧	N/A	78.7%	80.5%
Medication errors (administration)	None	⇩		26	31
MRSA	0	⇔	0	0	0
Never event incidence	0	⇔	0	0	1
Pressure Ulcers: Total grade 3 & 4 hospital acquired (incidence)	None	⇩	8	11	8
Pressure Ulcers: Avoidable grade 3 & 4 (incidence)	3	⇩	7	6	8
Pressure Ulcers: Avoidable grade 2 (incidence)	7	⇩	10	12	11
Open Serious Incidents Requiring Investigation (SIRI)	None	⇩	12	12	15
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%	⇩	0.6%	0.3%	0.6%
VTE Risk Assessment	95%	⇔	97.2%	97.4%	97.7%

Responsive

Indicator	Target	Trend	Mar-14	Apr-14	May-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇧	90.4%	92.3%	94.6%
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	None	⇧	320	317	264
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	⇧	90.9%	92.5%	95.2%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	⇧	86.0%	94.3%	94.1%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	⇧	94.4%	100.0%	100.0%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇩	92.9%	88.2%	70.6%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇩	79.2%	78.0%	75.7%
Cancer: Percentage of patients treated within 31 days	96%	⇔	93.2%	94.3%	94.1%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	⇩	100.0%	96.2%	94.7%
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%	⇔	96.2%	97.9%	96.2%
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	1	0
RTT for admitted pathways: Percentage within 18 weeks	90%	⇔	95.2%	94.1%	95.1%
RTT for non- admitted pathways: Percentage within 18 weeks	95%	⇔	98.6%	98.6%	98.7%
RTT waiting times incomplete pathways	92%	⇔	97.1%	97.3%	97.5%
RTT over 52 weeks	0	⇔	0	0	0

Well Led

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Friends & Family: NHS England Inpatient response rate	25%	⇩	47.8%	33.3%	27.6%
Friends & Family: NHS England A&E response rate	15%	⇩	11.6%	16.6%	11.4%
Friends & Family: NHS England Maternity response rate	20%	⇩	39.9%	36.6%	34.9%
Data quality of Trust returns to HSCIC (SUS)	None	⇧	89%	89%	93%
Staff: Percentage of staff that would recommend the trust as a place of work (national)	59?	⇔		53	
Staff: Trust turnover rate	8%	⇔	11.8%	11.5%	11.7%
Staff: Trust level sickness rate	3.8%	⇔	4.2%	4.3%	4.3%
Staff: Trust level vacancy rate - Doctors		⇔		6.1%	7.4%
Staff: Trust level vacancy rate - Nurses		⇔		9.3%	9.1%
Staff: Trust level vacancy rate - Other		⇔		12.5%	12.5%
Staff: Temporary costs & overtime as a % of total pay bill	None	⇔	9.9%	12.3%	11.6%
Staff: Percentage of staff with annual appraisal	85%	⇧	41.7%	62.8%	64.3%
Staff: Percentage of all trust staff with mandatory training compliance	85%	⇧	75.5%	76.9%	78.1%
Staff: Percentage of all trust staff with role specific training compliance	85%	⇔		63.7%	63.9%

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	2	1	2	4	9
Effective	3	1	4	12	20
Safe	7	1	9	4	21
Responsive	4	0	14	1	19
Well-Led	6	0	2	6	14
Total	22	3	31	27	83

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

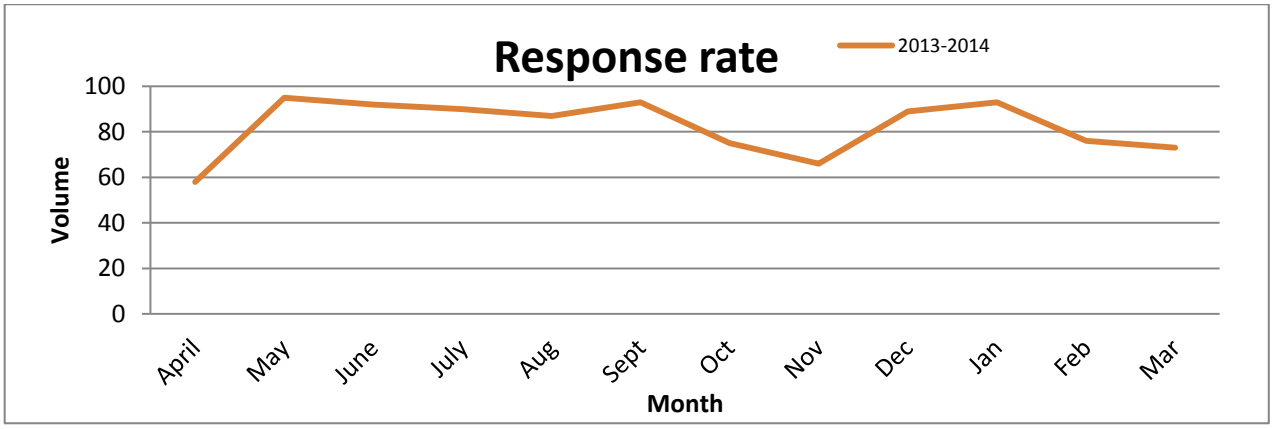
* SHMI October 2012 to September 2013 (published April 2014)
** HSMR Rolling year March 2013 to February 2014
***Currently a manual audit until central reporting is in place - June 2014

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Complaints response rate - 73% (March 2014)	Report period:	May 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. -Additional 20 hour band 5 recruited – awaiting HR clearances etc… -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. Benchmarking data has been obtained from other local acute Trust's to identify internal targets for response rates at a corporate level. The Deputy Director of Nursing & Head of Complaints have since agreed the following measures moving forwards: Below 80% - red 80-90% - amber 90% + - green
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Not possible to say at present	Most likely the same
Lead for recovery:	**Lead Director:**
Lisa Cooper, Head of Complaints	Jane Bradley, Interim DoN

Historical Target Performance



Trust Board Quality Scorecard
Exception Report

Target underperformed:	Friends & Family Test: Inpatient Services score	Report period:	May 2014

Driver for underperformance:	Actions to address the underperformance:
The Net Promoter Scores have seen a severe drop in May from April, particularly within Inpatient Services, an area which typically achieves well. There are a number of areas in particular that scored very low against the Trusts own targets; Abington Allebone Benham Cedar Collingtree Eleanor EAU Holcot Knightley	• Contact has made with all Matrons and Sisters with a request for them to feed back to the Patient Experience Lead by Monday 16th, actions that they are taking to address depreciations in scores. • They have all been advised to read the comments received from the FFT and to identify any areas of concern • Where the comments do not provide information and the score is particularly low, it is expected that the sister for the ward will investigate further any issues within their own areas. • Progress will be monitored through the following months FFT scores
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
N/A	July 2014
Lead for recovery:	**Lead Director:**
Rachel Lovesy, Patient Experience Lead	Jane Bradley, Interim Director of Patient & Nursing Services

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Friends & Family Test: Inpatient score	70	⇩	74	71	57

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Caesarean Rates – Total 27.9%: Electives-13.9% and Emergencies-14.2%	Report period:	May 2014

Driver for underperformance:	Actions to address the underperformance:
Unexpected increase of elective caesarean sections this month 13.9% national average 10%	All caesarean sections are monitored via the maternity dash board and discussed at the monthly obstetric governance meetings. The birth after caesarean (BAC) clinic is well established and embedded as usual practice. The quarterly audit report continues to demonstrate compliance against NICE guidelines. The Barratt Birth Centre opened in December 2013, to encourage and support normal birth together with the homebirth team offering a greater choice of place of birth.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
October 2014	27.0% (27.9% this month)
Lead for recovery:	**Lead Director:**
Mr Von Widekind	Debbie Needham

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Maternity: C Section Rates - Total	<25%	⇩	29.2%	27.3%	27.9%
Maternity: C Section Rates - Elective	<10%	⇩	12.4%	10.9%	13.7%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Healthcare Records Audit	Report period:	May 2014

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 SMB. With effect from **1st 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.
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	Medical Director

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Medical notes: Documentation - Doctors	95%	⇧	N/A	73.2%	75.7%
Medical notes: Documentation - Nurses	95%	⇧	N/A	65.8%	66.4%
Medical notes: Documentation - Allied Health	95%	⇧	N/A	78.7%	80.5%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Pressure Ulcers	Report period:	May 2014

Driver for underperformance:	Actions to address the underperformance:
Documentation- • Lack of pressure ulcer re-assessments in timely manner • Lack of repeated skin assessments. • Lack of evidence of care delivered/implemented. High Risk Vulnerable areas – lack of evidence that all areas checked. Device related pressure ulcers Grade 3 = 2 Grade 2 = 6 Knowledge – • Identification of at risk patients • Skills to stage/grade pressure damage • Knowledge in risk factors	Documentation – • Redesigned documentation, including plan of care which will encompass daily evaluation of SSKIN bundle. Will be trialled on 6 wards within the next month. • Audit of documentation to be undertaken within the next month. Skin inspections- • Stickers designed as short term solution to ensure Skin assessments all patients with Risk score of 15+ are performed at least once per shift. • Following the role out there has been an increase of Datix reports regarding device related pressure ulcers, outside of critical care. Device related damage- • Roll out of training for the use of pressure redistribution Pads (Aderma) has been completed. • Wards have now these devices in stock. Knowledge- • Multiple class room based training continues. • 1:1, bedside training continues • TV Buddies are now attending ward meetings and huddles, to provided support and education to staff.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
September 2014	
Lead for recovery:	**Lead Director:**
Sylvia Woods/Fiona Barnes	Jane Bradley

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Pressure Ulcers: Avoidable grade 3 & 4 (incidence)	3	⇩	7	6	8
Pressure Ulcers: Avoidable grade 2 (incidence)	7	⇩	10	12	11

Trust Board Quality Scorecard
Exception Report

Target underperformed:	UTI with catheter (safety thermometer-percentage new) (CRUTI)	Report period:	May 2014
Driver for underperformance:		Actions to address the underperformance:	
The Safety Thermometer point prevalence survey for May 2014 identified that four patients had a catheter related new UTI in May. To achieve the target of 0.4% as a proportion of the total number of inpatients in the Trust on the day of the survey approximately three patients or fewer would be the maximum limit. Root Cause Analysis of the four patients identified a number of areas of poor practice;		The CRUTI working group has been focusing on the following areas of practice: • New Catheter care plan for ward areas to use to provide evidence based care for patients with urinary catheters. These will be piloted on four of our wards • Piloting draft RCA tool for wards to complete to enable better understanding of the issues that may have contributed to the development of a catheter related UTI. • Confirm & challenge for those wards where a CRUTI was identified • Train the IPC Link Nurses on HOUDINI which enables nurses to assess the patients clinical need for a catheter and reduce the need to have urinary catheters.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
June		3	
Lead for recovery:		Lead Director:	
Fiona Barnes		Jane Bradley	

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
UTI with Catheters (Safety Thermometer-Percentage new)	0.4%	⇩	0.6%	0.3%	0.6%

. Trust Board Quality Scorecard
Exception Report

Target underperformed:	A&E 4 hours	Report period:	May-14

Driver for underperformance:	Actions to address the underperformance:
1. Volume of patients attending ED and subsequent quantity of admissions 2. Delays discharging patients with complex needs 3. Lack of flow throughout the Trust	• Working with Urgent Care Working Group South on admission avoidance to reduce ED pressures. • Introduction of IC24 in ED – streaming nurse and GP at front door • Implemented FIT (fast intervention) into ED • Improved speciality referral response processes • Daily Discharge to Assess meetings • Daily Delayed Transfer of Care meetings • Daily Community MDT meetings • Twice daily Clinical Safety Huddle • Improved structure of the Urgent Care Programme
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
July 2014	94.80%
Lead for recovery:	**Lead Director:**
Urgent Care Programme Leads	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇧	90.4%	92.3%	94.6%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Cancer Access Targets:- - *62 days of referral from hospital specialist* - *62 days urgent referral to treatment of all cancers* - *31 days*	Report period:	May 2014

Driver for underperformance:	Actions to address the underperformance:
• Reallocation policy not agreed with KGH • Recruitment to oncology positions • Need to agree pre-biopsy MRI pathway for more patients • Joint Clinic for prostate patients • 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	• Meeting between Chief Operating Officers • Locum and permanent positions being advertised / recruited to. • Urology pathway to be reviewed again as part of the cancer board. • 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
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
We are aiming to deliver the 62 day standard for Q2 but in order to do this the Trust will only be able to tolerate 30 breaches on 201 treatments. 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:**
	Chris Pallot

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇩	92.9%	88.2%	70.6%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇩	79.2%	78.0%	75.7%
Cancer: Percentage of patients treated within 31 days	96%	⇔	93.2%	94.3%	94.1%

Trust Board Quality Scorecard
Exception Report

Rachel Lovesy, Patient Experience Lead		Jane Bradley, Interim Director of Patient & Nursing Services	
Target underperformed:	Friends & Family Test: Response Rates	Report period:	May 2014

Driver for underperformance:	Actions to address the underperformance:
A&E response rates have continued to drop with May achieving below the required CQUIN target of 15%. In addition to this, Inpatient Services have seen a large drop in their response rate, although this is still within the required target, it does pose a risk that if it falls further it may slip below. Although Maternity services have seen a slight decline, they are still performing significantly above the required response rate.	• Contact has made with all Matrons and Sisters with a request for them to feed back to the Patient Experience Lead by Monday 16th, actions that they are taking to address depreciation in response rate. • An urgent meeting has been called between patient experience lead, A&E sister and the service manager to identify an improvement plan. • A more sustainable method of collecting data is currently being identified with support from finance, procurement and IT. • Areas which are continuously underperforming have been asked to contact an area that is managing to maintain the response rate and gain support for how they could improve their processes.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
N/A	June 2014
Lead for recovery:	**Lead Director:**
Rachel Lovesy, Patient Experience Lead	Jane Bradley, Interim Director of Patient & Nursing Services

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Friends & Family: NHS England Inpatient response rate	25%	↓	47.8%	33.3%	27.6%
Friends & Family: NHS England A&E response rate	15%	↓	11.6%	16.6%	11.4%
Friends & Family: NHS England Maternity response rate	20%	↓	39.9%	36.6%	34.9%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Staff: Trust turnover rate	Target	<8%	Report period:	May 2014
Achieved	11.7%				

Driver for underperformance:	Actions to address the underperformance:
This month's figure is higher than normal due to the closure of the community wards previously managed by the trust and their re-opening by NHFT.	Not applicable
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

Historical Target Performance

Indicator	Target	Trend	Mar-14	Apr-14	May-14
Staff: Trust turnover rate	8%	⇔	11.8%	11.5%	11.7%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Staff Sickness Rates	Report period:	May 2014

Driver for underperformance:	Actions to address the underperformance:
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 is above the Trust target.** • Short term sickness absence decreased by 0.25% to 2.06%. • Long term sickness absence increased slightly to 2.00% which remains below Trust Target. • The total calendar days lost to sickness absence decreased by 163 to 5915 days lost. The number of days lost per employee decreased, to 1.24 days.	
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

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%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Appraisals	Target	85%	Report period:	May 2014
Performance: Trust compliance with exception of Medical Staff – 64.30%					

Driver for underperformance:	Actions to address the underperformance:
Different appraisal processes in recent years have led to limited information being provided to the L&D Department on in-date appraisals.	On-going Appraisal audit, where evidence of in-date appraisals is seen and entered onto ESR until end June 2014 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	66.37% (64.30% in May)
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance

Indicator	Target	Trend	Jan-00	Jan-00	Jan-00
Staff: Percentage of staff with annual appraisal	85%	⇧	41.7%	62.8%	64.3%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Mandatory Training	Target	85%	Report period:	May 2014
Performance: Mandatory Training overall compliance 78.06% in May 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 RoK sessions, thereby providing sufficient capacity. Encourage A&C 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	78.75% (78.06% in April)
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance

Indicator	Target	Trend	Jan-00	Jan-00	Jan-00
Staff: Percentage of all trust staff with mandatory training compliance	85%	⇧	75.5%	76.9%	78.1%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Mandatory Role Specific Training	Target	75%	Report period:	May 2014
Performance: 63.92% Trust overall					

Driver for underperformance:	Actions to address the underperformance:
Proposed target of compliance agreed as 75% by August 2014 and 85% in March 2015 as per the Quality Schedule Scoping exercise incomplete on which roles need to do which training therefore limited assurance about the reports. Inaccuracies with data which is input into OLM and then not reported upon by ESR.	Scoping and amending OLM and ESR to ensure that reports are generated to reflect who needs to. This is almost complete and will require uploading by ESR/McKesson Continued dialogue with ESR and McKesson and increased scrutiny of reports, escalating issues where found. Mandatory & Role Specific Essential Performance Wave refined providing a trajectory to Directors to be able to challenge senior managers to assess progress against targets
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
August 2014	Trust overall percentage 67.61% (63.92% May)
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance

Indicator	Target	Trend	Jan-00	Jan-00	Jan-00
Staff: Percentage of all trust staff with role specific training compliance	85%	⇔		63.7%	63.9%

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Finance Report Month 2
Agenda item	14
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 May 2014/15

Executive summary

- The position for M2 is a £3.9m deficit giving rise to early concern in relation to achievement of the TDA plan for 14-15
- The M2 position includes the Trust estimated provisions for potential fines, data challenges and penalties. The CCG have issued total challenges of £3m in relation to the reconciliation process for April. MRET penalty "capped" at 50% above plan
- NEL activity has performed above plan again in May, giving rise to an increased provision for the associated MRET penalty
- There is slippage evident in the IQE programme delivery in month 2 and forward risk in terms of the most likely forecast delivery
- The cashflow position has remained positive although action needs to be taken to ensure loan applications are progressed in June
-

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, 18,19
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Enclosure K

Actions required by the Trust Board

The Trust Board is asked to:

- 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 2 2014/15

Report to
Trust Board
June 2014

Enclosure K

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	-£3,943	-£2,023	£ 1,919 Adv	-£7,829	-£7,829	-
Achieving EFL (£000's)				£16,337	£16,337	£0
Achieving the Capital Resource Limit (£000's)	£854	£1,106	£ 252 Fav	£19,937	£19,937	£0
Better Payment Practice Code:						
Volume of Invoices	94.09%	95.00%	0.91% Adv	93.00%	95.00%	2.00% Adv
Value of Invoices	96.67%	95.00%	1.67% Fav	94.50%	95.00%	0.50% Adv

Financial Performance

- Financial performance for the period ended May 2014 is a normalised deficit of £3.9m (April £2.2m).
- This position remains subject to full validation of case mix and coding for discharges during May.
- The position as set out in his report was submitted to the TDA on Monday 16th June in accordance with the national reporting timetable.
- The Trust is currently forecasting delivery of the plan as submitted to the TDA in April although early results suggest a significant emerging I&E risk unless robust recovery actions are implemented swiftly.

Capital Expenditure

- The full year planned capital expenditure is forecast at £20.2m and includes the latest assessment of replacement Radiology and Radiotherapy equipment schemes.
- YTD expenditure of £0.9m has been recorded for the period with 14% of the full year plan committed to date.
- 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.

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

- The EFL for 14/15 stands at £15.2m(+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 fell marginally short of the 95% target to pay suppliers within 30 days in May.

Key issues

- The position for M2 is a £3.9m deficit giving rise to early concern in relation to achievement of the TDA plan for 14-15.
- The overall expenditure run rate has remained static month on month, despite the one off costs experienced in April.
- The M2 position includes the Trust estimated provisions for potential fines, data challenges and penalties. The CCG have issued total challenges in excess of 3m in relation to the reconciliation process for April. MRET penalty "capped" at 50% above plan.
- NEL activity has performed above plan again in May giving rise to an increased provision for the associated MRET penalty.
- There is slippage evident in the IQE programme delivery in month 2 and forward risk in terms of the most likely forecast delivery.
- The cashflow position has remained positive although action needs to be taken to ensure loan applications are progressed in June.

Actions

A range of actions and recommendations are set out at section 9 and cover:

- Financial Recovery plan and actions.
- Review of IQE financial projections and targets.
- Review of outsourced activity, data capture and contracts.
- Review nurse staffing strategy and implement recommendations of temporary staffing report.
- Approach to CCG fines and challenges.
- Management of agency staff costs.
- PDC loans.

2.Financial Performance Dashboard

KPIs	May 14		April 14	March 14
Continuity of Service Risk Rating	2	Monitor CSR Rating 2.	3	2
EBITDA %	-2.6%	% Earnings Before Interest, Tax and Depreciation.	-4.5%	5.3%
Liquidity (days cover)	-11	Liquidity days cover.	3	4
Surplus Margin	-9.32%	% earnings after interest, tax and depreciation.	-10.47%	0.07%
Pay / Income	69.6%	Total YTD Pay costs as % of YTD income.	70.7%	64.3%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position (YTD)	(3,896)	Deficit before impairment and donated asset adjustment.	(2,288)	2,151
Impairment and Donated Assets	(47)	Donations and donated asset depreciation adjustment.	46	(1,954)
Normalised Position (YTD)	(3,943)	I&E position (normalised and adjusted for donated assets).	(2,242)	197
TDA Plan (Year to date)	(2,023)	Year to date TDA Plan 14/15.	(1,137)	(4,822)
CCG SLA Income Variance	(422)	SLA income £194k adverse to plan.	(194)	7,912
Value of CCG Fines & Penalties	1,634	£1.6m provision for potential fines and penalties.	1,013	0
Forecast EOY I&E postion	(7,829)	Forecast to deliver £7.8m deficit plan for 14-15.	(7,829)	197
EBITDA Performance	**£000's**		**£000's**	£000's
Variance from plan	(1,779)	Adverse variance to planned EBITDA position	(1,104)	837
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	1,049	TDA plan for YTD	545	13,000
YTD Actual	873	Actual delivered for YTD	437	11,451
% Delivered	83%	% delivery of plan for year to date.	80%	88%
LTF	8,927	Most likely delivery FY14-15	12,387	11,451
Annual Plan	12,668	Annual CIP target.	12,668	13,000
LTF v. Plan	70%	Planned annual % delivery of plan.	98%	88%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	854	Capital expenditure for year to £52k behind plan.	265	14,169
Committed as % of plan YTD	14%	% of annual plan committed.	8%	100%
Annual Plan	20,246	Includes Radiology & Radiotherapy equipment replacement.	21,501	14,221
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	(52)	Decrease in non current assets.	(446)	3,188
Current assets	(3,709)	Decrease in NHS debtors.	1,833	(8,718)
Current Liabilities	(2,404)	Increase in creditors and accruals.	3,406	(10,111)
Cash	**£000's**		**£000's**	**£000's**
In month movement	990	In month Increase / (decrease) in cash balance.	(100)	(5,901)
In Year movement	890	YTD Increase / (decrease) in cash balance.	(100)	0
DH Temporary Loans	0	TBL Loan facility of £8m requested for 14-15.	0	0
New PDC Capital	0	PDC capital required for Radiology / Radiotherapy scheme.	0	
Debtors Balance > 90 days	1,030	CRIPPS centre, NCA and Overseas Patients.	948	1,312
Creditors % > 90 days	1.13%	No material creditor balances over 90 days.	2.84%	0.00%
Cummalative BPPC (by volume) YTD	94.1%	BPPC improved in May but below 95% target.	92.0%	90.9%

Key issues

KPIs

- Shadow Continuity of Service Rating (CSR) of 2 supported by cash balance of £5.3m (April £4.3m).

I&E Position

- I&E position adverse to plan by £1.9m (April £1.1m).
- Current forecast aims to deliver plan submitted to TDA in April but emerging risk.
- Formal TDA agreement of plan expected.
- YTD Pay / Income ratio reduced to 69% in May.

Cost Improvement Programme

- CIP programme delivery is £0.87m, £0.175m adverse to plan for the period to May.
- Most likely case forecast delivery is £3.7m adverse to plan.

Capital

- Full year capital expenditure plan stands at £20.25m (includes £309k assumption for donated assets).

Cash

- Cash balances continue to be maintained with a £990k increase month on month.
- Loan applications required to secure temporary borrowing and PDC funding to support capital programme.
- BPPC performance improved to 94% by volume (April 92%).

3. 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	38,793	39,211	(418)	237,701
Other Clinical Income	2,690	343	448	(105)	2,690
Other Income	24,056	3,676	3,965	(289)	24,056
Total Income	264,446	42,812	43,624	(812)	264,446
					0
Pay Costs	(175,834)	(29,790)	(29,381)	(409)	(175,834)
Non-Pay Costs	(77,985)	(14,140)	(13,679)	(461)	(77,985)
CIPs	0	0	0	(0)	0
Reserves/ Non-Rec	(2,250)	0	97	(97)	(2,250)
Total Costs	(256,069)	(43,930)	(42,963)	(967)	(256,069)
					0
EBITDA	8,377	(1,118)	661	(1,779)	8,377
					0
Depreciation	(12,268)	(2,045)	(2,045)	(0)	(12,268)
Amortisation	(10)	(2)	(2)	0	(10)
Impairments	0	0	0	0	0
Net Interest	29	4	5	(1)	29
Dividend	(4,409)	(735)	(735)	0	(4,409)
					0
Surplus / (Deficit)	(8,281)	(3,896)	(2,115)	(1,780)	(8,281)
Normalised Postion:					
Donated Assets	452	(47)	92	(139)	452
Impairments	0	0	0	0	0
I&E Position	(7,829)	(3,943)	(2,023)	(1,919)	(7,829)

I&E Performance

- Financial performance for the period ended May 2014 is a normalised deficit of £3.9m, compared to a planned deficit of £2.0m giving rise to an adverse variance of £1.9m for the period ended May .
- Income is £0.8m adverse to plan. (April £0.6m)
- Pay expenditure is £0.41m adverse to plan. (April £0.15m)
- Non-Pay expenditure is £0.46m adverse to plan. (April £0.15m).
- Forecast is for delivery of the I&E plan as submitted to the TDA in April however the YTD position gives risk to significant risk of delivery without remedial action plan.

Key issues

SLA Income

- Underling overperformance offset by requirement to make provision for potential fines and penalties.
- EL activity on plan in May. Daycase activity increased by 137 spells (4%) month on month but falling marginally below YTD plan.
- NEL activity above plan in May giving rise to increased MRET exposure.
- Provision for MRET fine "capped" at 50% above plan (subject to agreement with NENE CCG).

Other Income

- Overall improvement in May.
- Private Patient income £26k adverse to plan.
- RTA income £80 adverse to plan.
- Income Generation £289k adverse to plan.

Pay

- Pay expenditure £0.4m adverse to plan.
- Locum medical staff and ADH costs increased by £90k month on month to £371k in May.
- Nursing pay expenditure £178k adverse to plan overall.
- Temporary management and administration cost increasing, £258k for month of May.

Non-Pay

- Non-Pay expenditure £0.465m adverse to plan.
- Consultancy Fees £212k adverse to plan.
- Patients appliances
- Equipment hire & maintenance £126k adverse to plan.
- Non-Pay CIPs £107k adverse to plan.

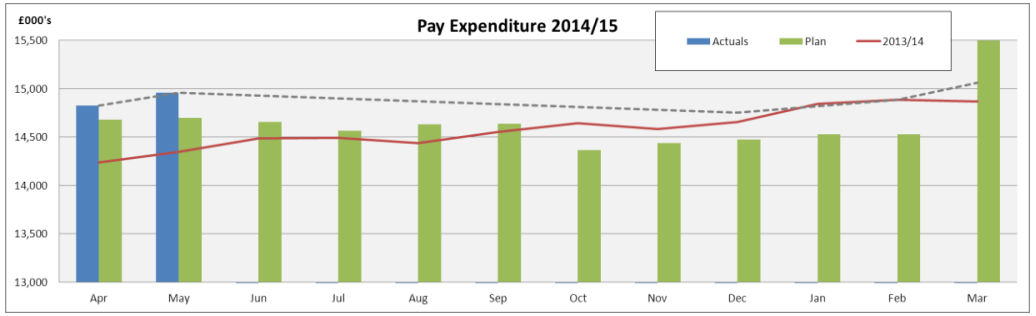
3.1 Pay Expenditure

Highlights

- Overall pay expenditure is £259k adverse in the month 2; a **YTD adverse variance of £409k**.
  This is mainly due to Nursing temporary staffing costs which are still running high despite losing the community wards, which have historically had high usage, (£139k adverse to the year to date plan). Un-validated at this stage, but it is possible that wards are using staffing levels as per the 'year 2 investment' levels; this being only budgeted for from later in the year due to phasing of the investments in the budget round.
- More significant is the under-achievement of pay CIPs; from the graph opposite it can be seen that from October pay costs are planned to decrease significantly, this is unlikely to happen based on current performance unless specific plans are progressed.
- All other staff categories are broadly in line with the plan on a year to date basis.
- Significant increase in Medical locums and ADH costs in May(increase from £345k in M1 to £476k in month 2).
- Temporary staffing costs represent **8%** of total Trust pay cost in month 2.

Actions

- An 'Agency Costs Report' has been prepared for the Finance Committee which details areas of spend and measures required to minimise spend.
- Acting Director of Nursing to issue communication about nursing investment assumptions.
- Pay CIP under-performance; specific actions are needed and will be covered in the Transformation report; action is required to address the expected, required rate of savings increases significantly in month 7.



Staff Numbers (WTE) Analysis

	Budget Month 2	Permanent Staff worked Month 2	Temporary Staff worked Month 2	Variance
	WTE	WTE	WTE	WTE
Medical Staff	515.56	461.34	29.01	(25.21)
Nursing Staff	1934.29	1640.98	201.25	(92.06)
Managerial and Administration	968.27	843.18	136.86	11.77
Other Clinical Staff	307.67	269.33	13.28	(25.06)
Scientific and Technical Staff	396.36	341.44	5.55	(49.37)
Estates Staff	30.22	24.76	1.00	(4.46)
All other Staff	405.18	353.36	54.00	2.18
Cost Challenges	-	-	-	-
Total WTE	4,558	3,934	441	-182

Permanent Staff Worked Trend

	March 2013/14	April 2014/15	May 2014/15
	WTE	WTE	WTE
Medical Staff	459.51	460.80	461.34
Nursing Staff	1740.43	1650.18	1640.98
Managerial and Administration	846.23	846.58	843.18
Other Clinical Staff	283.21	266.74	269.33
Scientific and Technical Staff	345.23	349.04	341.44
Estates Staff	26.68	25.51	24.76
All other Staff	370.19	372.77	353.36
Cost Challenges	-	-	-
Total WTE	4,071	3,972	3,934

Temporary Staff Worked Trend

	March 2013/14	April 2014/15	May 2014/15
	WTE	WTE	WTE
Medical Staff	31.55	33.69	29.01
Nursing Staff	234.95	189.43	201.25
Managerial and Administration	98.32	105.97	136.86
Other Clinical Staff	9.60	7.76	13.28
Scientific and Technical Staff	12.75	4.74	5.55
Estates Staff	1.00	1.00	1.00
All other Staff	56.10	56.09	54.00
Cost Challenges	-	-	-
Total WTE	444	399	441

Nursing - 201.25 temporary WTE being used –
this represents a high 13% of nursing costs in month 2 – an increase to previous month

Pay Costs Analysis (Month 2)

	Budget Month 2	Permanent Staff worked Month 2	Temporary Staff worked Month 2	Variance
	£'000	£'000	£'000	£'000
Medical Staff	4,090	3,651	476	37
Nursing Staff	5,600	4,929	713	42
Managerial and Administration	2,323	2,071	258	7
Other Clinical Staff	974	906	119	51
Scientific and Technical Staff	1,171	1,047	16	(108)
Estates Staff	81	67	11	(3)
All other Staff	636	558	138	60
Cost Challenges	(173)	-	-	173
Total Pay Cost	14,702	13,229	1,732	259

Permanent Staff Pay Costs

	March 2013/14	April 2014/15	May 2014/15
	£'000	£'000	£'000
Medical Staff	3,765	3,611	3,651
Nursing Staff	4,958	4,858	4,929
Managerial and Administration	1,904	2,063	2,071
Other Clinical Staff	913	861	906
Scientific and Technical Staff	1,047	1,065	1,047
Estates Staff	67	63	67
All other Staff	578	596	558
Cost Challenges	-	-	-
Total Pay Cost	13,233	13,118	13,229

Temporary Staff Pay Costs

	March 2013/14	April 2014/15	May 2014/15
	£'000	£'000	£'000
Medical Staff	436	345	476
Nursing Staff	756	844	713
Managerial and Administration	231	245	258
Other Clinical Staff	72	124	119
Scientific and Technical Staff	(13)	3	16
Estates Staff	19	2	11
All other Staff	133	148	138
Cost Challenges	-	-	-
Total Pay Cost	1,634	1,711	1,732

Nursing B&A costs are high in Month 1 despite loss of community wards

Enclosure K

3.2 Non- Pay

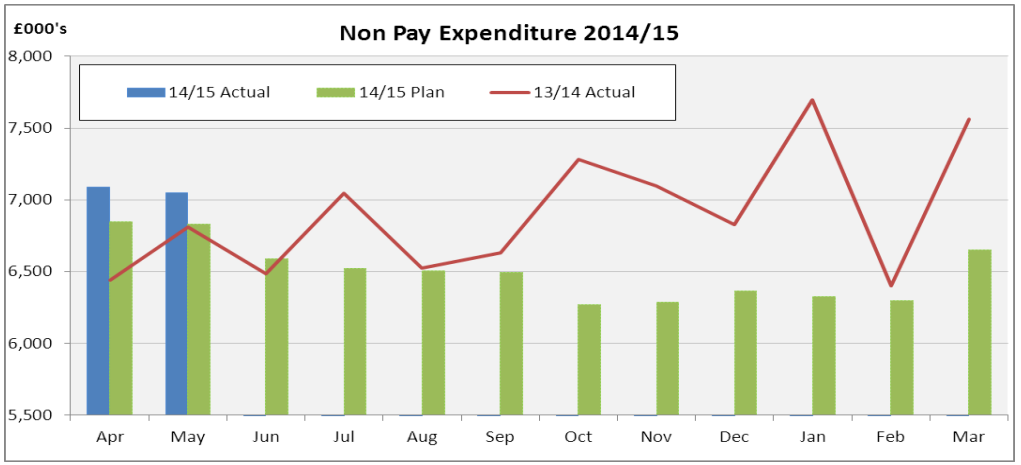
Highlights

- Non-Pay expenditure £216k adverse to plan in month of May; **a YTD adverse variance to plan of £461k.**

- Despite one-off consultancy costs in April dropping off, the operational costs have picked up with activity being higher in May than in April ; effectively off-setting the benefit from no one-off costs.

- **Clinical costs** are £181k adverse to plan (2%) and linked to activity levels.

- **Non Clinical costs** are 271k adverse overall;
- over-spending items are due to consultancy, nurse recruitment and T&O outsourcing costs as well as under-performing non-pay CIP. This in total drives an adverse variance of c.£500k
- This is then lowered to the YTD £271k adverse variance by other costs which are favourable to budget at this stage; but this could present a further risk to the plan when these start being incurred.



Actions

- Directorates need to tighten their controls on non-pay costs and be more demanding of budget holders.
- CIP plans need to be re-visited.
- Understand if the under-spending items can be held at these low levels hence avoid the risks of larger over-spends going forward.

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	6,161	6,019	(142)	3,762	3,745	(18)
Elective Inpatients	1,151	1,123	(28)	3,009	2,930	(79)
Elective Excess Bed Days	473	320	(153)	114	74	(40)
Non Elective	5,732	7,023	1,291	10,194	11,564	1,370
Non Elective Excess Bed Days	5,426	4,428	(998)	1,254	1,007	(248)
New Outpatients	10,365	9,675	(690)	1,570	1,481	(90)
Follow Up Outpatients	20,827	21,214	387	1,828	1,839	11
Non Cons Led Outpatients New	4,475	3,847	(628)	394	344	(51)
Non Cons Led Outpatients Follow Up	10,530	7,983	(2,547)	498	330	(168)
Outpatient Procedures	10,336	10,368	32	1,749	1,797	47
CQUIN		2	2	882	750	(132)
Block Contracts - Fixed				3,412	3,412	
Cost Per Case	425,736	424,349	(1,387)	6,395	6,331	(63)
A&E	15,954	16,347	393	1,657	1,730	73
Excluded Medicines				2,418	2,554	137
Excluded Devices		210	210	245	318	73
Contract Challenges		111	111	22	(758)	(780)
Readmissions				(314)	(323)	(9)
MRET				(260)	(559)	(299)
Other Central SLA Income		3	3	(10)	229	239
Productivity CIPs				394		(394)
Total SLA Income				**39,215**	**38,793**	**(422)**

Key issues

Underlying Performance
Month 2 position showing underperformance of £422k. The main driver is £1,370k over performance in non elective activity, offset by a total of £1,634k provision for challenges (£1,079k not in the plan). There is a £394k adverse variance relating to productivity CIPs which will continue to drive an adverse variance throughout the year. There is also underperformance in outpatient and elective activity.

Non Elective
The main drivers of the Non Elective over performance are: General Medicine (£710k) , A&E admissions (£385k), and Paediatrics (£80k).

Fines & Penalties
An assessment of potential fines and penalties has been deducted from the M2 income estimate. It is noted that the CCG has published its intention to recover its financial position through raising c.£3.5m of challenges to providers.
Month 1 challenges have been received and are in excess of £3m alone which includes a blanket challenge of the whole of the NEL over-performance.

CCG QIPP Schemes
Nene CCG have included £2.6m QIPP plans for 14/15. An assessment of the impact of the planned schemes is underway.

Risks
The over performance on non elective activity poses a risk to the Trust's financial position as this exceeds 13-14 outturn and incurs additional MRET penalty. This penalty has been reported as a 50:50 risk share with the CCG which has not been formally agreed. The M2 position is subject to case mix and the formal M1&M2 reconciliation process with CCGs. NENE CCG “Phase 2” QiPPs expected in Q2.

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		269	518	249	(180)	(180)
In year movements		267	1,029	762	21,501	10,239
Less depreciation		(982)	(2,045)	(1,063)	(12,268)	(9,750)
Net Book Value	143,694	143,248	143,196	(52)	152,747	309
Current Assets						
Inventories	5,136	5,318	5,311	(7)	5,119	(17)
Receivables:						
NHS Debtors	6,902	8,645	2,852	(5,793)	7,500	598
Other Trade debtors	1,710	1,453	1,378	(75)	1,800	90
Debtor impairments provision	(675)	(675)	(675)		(700)	(25)
Capital receivables						
Non NHS other debtors	236	416	510	94	250	14
Compensation debtors (RTA)	2,694	2,620	2,626	6	2,800	106
Other receivables	1,058	771	1,241	470	1,200	142
Irrecoverable provision	(548)	(548)	(548)		(600)	(52)
Prepayments & accruals	1,124	1,570	2,176	606	1,100	(24)
	12,501	14,252	9,560	(4,692)	13,350	849
Non Current Assets for sale						
Cash	4,445	4,345	5,335	990	4,547	102
Net Current Assets	22,082	23,915	20,206	(3,709)	23,016	934
Current Liabilities						
NHS	637	1,798	898	(900)	650	13
Trade Creditors Revenue	1,302	4,409	3,652	(757)	2,900	1,598
Trade Creditors Fixed Assets	3,261	1,132	1,084	(48)	5,000	1,739
Tax and NI owed	3,433	3,534	3,441	(93)	3,500	67
NHS Pensions agency	2,201	2,222	2,241	19	2,500	299
Other creditors	374	390	388	(2)	500	126
Short term loans	285	285	285		221	(64)
Accruals	6,658	8,091	6,513	(1,578)	6,500	(158)
Receipts in advance	535	426	917	491	500	(35)
PCD Dividend due		345	713	368		
Staff benefits accrual	811	712	712		750	(61)
Provisions < 1 yr	2,338	1,897	1,993	96	366	(1,972)
Net Current Liabilities	21,835	25,241	22,837	(2,404)	23,387	1,552
NON CURRENT LIABILITIES						
Short Term Loans > 1 year	341	341	341		229	(112)
Provsions > 1 year	1,384	1,384	1,384		1,384	
Net Current Liabilities	1,725	1,725	1,725		1,613	(112)
Total Assets Employed	142,216	140,197	138,840	(1,357)	150,763	(197)
Financed by:						
PDC Capital	103,611	103,611	103,611		120,619	17,008
Revaluation Reserve	35,727	35,996	36,247	251	35,547	(180)
I & E balance	2,878	2,878	2,878		2,878	
I & E current year		(2,288)	(3,896)	(1,608)	(8,281)	(8,281)
FINANCING TOTAL	142,216	140,197	138,840	(1,357)	150,763	8,547

Key Movements

Non Current Assets

- Little movement as a result of indexation and additions being offset by the depreciation charge in May.

Net Current assets

- Decrease in NHS Receivables of £5.8m, system generated £4.7m & manual adjust of £1.1m.
- Increase in Other Receivables of £0.5m, £0.4m VAT recovery (2 months claim) and £0.1m relating to the home computing salary sacrifice scheme.
- Increase in Prepayments & Accruals of £0.6m.
- Overall cash balance increased to £5.3m.

Net Current Liabilities

- Decrease in net current liabilities led by NHS and Trade creditors and accruals.
- PDC dividend accrued – 6 months dividend due for half year payment in September.
- Receipts in advance increased by £0.5m

Non Current Liabilities

- No movement on these.

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	M2 Plan £000's	M2 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	737	30	26	-4	4%	482	65%
CEF Scheme	350	200	106	-94	30%	302	86%
A&E / Orthopaedics	2,331	370	366	-4	16%	494	21%
Annual Strategic Planning Approvals	223	0	0	0	0%	0	0%
Annual Strategic Planning Approvals - MES	453	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	1,798	218	223	5	12%	263	15%
Estates Sub Committee	4,085	310	155	-155	4%	230	6%
IT Sub Committee	2,752	137	139	2	5%	1,108	40%
Other	309	4	3	-1	1%	3	1%
Total - Capital Plan	**20,246**	**1,269**	**1,018**	**-252**	**5%**	**2,882**	**14%**
Less Charitable Fund Donations	-309	-164	-164	0	53%	-183	59%
Total - CRL	**19,937**	**1,106**	**854**	**-252**	**4%**	**2,699**	**14%**

Resources - Trust Actual	
Internally Generated Depreciation - Core	11,704
Internally Generated Depreciation - Core	453
SALIX	125
SHSWTF - E Prescribing	448
MES - PDC subject to approval	7,207
Total - Available CRL Resource	**19,937**

Key Issues

- Linear Accelerator Corridor is linked to first linear accelerator replacement in the MES FBC, located in the existing bunker and has now been removed from the 2013/14 plan.
- MES Equipment - Do Minimum FBC Option relates to the business case submitted to the TDA, a capital loan will now be submitted to the Independent Trust Finance Facility and requires a refresh of the LTFM which won't be submitted till June it's unlikely that the funding if approved will be available until September. This has now been reduced by £1.4 million in 2014/15 to a more realistic phasing.
- 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 £0.223 million and a further £0.453 million associated with the proposed MES purchases however this assumes the full year effect as per business case whilst in reality it's likely to be a part year effect - this will be remodelled on revised profile agreed with Radiology & Radiotherapy.
- Full year depreciation forecast is currently £12.157 million (was £12.268 million) which includes £0.453 million associated with the proposed MES purchases.
- Charitable Donations assumptions for additions in year has increased to £309k (this includes £100k NGH CF equipment, Health Education England £152k and NGH CF building works of £57k).

7. Receivables, Payables and BPPC Compliance

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	Total at April £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	1,452	180	591	81	600
Receivables NHS	6,698	5,177	994	179	348
Total Receivables	**8,150**	**5,357**	**1,585**	**260**	**948**
Payables Non NHS	(3,084)	(2,987)	(89)	(8)	
Payables NHS	(468)	(464)	(4)		
Total Payables	**(3,552)**	**(3,451)**	**(93)**	**(8)**	

	April 2014	May 2014	Cumulative 2014/15	Cumulative 2013/14
NHS Creditors				
No.of Bills Paid Within Target	165	170	335	1,680
No.of Bills Paid Within Period	200	180	380	2,341
Percentage Paid Within Target	**82.5%**	**94.4%**	**88.2%**	**71.8%**
Value of Bills Paid Within Target (£000's)	1,080	1,586	2,666	18,359
Value of Bills Paid Within Period (£000's)	1,164	1,643	2,807	20,478
Percentage Paid Within Target	**92.8%**	**96.5%**	**95.0%**	**89.7%**
Non NHS Creditors				
No.of Bills Paid Within Target	6,363	6,405	12,768	74,920
No.of Bills Paid Within Period	6,897	6,649	13,546	81,899
Percentage Paid Within Target	**92.3%**	**96.3%**	**94.3%**	**91.5%**
Value of Bills Paid Within Target (£000's)	7,759	8,607	16,367	87,974
Value of Bills Paid Within Period (£000's)	8,214	8,667	16,881	92,882
Percentage Paid Within Target	**94.5%**	**99.3%**	**97.0%**	**94.7%**
Total				
No.of Bills Paid Within Target	6,528	6,575	13,103	76,600
No.of Bills Paid Within Period	7,097	6,829	13,926	84,240
Percentage Paid Within Target	**92.0%**	**96.3%**	**94.1%**	**90.9%**
Value of Bills Paid Within Target (£000's)	8,840	10,193	19,033	106,333
Value of Bills Paid Within Period (£000's)	9,378	10,310	19,688	113,360
Percentage Paid Within Target	**94.3%**	**98.9%**	**96.7%**	**93.8%**

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 May
- Slight increase in over 90 day debt of £1m. Significant balances relate to CRIPPS, NCA's and Overseas Patients debt 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 (94.09% by volume, 96.67% 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	ACTUAL APR	ACTUAL MAY	FORECAST JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS													
SLA Base Payments	242,754	16,228	23,419	18,301	24,815	18,393	18,393	24,815	18,393	18,393	24,815	18,393	18,393
SLA Performance/ Other CCG Investment	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Education Payments (SIFT etc)	9,667	130	2,089	320	775	775	798	799	799	799	799	799	786
Other NHS Income	15,776	3,110	1,187	1,799	1,075	1,075	1,075	1,075	1,075	1,075	1,075	1,075	1,075
PP / Other (Specific > £250k)	264	264	0	0	0	0	0	0	0	0	0	0	0
PP / Other	12,894	953	941	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	125	0	0	0	0	0	0	0	45	40	40	0	0
PDC - Capital	7,655	0	0	0	54	0	1,211	0	4,381	230	359	0	1,420
PDC - Revenue	8,000	0	0	0	0	0	2,000	0	1,000	1,000	1,000	1,000	2,000
Temporary Borrowing	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Receivable	30	3	2	3	2	2	3	2	2	3	2	2	4
TOTAL RECEIPTS	**297,166**	**20,689**	**27,638**	**21,523**	**27,822**	**21,346**	**24,581**	**27,792**	**26,796**	**22,641**	**29,191**	**22,370**	**24,779**
PAYMENTS													
Salaries and wages	169,607	14,056	14,151	14,140	14,140	14,140	14,140	14,140	14,140	14,140	14,140	14,140	14,140
Trade Creditors	83,027	3,909	9,598	5,884	7,435	7,539	7,212	7,502	6,064	6,509	8,682	7,005	5,688
NHS Creditors	18,615	1,123	1,645	1,611	1,611	1,611	1,611	1,611	1,611	1,611	1,611	1,198	1,759
Capital Expenditure	21,067	1,749	1,231	775	635	833	1,409	2,223	2,179	4,725	1,897	1,456	1,955
PDC Dividend	4,387	0	0	0	0	0	2,183	0	0	0	0	0	2,205
Repayment of Loans	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Salix loan	301	0	0	0	0	0	177	0	0	0	0	0	124
TOTAL PAYMENTS	**297,003**	**20,837**	**26,625**	**22,410**	**23,821**	**24,123**	**26,732**	**25,476**	**23,994**	**26,985**	**26,330**	**23,799**	**25,871**
Actual month balance	163	-148	1,014	-887	4,001	-2,777	-2,151	2,315	2,801	-4,345	2,860	-1,429	-1,092
Cash in transit & Cash in hand adjustment	-62	48	-24	-86	0	0	0	0	0	0	0	0	0
Balance brought forward	4,445	4,445	4,345	5,335	4,362	8,363	5,586	3,436	5,751	8,552	4,208	7,068	5,639
Balance carried forward	**4,547**	**4,345**	**5,335**	**4,362**	**8,363**	**5,586**	**3,436**	**5,751**	**8,552**	**4,208**	**7,068**	**5,639**	**4,547**

Key Issues

- May cash balance increased to £5.3m, related to receipt in advance associated with Health Education England for June.
- Cashflow plan includes receipt of temporary borrowing of £8m during the financial year due to planned I&E deficit. Application to access temporary borrowing to be submitted to TDA in June.
- Revised capital PDC loans of £7.2m included in forecast, this was included at a level of £8.6m in the submitted TDA plan following revision with Radiology and Radiotherapy. Application to Independent Trust financing Facility (ITFF) required, supported by TDA. Requirement to update LTFM to support application.
- Capital expenditure profile includes the revised planned phasing of Radiology and Radiotherapy equipment.

9. Conclusions and Recommendations

Conclusion:

The financial position for May 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. There current level of fines and challenges proposed by NENE CCG (£3m for month of April) is not sustainable and has not been fully provided for in the financial position. Within the reported position for May, the Trust has made an assumption that the MRET penalty will be limited to only 50% of the value above plan. This position needs to be agreed formally with the CCG. The most likely delivery for the IQE programme highlights current gap of up to £3.7m in CIP delivery by the financial year end necessitating a range of mitigating actions to be developed if financial plans are to be delivered.

Recommendations & actions

- Executive Team to develop Financial Recovery Plan and strategy to address emerging financial position.
- Robust response to CCG M1 £3m challenges to income position required.
- Agreement of 50% cap on MRET penalty to be secured with CCG.
- CIP delivery – detailed review financial projections project plans and milestones to be undertaken to inform financial recovery plan.
- Actions to review and formalise contractual position in relation to outsourced activity to be taken forward with a view to exercising leverage for longer term commitments.
- Activity capture and recording of outsourced activity to be reviewed and reconciled monthly.
- 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 June).
- Increased controls over agency usage in Nursing and medical staffing required / increased recruitment
- Nurse staff recruitment strategy and ward targets to be reviewed and confirmed to all areas.
- Management and administration agency expenditure to be reviewed and curtailed.
- Reserves – review allocation and commitments against of revenue reserves to ensure mitigation for month 1 adverse deficit and future commitments (e.g. Avery beds).
- Engagement with the NTDA to understand the potential impact to NGH in relation to national announcements regarding support, RTT and winter funding.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	Improving Quality and Efficiency Report
Agenda item	15
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Paul Devlin – Assistant Director IQE
Purpose	Update to the Trust Board on the Latest Thinking Financial forecast of the Improving Quality and Efficiency Programme

Executive summary

The most likely delivery at M2 is £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 is £873k, off plan by £176k.

Related strategic aim and corporate objective	Strategic Aim 5: To be a financially viable organisation.
Risk and assurance	Action has 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 is planned in order to address the under-delivery in month 1 and 2 ensuring that the overall target of £12.668m can be delivered. Executive sponsors will be allocated and agree values at the planning phase during June-July 2014.
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**)

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

JUNE 2014

STRICTLY PRIVATE AND CONFIDENTIAL

Enclosure L

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 2 May 2014

The most likely delivery at M2 is £8.9m, against the £12.668m required delivery, off plan by £3.7m prior to mitigation (see page 4).

The plan submitted to the TDA required delivery of £1.049m in the first 2 months. Actual delivery is £873k, off plan by £176k.

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 (performance management)
- 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 to deliver a greater contribution such as centralised procurement and improvements in patient flow

Quality Impact Assessments (QIAs)

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

Maturity against QIA completion is presented on page 8. The IQE Team have continued to provided focus on this aspect over the last month in order to maximise the value of QIA'd Schemes and Themes. We currently have circa £7.2M worth of plans with completed QIAs.

An update of this progress will be reported to IHGC in line with the QIA policy. The IQE Team is driving and monitoring this progress.

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 been taken to mitigate the risk of under-delivery by integrating an additional £2.237m worth of new schemes into the existing work streams. Progress relating to this is presented on page 9.

Further mitigating is required to address the under-delivery in month 1 and 2 (see next steps) ensuring that the overall target of £12.668m can be delivered. Executive sponsors will be allocated and agree values at the planning phase during June-July 2014.

2014/15 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M2 Most Likely £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	12,005	95%	8,927	70%	3,078
Shortfall	663	5%	3,741	30%	-3,078
Total Efficiency	**12,668**	**100%**	**12,668**	**100%**	**0**
CIP delivery vs turnover	**4.6%**		**3.4%**		

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 £8.9m if delivered in full would be a 3.4% CIP.

This leaves a shortfall of £3.7m to be identified.

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Recurrent schemes	8,303	66%
Non-recurrent schemes	624	5%
Total needed to be identified	3,741	30%
Total Efficiency	**12,668**	**100%**

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Pay	3,124	25%
Non pay	2,559	20%
Income	3,244	26%
Total needed to be identified	3,741	30%
Total Efficiency	**12,668**	**100%**

Pay schemes account for 25% whereas pay costs are 68% of turnover.

This suggests that there are likely to be more opportunities from workforce related schemes.

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
CIP Schemes	5,344	42%
Run rate Schemes	3,583	28%
Total needed to be identified	3,741	30%
Total Efficiency	**12,668**	**100%**

Of the £8.9m forecast delivery, £5.3m is a budgetary CIP and £3.6m 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

	Year to date			Full year 2014/15		
Theme	Plan	Actual	Variance	Plan	Most Likely	Variance
Workforce	£40,000	£6,170	-£33,830	£239,000	£318,462	£79,462
Back Office	£0	£0	£0	£250,000	£120,300	-£129,700
Rightsizing the Organisation	£14,000	£14,000	£0	£85,000	£85,000	£0
Individual Driven Themes	£0	£0	£0	£0	£0	£0
Urgent Care	£0	£0	£0	£25,000	£10,000	-£15,000
Medical Productivity	£50,000	£17,924	-£32,076	£800,000	£252,971	-£547,030
Patient Pathways	£0	£18,000	£18,000	£537,000	£344,779	-£192,221
Nursing & Midwifery Productivity	£0	£0	£0	£1,001,000	£857,375	-£143,625
Procurement	£82,000	£119,673	£37,673	£1,249,000	£937,005	-£311,995
Directorate CIPs	£753,000	£646,677	-£106,323	£5,669,000	£4,966,419	-£702,581
2013/14 FYE	£0	£51,019	£51,019	£0	£139,854	£139,854
New Schemes	£0	£0	£0	£2,150,000	£894,800	-£1,255,200
Unidentified	£110,000	£0	-£110,000	£663,000	£0	-£663,000
Total	**£1,049,000**	**£873,464**	**-£175,536**	**£12,668,000**	**£8,926,964**	**-£3,741,036**

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.

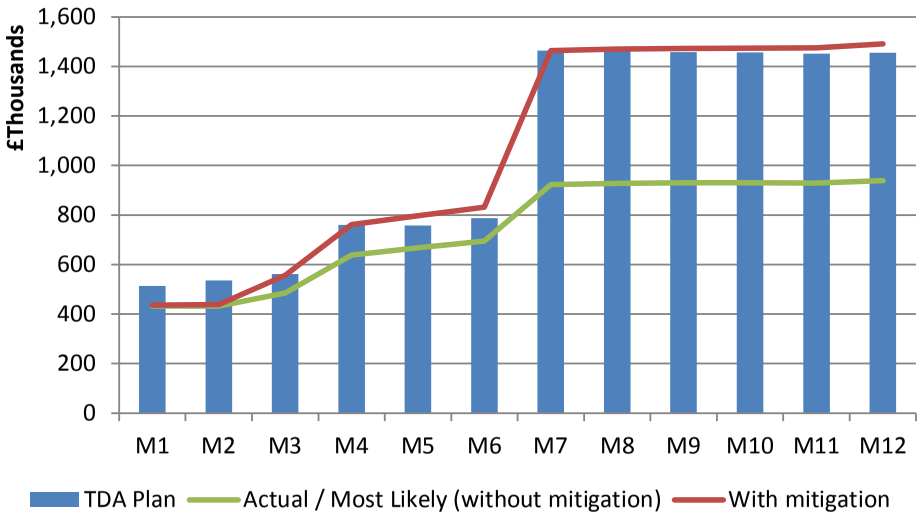
Mitigations to close the gap include

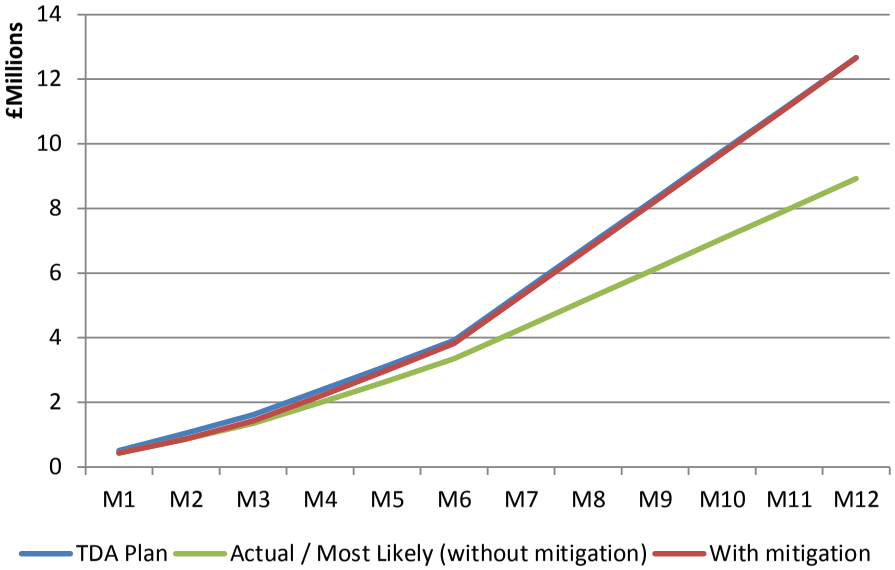
- Ensure that we convert the red and amber schemes into full delivery (£3.2m)
- Refocusing the remit of the existing Trust wide themes to include a central procurement model and expansion of patient
- flow initiatives.
- Improvement of performance management processes at Directorate level.
- Improvement 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 **Off trajectory**





Actual delivery in month 2 was £432k against planned delivery of £536k. 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 £176k behind the TDA plan at month 2. 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 £'000s	% of Total target	Most Likely with mitigation £'000s	Worst Case £'000s
Green	4,108	32%	4,108	4,108
Amber	3,440	27%	4,587	3,440
Red	1,379	11%	3,973	0
Total	**8,927**	**70%**	**12,668**	**7,548**
Gap	3,741	30%	0	5,120

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 £7.548m.

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

Scheme	FY14/15 LTF £'000 R	A	G	Total Identified
A1: Site Bed Team	-	-	-	-
A2: Surgery	200	81	103	384
A3: Anaesthetics	-	102	466	568
A4: T&O	200	140	17	357
A5: Head & Neck	50	4	35	89
A6: Child Health	-	375	176	551
A7: Obs & Gynae	42	491	46	578
A8: Opthalmology	-	425	22	447
A9: Surgical Care Management	-	-	-	-
SCG sub total	**492**	**1,618**	**865**	**2,975**
B1: General Medicine	150	-	855	1,005
B2: Pathology	-	343	86	429
B3: Oncology	10	46	111	168
B4: Radiology	5	79	31	115
B5: Research & development	-	-	10	10
B6: Pharmacy	-	-	76	76
B7: Therapies	-	-	-	-
B8: Medical Care Management	-	-	-	-
MCG sub total	**165**	**468**	**1,170**	**1,802**
C1-C7 Corporate Areas	-	80	260	340
C7: Facilities	-	611	326	937
Support sub total	**-**	**691**	**586**	**1,278**
Care Group & Corporate CIP Total	**656**	**2,777**	**2,621**	**6,054**
Workforce	219	-	231	450
Back Office	192	58	-	250
Rightsizing the Organisation	-	-	85	85
Individual Staff Lead Themes	-	-	-	-
Urgent Care	25	-	-	25
Medical Productivity	-	337	-	337
Patient Pathways	-	460	-	460
Nursing Productivity	118	955	94	1,167
Procurement	-	-	937	937
FYE of 13/14 schemes	-	-	140	140
New Schemes	2,237	-	-	2,237
Gap		-	-	526
Total	**3,447**	**4,587**	**4,108**	**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	£40,000	£6,170	-£33,830	£239,000	£318,462	£79,462
Back Office	£0	£0	£0	£250,000	£120,300	-£129,700
Rightsizing the Organisation	£14,000	£14,000	£0	£85,000	£85,000	£0
Individual Driven Themes	£0	£0	£0	£0	£0	£0
Urgent Care	£0	£0	£0	£25,000	£10,000	-£15,000
Medical Productivity	£50,000	£17,924	-£32,076	£800,000	£252,971	-£547,030
Patient Pathways	£0	£18,000	£18,000	£537,000	£344,779	-£192,221
Nursing & Midwifery Productivity	£0	£0	£0	£1,001,000	£857,375	-£143,625
2013/14 FYE	£0	£51,019	£51,019	£0	£139,854	£139,854
Procurement	£82,000	£119,673	£37,673	£1,249,000	£937,005	-£311,995
Total	**£186,000**	**£226,787**	**£40,787**	**£4,186,000**	**£3,065,745**	**-£1,120,255**

The Improving Quality & Efficiency Themes are currently projecting a shortfall of £1.12m against the required plan of £4.186m.

Workforce is off plan by £34k after 2 months due to the removal of the 35 hour scheme and no reduction in overtime payments. This is expected to deliver the target by the end of the year.

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 achieving YTD and will achieve 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 £32k after 2 months and forecasting £547k 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 £18k after 2 months due to savings starting earlier than expected. This is due to the removal of the expected PA efficiencies.

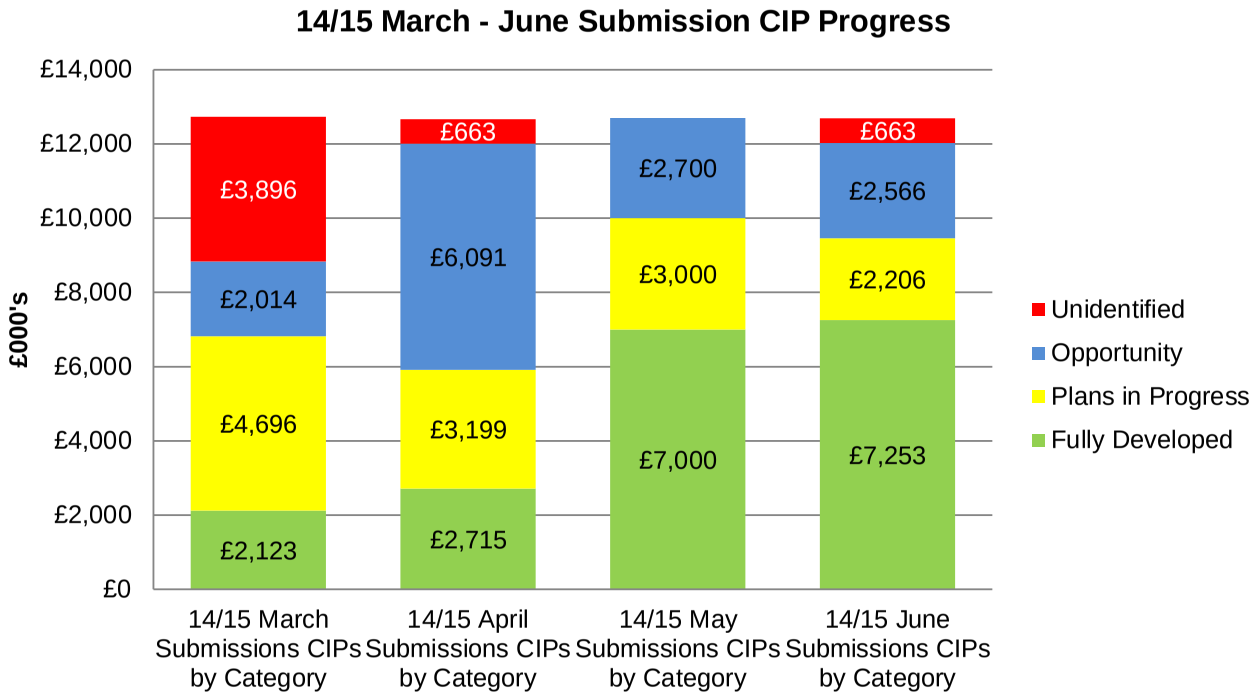
Nursing & Midwifery Productivity are behind plan by £143k . This is due to the savings being revised down due to risk.

Procurement are behind plan by £312k . This is due to a stretched target.

QIA Maturity

Northampton General Hospital NHS
NHS Trust

The completion of QIA of all schemes identified is in progress. A report on this will be provided to IHCG in line with Trust QIA policy. The IQE team is driving and monitoring the QIA of the directorate CIP schemes and taking direct responsibility for the QIA of IQE themes. The progress relating to QIA completion is presented below. This does not take account of additional schemes which are all at maturity two (opportunity).



Additional Opportunities CIP Schemes

Northampton General Hospital NHS
NHS Trust

Contingency Initiatives for 2014-2015 CIPs		2014/15 Value	Full Year Value	Progress Against Integration with Existing Themes - June 2014				
Ser.	**Strategy = Expansion of Current Themes**	4 months	12 Months	**Existing Theme Adopting Idea**	**Project Lead Assigned**	**Exec Lead Informed**	**New Value Agreed by Steering Group**	**Project Plan Updated**
1	Clinical Excellence Awards	£60	£181	Medical Productivity	Y	Y	WIP	Y
2	Sickness absence management system	£293	£880	TBC	N	N	N	N
3	Improve theatre efficiency	£270	£810	Patient Pathway	Y	N	N	N
4	Discretionary non-pay spend controls	£134	£402	Back Office	Y	Y	N	N
5	Medicines management	£402	£1,206	TBC	N	N	N	N
	Pharmacy outsourcing	£67	£201	TBC	N	N	N	N
6	Extension of salary sacrifice scheme	£67	£201	Workforce	N	N	N	N
8	Stretch procurement	£226	£679	Procurement & Commercial	Y	Y	WIP	WIP
9	Junior Doctor travel & relocation	£34	£101	Medical Productivity	Y	Y	WIP	WIP
10	Diagnostic test rationalisation	£13	£40	TBC	N	N	N	N
11	Non-elective flow average LOS	£335	£1,005	Urgent Care	Y	Y	WIP	WIP
	Repatriation of surgical procedures delivered by independent providers	£168	£503	Theatre Productivity	Y	Y	WIP	WIP
12	Clinical strategy review (Deloitte)	£168	£503	**Working Outside of IQE Themes**				
	Total	**£2,237**	**£6,711**					

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board Meeting**
Date of Meeting	**26 June 2014**

Title of the Report	Workforce Report
Agenda item	16
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 a decrease in sickness absence.
- An update on Mandatory and Role Specific Essential Training, and Appraisals.
- An overview of the Friends and Family Test
- An update on employment policies approved

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 Trust Board is asked to:

- note the report

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26 June 2014

Workforce Report

1. Introduction

This report identifies the key themes emerging from May 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:

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 is above the Trust target.

The non-medical sickness absence rate for the General Surgery Care Group increased to 4.82%. The in-month rate increased in all directorates within the Surgery Care Group with the exception of the Women's and Children's directorates, where the rates fell, and the Children's directorate figure was below the Trust target at 3.64%. The highest ward based sickness was on Althorp Ward with total sickness absence of 18.57%. Maternity Observation Ward has overall sickness of 11.87%. This is due to 2 Long Term sick cases which are actively being managed, one of which will be considered for possible ill health termination. There is extremely high activity on this high risk ward leading to high levels of stress and these concerns have been raised by employees and addressed, with 5 new midwife posts being made available. Regular listening in to action meetings take place with employees on the ward, working to address issues as they arise.

In Medical Records the total sickness rate in March was slightly increased at 8.91%. Anyone hitting a trigger point is being actively managed in line with trust policy.

The non-medical sickness absence rate for the General Medicine Care Group decreased to 4.55%, with improvement in the General Medicine & Emergency Care directorate, but increased rates in all other directorates in the Care Group.

The highest ward sickness rate was in Talbot-Butler Ward at 12.46%, with increases for both Compton (11.38%) and Collingtree (10.52%).

The total sickness absence rate within Facilities decreased in May to 3.56%. Hospital Support also saw an improvement to 2.96%, bringing the rate for Support Services to 3.20%, below Trust target.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) increased by 22.72 FTE in May to 4,329.89 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,550.86 FTE.

Substantive workforce capacity increased by 40.40 FTE to 4,080.23 FTE.

Temporary workforce capacity (excluding Medical Locums) decreased by 17.68 FTE to 249.66 FTE.

2.2 Workforce Updates

Mandatory and Role Specific Essential Training

The current rate of Mandatory Training is 78.06% and Role Specific Essential Training is 63.92% as at the end of May 2014. The Mandatory & Role Specific Essential Performance Wave is being continuously refined and all Directors will now, on monthly basis, be provided with a trajectory report to show compliance against the targets within their directorates. This can then be used to challenge managers and request action plans as to how and when rates will be improved against Trust agreed targets.

A further monthly report has 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.

It is proposed that areas that are currently achieving less than 80% compliance with training should ensure that this is identified on their Risk Register and develop action plans accordingly to demonstrate when they will achieve overall compliance. From October 2014, this target will change to 85% and therefore any action plans should reflect this increase.

Work is ongoing to monitor the accuracy of reports and report any anomalies to ESR & McKesson who are providing assistance by mass uploading information. The scoping of Role Specific Essential Training has been shared with Mandatory Training Leads and General Managers, when this information is complete it will be collated and forwarded to ESR & McKesson who will update the system with competences against positions. Although this piece of work will be completed by the end of June 2014 by the Trust, we are unable to guarantee when this information will be updated in the system; however once completed it will provide a greater level of accuracy about which members of staff will require which RSET thereby enhancing support to managers and increasing confidence in the reports provided.

Appraisals

The ongoing Appraisal audit combined with the new appraisal process has produced a compliance rate of 64.3% in May 2014. Whilst the level of compliance is increasing it is still considered to be lower than acceptable at this stage and therefore the appraisal audit will continue until the end of June. The planned audit on appraisal quality has therefore been temporarily suspended until after this point in time; however during the current audit appraisal documentation is being assessed for completeness and challenged appropriately. It is proposed that a Trust target is set to achieve an appraisal compliance rate of 85% by March 2015 in accordance with the Contract Quality Schedule.

As with Mandatory & Role Specific Essential Training it is proposed that areas that are currently achieving less than 80% compliance with Appraisals should ensure that this is identified on their Risk Register and develop action plans accordingly to demonstrate how they will achieve the target, currently 80%, moving to 85% by March 2015.

Staff Friends & Family Test

In April, we launched our first Friends and Family Test to Staff, concentrating on the non-clinical support areas. We asked if staff would recommend us for treatment; 69% 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.

These percentages are an indication of how people are feeling, but the true value of the responses has been in the free text comments. Following the free text comments, there will be a strong focus on staff engagement across the Trust in the coming months and there will be some workshops to help all staff to see how they 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. See the fuller report at Appendix 1

Organisational Development
Tuesday 2 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. 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.

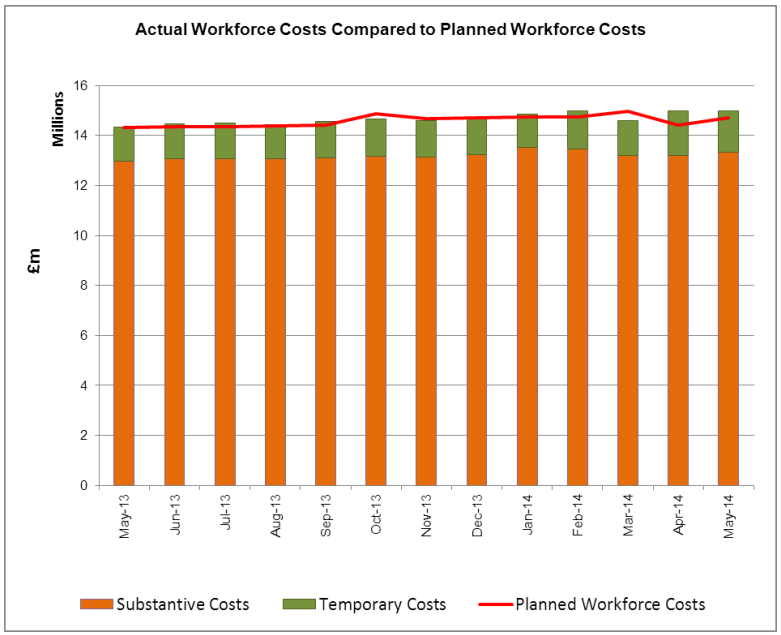
Policy Changes
The Job Banding Policy has been ratified and is now available.

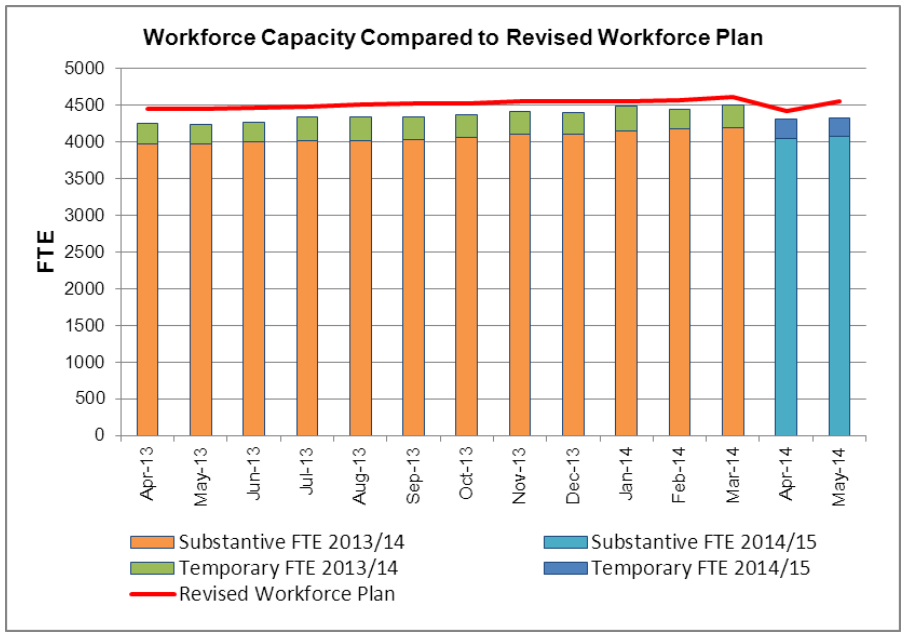
3. Assessment of Risk
Managing workforce risk is a key part of the Trust's risk assessment programme.

4. Recommendations/Resolutions Required
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 02





	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										
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										
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										

	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										
Temporary FTE 2013/14	266	263	260	329	329	305	316	303	291	334	269	324
Temporary FTE 2014/15	267	250										
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										

Workforce Expenditure

Total Workforce Expenditure (all pay elements) increased by £19,601 in May to £14.991m (this is above plan for Month 2).

Substantive workforce expenditure increased by £119,661 to £13,316,902.

Temporary Workforce Expenditure (including Medical Staff) decreased by £100,060 to £1,673,770, equating to 11.17% of the of the total workforce expenditure.

Workforce Capacity

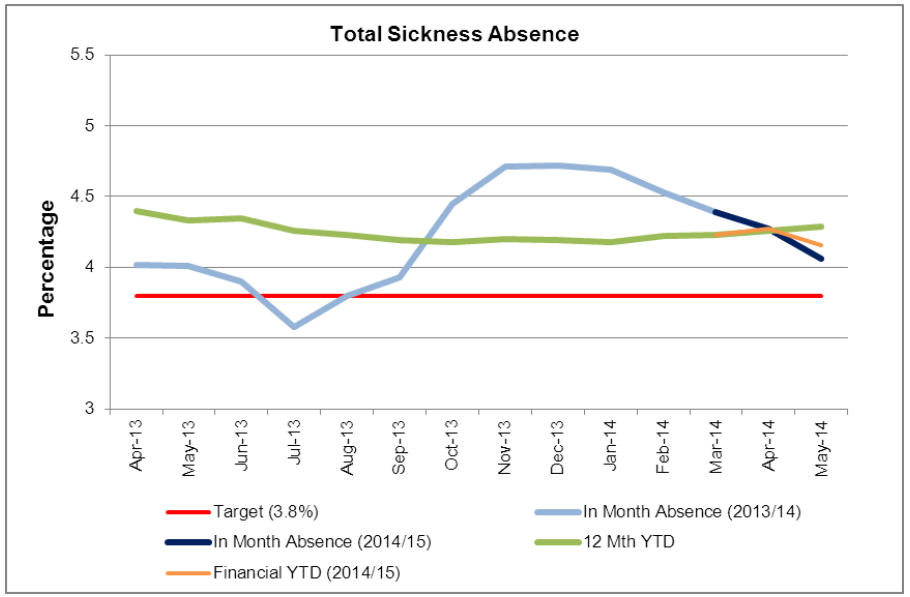
Total Workforce Capacity (including temporary staff but excluding Medical Locums) **increased by 22.72 FTE in May to 4,329.89 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,550.86 FTE.**

Substantive workforce capacity increased by 40.40 FTE to 4,080.23 FTE.

Temporary workforce capacity (excluding Medical Locums) **decreased by 17.68 FTE to 249.66 FTE.**

Human Resources Workforce Performance Indicators 2014/15 Month 02

	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%	89.67%	89.76%	92.41%	82.70%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	5.77%	8.32%	**4.46%**	**2.04%**
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 -97% Over 100%	100%	**95.16%**	97.91%	**96.73%**	84.43%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	11.69%	16.17%	**7.83%**	9.85%



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										
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										
Financial YTD (2014/15)	4.27	4.16										

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 32,017 hours (197.03 FTE), which is an increase of 4349 hours (26.76 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 42.73% (decrease of 1.41%), Agency fill rate = 31.43% (increase of 5.77%). Total bank & agency fill rate = 74.16% (increase of 4.36% compared with the previous month).
- Changes in the authorisation process for use of agency nursing may have contributed to a rise in the proportion of shifts filled by agency staff. A total of 13569 hours were covered by external nursing staff; an increase of 3398 hours over the previous month.

Sickness Absence

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 is above the Trust target.

- Short term sickness absence decreased by 0.25% to 2.06%.
- Long term sickness absence increased slightly to 2.00% which remains below Trust Target.
- The total calendar days lost to sickness absence decreased by 163 to 5915 days lost.
- The number of days lost per employee decreased, to 1.24 days.

Human Resources Workforce Performance Indicators 2014/15 Month 02

		Surgery Care Group						
		Directorate						
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck	Women	Children
Short Term Sickness Absence		1.60%	2.44%	3.88%	2.77%	2.86%	2.04%	2.10%
Long Term Sickness Absence		2.20%	2.60%	2.02%	1.96%	1.79%	2.63%	1.54%
Total Sickness Absence	Over 4.2%	3.80%	5.04%	5.90%	4.73%	4.65%	4.67%	3.64%
	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 4.82%.
- The highest ward based sickness was on Althorp Ward with total sickness absence of 18.57%. Maternity Observation Ward has overall sickness of 11.87%. This is due to 2 Long Term sick cases which are actively being managed, one of which will be considered for possible ill health termination. There is extremely high activity on this high risk ward leading to high levels of stress and these concerns have been raised by employees and addressed, with 5 new midwife posts being made available. Regular listening in to action meetings take place with employees on the ward, working to address issues as they arise.
- In Medical Records the total sickness rate in March was slightly increased at 8.91%. Anyone hitting a trigger point is being actively managed in line with trust policy.

		Medicine Care Group						
		Directorate						
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies	Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	1.47%	2.39%	2.90%	1.81%	1.37%	2.41%
Long Term Sickness Absence		2.20%	0.78%	2.02%	1.64%	1.29%	3.96%	2.40%
Total Sickness Absence	Over 4.2%	3.80%	2.25%	4.41%	4.54%	3.10%	5.33%	4.81%
	3.9-4.2%							
	Under 3.8%							

Medicine Care Group Summary

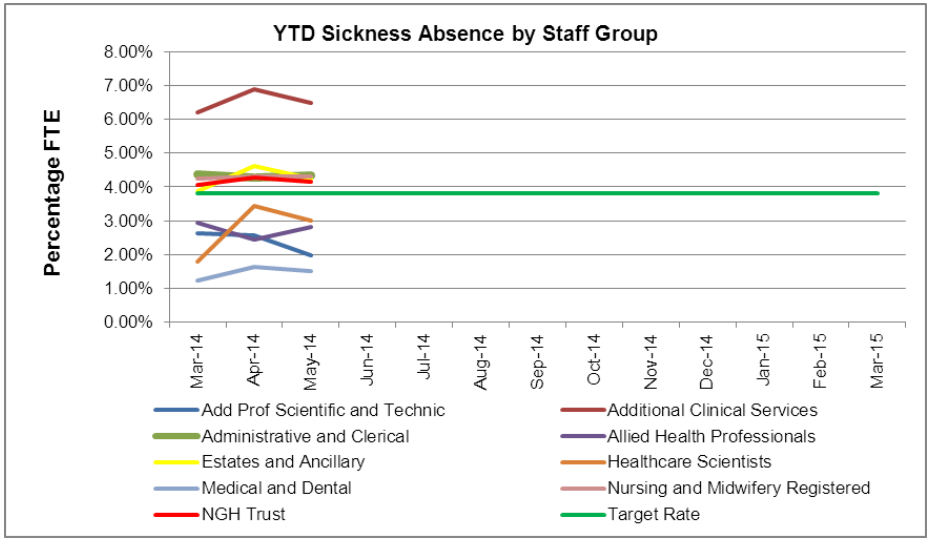
- The non-medical sickness absence rate for the General Medicine Care Group decreased to 4.55%, with improvement in the General Medicine & Emergency Care directorate, but increased rates in all other directorates in the Care Group.
- The highest ward sickness rate was in Talbot-Butler Ward at 12.46%, with increases for both Compton (11.38%) and Collingtree (10.52%).

		Support Services			M&D
		Directorate			
	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	2.00%	1.68%	0.01%
Long Term Sickness Absence		2.20%	1.56%	1.28%	1.34%
Total Sickness Absence	Over 4.2%	3.80%	3.56%	2.96%	1.35%
	3.9-4.2%				
	Under 3.8%				

Hospital Support and Medical & Dental Summary

- The total sickness absence rate within Facilities decreased in May to 3.56%.Hospital Support also saw an improvement to 2.96%, bringing the rate for Support Services to 3.20%, below Trust target.
- Medical & Dental staff sickness absence decreased by 0.30% to 1.35% in May 2014.

Human Resources Workforce Performance Indicators 2014/15 Month 02



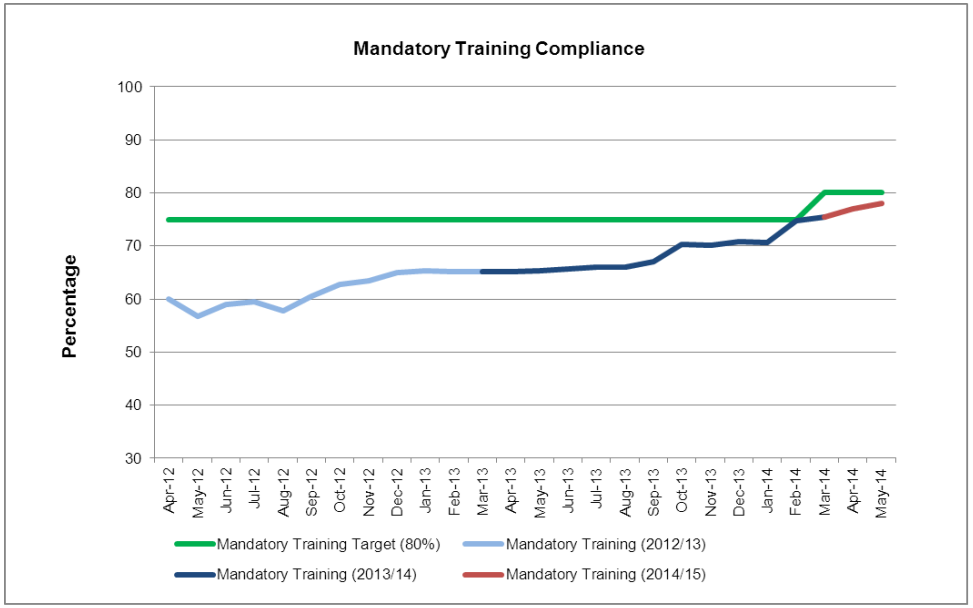
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Add Prof Scientific and Technic	2.63%	2.56%	1.98%										
Additional Clinical Services	6.20%	6.90%	6.50%										
Administrative and Clerical	4.36%	4.27%	4.34%										
Allied Health Professionals	2.94%	2.45%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

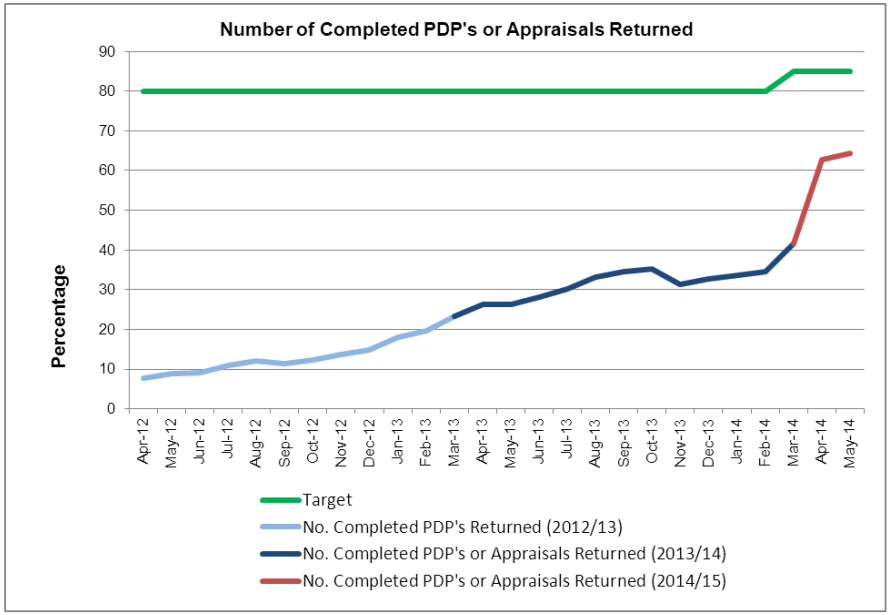
	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Support Services
Sickness Absence Rate (%) - in Month	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	4.06%	4.19%	4.25%	3.20%
No. of completed PDP's returned & completed Appraisals	Under 75% 75 -79% 80% & over	85%	64.30%	63.47%	62.56%	72.26%
% Statutory & Mandatory Training Compliance	Under 75% 75 -79% 80% & over	85%	78.06%	78.81%	76.87%	79.43%
% Role Specific Training Compliance	Under 75% 75 -79% 80% & over	80%	63.92%	65.28%	62.97%	62.86%

Number of 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 64.30%; continuing the improvement seen since March. The appraisal audit will however continue to the end of June.
- Mandatory Training compliance has increased again to 78.06%. RSET compliance stands at 63.92%.
- 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.

Human Resources Workforce Performance Indicators 2014/15 Month 02





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										

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										

We reflect, we learn, we improve

Northampton General Hospital NHS
NHS Trust

In April, we launched our first Friends and Family Test to Staff. For the first quarter, we concentrated on the non-clinical support areas and gathered surveys both electronically and on postcards. Nearly 200 of you responded and provided us with some very valuable feedback which we have now had time to look at and would like to share with you the general themes. We are taking your feedback very seriously and hope that the interventions we are putting in place will support your own drive and commitment for making NGH a great place to work

We asked you two questions	Likely or extremely likely	Neither likely or unlikely	Unlikely or extremely unlikely
How likely are you to recommend NGH to friends and family if they needed care or treatment?	69%	25%	15%
How likely are you to recommend NGH to friends and family as a place to work?	67%	18%	6%

You said	You also said	We're going to
Staff are skilled and caring, compassionate and trustworthy Professionals work hard and Doctors and nurses work well together	Staff not supported or heard or consulted with in Departmental meetings	There will be a strong focus on staff engagement across the Trust which extends on the success of the Listening in Action programme. We will continue to listen to you through the SFFT and the annual staff survey. We will be holding some workshops across the Trust to help us all to see how we can bring our values to life in our day to day work.
There is a strong safety ethos at NGH Staff are committed to the improvement of patient care There is a balance between achieving efficiency and maintaining quality care	Resources feel too stretched Unstable environment caused by change fatigue and firefighting rather than a proactive approach to service delivery	It is very encouraging that Staff believe that safety is at the top of the Hospital's agenda and this is echoed by the Safety Culture Questionnaire undertaken by Safety Champions twice yearly. The Improving Quality and Efficiency and Organisational Development teams will work closely with the Safety Academy over the coming months to ensure this is only strengthened further. We are launching our 'Making Quality Count' development programme next month, which will put the ownership for improving the quality of the care we provide at the front line.
Good conditions of employment, career progression and opportunities with good job security NGH is a friendly and supportive environment in which to work, with a good team spirit and collaborative working and that overall communication is good	Poor pension and salaries in comparison to private sector equivalent Leadership across the Trust needs to be improved Poor management relationships with staff including absence of praise and respect	We are introducing Total Reward Statements this year which will give you more details on the overall value of your employment package. We are currently developing a set of local behaviours to support the Trust and our leaders to identify development areas. A leadership development programme will be launched later in the year. We will carry out a training needs analysis and then develop an NGH managers development programme , which be challenging, but have a practical focus to ensure we have the best managers for the future.
NGH is an ethical employer and a provider of good quality care NGH is a good central location to work	There are inconsistencies in delivering basic patient care needs	We are working with HR colleagues to embed our values in all our HR processes and have started with introducing questions around our values at recruitment and exit interview. We are working to embed our values in everything we do, starting with 'walking in the patients shoes'.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 June 2014**

Title of the Report	TDA Self-Certification
Agenda item	17
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

Enclosure N

Actions required by the Trust Board

The Trust Board is asked to:

- approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for May 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:

Enclosure N

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

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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:

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:

Enclosure N

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:

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:

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:

Enclosure N

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

Enclosure N

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 June 2014
09:30 in the Board Room at NGH

Time		Agenda Item	Action	Presented by	Enclosure
INTRODUCTORY ITEMS					
09:30	**1.**	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 29 May 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 Quality Report	Assurance	Dr M Wilkinson	**E.**
	9.	Director of Nursing & Midwifery Care Report	Assurance	Mrs J Bradley	**F.**
	10.	Hard Truths Commitments regarding the publishing of staffing data	Assurance	Mrs J Bradley	**G.**
	11.	Personalised Care Plan for the Dying	Decision	Mr C Pallot	**H.**
10:25	**STRATEGIC**				
	12.	Organisational Effectiveness Strategy	Decision	Mrs J Brennan	**I.**
10.35	**OPERATIONAL ASSURANCE**				
	13.	Integrated Performance Report and Quality Scorecard	Assurance	Mrs D Needham	**J.**
	14.	Finance Report Month 2	Assurance	Mr S Lazarus	**K.**
	15.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**L.**
	16.	Workforce Report	Assurance	Mrs J Brennan	**M.**

Time		Agenda Item	Action	Presented by	Enclosure
11. 35	**GOVERNANCE**				
	17.	TDA Self-Certification	Decision	Mr C Pallot	**N.**
11:45	**18.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting will be held at 09:30 on 31 July 2014 in the Board Room at NGH

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).